Digit Life Healthy Glow Policy

(Health Plus Life Combi Product from Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd)

UIN: GODHLIP25032V012425

Policy Wordings

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Think of Digit as your running or gym buddy, keeping pace with you all the way.

This is a Retail Combi Product, combination of health insurance product (i.e., I. Digit Health Insurance Policy) and life insurance product (i.e., II. Digit Glow Term Life Insurance). Digit Health Insurance Policy is being offered by Digit General Insurance Limited and Digit Glow Term Life Insurance Policy is being offered by Digit Life Insurance Limited.

While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at:
For Health: 1800-258-4242 or mail us at healthclaims@godigit.com.
For Life: 9960126126 or mail us at lifeclaims@godigit.com.

I. Digit Health Insurance Policy

A. PREAMBLE

Based on the declaration provided by You to us, **Go Digit General Insurance Limited** (hereinafter called 'the Company/DIGIT') which forms the basis of this health policy contract, and having received your premium, we take pleasure in issuing this policy to you.

Go Digit General Insurance Limited will cover You under this Policy up to the Sum Insured, during the policy period mentioned in your Policy Schedule. Of course, like any insurance cover, it is governed by, and subject to certain terms, conditions and exclusions mentioned in this Policy.

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule to know exact details of Sections as per plan opted by You. Only Wordings related to Sections mentioned in your Policy Schedule are applicable.

Disclaimer: The Description mentioned under "Digit Simplification"/ "Examples" /"This space needs your special attention" throughout the Insurance Policy is only to aid Your understanding of the Coverage / Benefit Offered. In case of dispute, the Terms and Conditions detailed in the Policy Document and Policy Schedule shall prevail.

B. DEFINITIONS

Digit Simplification: ***Who says it's hard to crack Insurance terms? At least in Digit, we don't! Simply put, below are some definitions. These are no ordinary definitions that you used to mug up at school. These are like magic spell words that instil power of understanding this policy better. Abra..ca..dabra!*** 😊

I. STANDARD DEFINITIONS:

1. **Accident, Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. **AYUSH treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
6. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.
7. **Cashless facility** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Insurer to the extent Pre-authorization is approved.
8. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
9. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly means a Congenital anomaly which is not in the visible and accessible parts of the body.
   b. External Congenital Anomaly means a Congenital anomaly which is in the visible and accessible parts of the body
10. **Co-Payment** means a cost sharing requirement under a Health Insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
11. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
12. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
    i. has qualified nursing staff under its employment;
    ii. has qualified medical practitioner/s in charge;
    iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
13. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.
    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
14. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies. A deductible does not reduce the Sum Insured.
15. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
16. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
17. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) the condition of the patient is such that he/she is not in a condition to be moved to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.
18. **Emergency / Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
19. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received.

The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

20. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act Or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    iii) has qualified medical practitioner(s) in charge round the clock;
    iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
21. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
22. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        1. it needsongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        2. it needs ongoing or long-term control or relief of symptoms
        3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        4. it continues indefinitely
        5. it recurs or is likely to recur
23. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
24. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
25. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
26. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
27. **Indemnity based health insurance section** means an insurance section that compensates an insured for the loss due to occurrence of an insured event as specified in the policy.
28. **Benefit based health insurance section** means an insurance section that pays fixed amount on the occurrence of an insured event as specified in the policy.
29. **Maternity expenses** means;
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the policy period.
30. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
31. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these

are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

32. **Medical Practitioner/Doctor** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
    The registered practitioner should not be the insured or close member of the family.
33. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i) is required for the medical management of the illness or injury suffered by the insured;
    ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii) must have been prescribed by a medical practitioner;
    iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
34. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
35. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
36. **New-born Baby** means baby born during the Policy Period and is aged upto 90 days.
37. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.
38. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
39. **Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    b) For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
40. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
41. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
42. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
43. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
44. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
45. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
46. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
47. **Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion

of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

48. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
49. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

II. SPECIFIC DEFINITIONS

50. **Hazardous Sports** means any sport, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport includes but not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/spelunking/pot holing, cave tubing, climbing/ trekking/ walking over 4,000 meters, cycle racing, cyclo-cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river- boarding, river bugging, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling snow and ice sports or involving a naval military or air force operation. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular schedule airline or air charter company.
51. **Policy** means the Proposal, the Policy Schedule (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
52. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule and includes both the commencement date as well as the expiry date. For policies having annual term, Policy Period and Policy Year will be same. “Policy Year” term is used for long term policies.
53. **Policy Year** means the period of one year commencing on the date of commencement specified in the Policy Schedule or any anniversary thereof.
54. **Psychiatric Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.
55. **Related Hospitalization** means hospitalization arising out of same illness including its complications, for which a claim has already been availed during the same policy year.
56. **Room** means a Single Room without wall/permanent partition, dining or waiting room and with or without following amenities: an attendant cot, one television, one sofa, a telephone, refrigerator, wardrobe, computer with internet connection and microwave oven.
57. **Sum Insured** means the amount as per plan opted by You and stated in the Policy Schedule for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy.
58. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
59. **You, Your, Yours, Yourself, Policyholder, Insured Person(s)** means the Person named in the Policy Schedule Members who has concluded this Policy with Us.

CRITICAL ILLNESS DEFINITIONS

I. STANDARD DEFINITIONS:

1. CANCER OF SPECIFIED SEVERITY

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

II. The following are excluded –
   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   iii. Malignant melanoma that has not caused invasion beyond the epidermis;
   iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
   v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
   vi. Chronic lymphocytic leukaemia less than RAI stage 3
   vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
   viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to balloon valvotomy/valvuloplasty are excluded.

4. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:
   i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

5. OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

6. END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

a. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
c. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
d. Dyspnoea at rest.

7. END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is **excluded.**

8. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

9. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. **The following are excluded:**

a. Other stem-cell transplants
b. Where only Islets of Langerhans are transplanted

10. BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

11. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

12. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit is to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
   i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv. Mobility: the ability to move indoors from room to room on level surfaces;
   v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
   i. Spinal cord injury;

13. PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

14. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
   a. Transient ischemic attacks (TIA)
   b. Traumatic injury of the brain
   c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

15. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

16. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

II. SPECIFIC DEFINITIONS:

17. SURGERY TO AORTA

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

18. APALLIC SYNDROME

Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

19. LOSS OF INDEPENDENT EXISTENCE

Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of the following Activities of Daily Living Activities of Daily Living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

20. APLASTIC ANAEMIA

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

C. BENEFITS COVERED UNDER THE POLICY

I. COVERAGE

SECTION 1. HOSPITALIZATION COVER

1.1. In-Patient Hospitalization

Digit Simplification: ***Hospital days can be exhausting. We understand this. That's why, we strive to make your days comfortable. After all, you are at the hospital to recover. Our Hospitalisation Cover is one such ray of hope that makes your stay comfortable, so that you only focus on getting healthy!***

If You suffer an Accidental Injury or Illness during the Policy Period that requires Hospitalization as an inpatient, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible claim upto the Sum Insured as mentioned in Your Policy Schedule and as per plan opted by You. The claim can be made under the following benefits as mentioned below:

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room
ICU	Intensive Care Unit ***when you require continuous monitoring or life support***
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

This space needs your special attention!

✗: Cost of consumables such as bandages, needles, cotton, etc. are not covered.

😊: Stay comfortable in the hospital room of your choice. Because there are no room rent limit or category restrictions!

1.2. Day Care Procedures

Digit Simplification: ***Technology has speed up healthcare. Get covered for treatments such as, shoulder dislocation, dialysis, etc. that are completed in a day. Say bye to hospital staff as soon as you get your treatment done! No more staying in the hospital overnight.***

If You suffer an Accidental Injury or Illness during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for stay less than 24 hrs because of technological advancement, We will pay the Medial Expenses Incurred for such Day Care Procedures

Note - This is NOT OPD: Treatment normally taken on an out-patient basis is NOT included in the scope of this Cover.

This space needs your special attention!

✗: Day to day doctors' consultations and minor treatments such as stiches and plaster for fractures, etc. are not covered.

😊: Pre and post expenses related to day care procedures will be covered under this section.

1.3. Pre-Hospitalization

Digit Simplification: There is so much to be taken care of before you get on the hospital bed. Doctors may recommend various tests and medication such as X-rays, CT scans, MRI scans, involving consultation fees for physicians, etc. We cover these expenses for the period mentioned in your Policy Schedule. So that you have a smooth treatment without looking into your pocket!

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as mentioned in Your Policy Schedule against this cover, prior to the date of Your admission in a hospital, provided that:

a) Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.
b) We have accepted an Inpatient Hospitalization Claim under **Section 1- Hospitalization Cover** of this Policy.

This space needs your special attention!

✗: Medical expenses which are not related to the current treatment for which you're admitted in the hospital are not covered.

😊: Expenses related to the hospitalization such as X-rays, CT scans, MRIs, investigative procedures, medication, etc., are covered for 30-90 days prior to the date of your hospitalisation, as per your chosen plan.

1.4. Post-Hospitalization

Digit Simplification: After treatment, do nothing but rest & recover. There are certain expenses that are incurred after discharge relating to the said hospitalization such as follow-up treatments, medical consultations, diagnostic tests, medication, etc. Don't worry! These expenses are covered for the period mentioned in your policy schedule.

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as mentioned in Your Policy Schedule against this cover, from the date of Your Discharge from the hospital, provided that:

a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
b) We have accepted an Inpatient Hospitalization Claim under **Section 1- Hospitalization Cover** of this Policy.

This space needs your special attention!

✗: Medical expenses which are not related to the current hospitalization are not covered.

😊: Just look at the bright side of recovering with this cover. Expenses related to hospitalization such as follow-up treatments, medical consultations, diagnostic tests, medication, etc., are covered for 60-180 days from the date of your discharge, as per your chosen plan.

1.5. Road Ambulance

Digit Simplification: Get reimbursed for the expenses of road ambulance, in case of emergency hospitalization. Please note: The benefit of this cover is not included in case you plan your hospitalisation in advance. (It's only available in case of emergency hospitalizations.)

We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency, provided that:

a) We have accepted a claim under **Section 1. Hospitalization Cover.**
b) The maximum liability per Policy Year is restricted to the amount as mentioned in Your Policy Schedule.
c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

This space needs your special attention!

✗: Expenses incurred in reaching home after discharge are not covered.

😊: Don't worry if You spend for an ambulance in case of a health emergency, because it'll be reimbursed by Us!

1.6. Bariatric Surgery

Digit Simplification: Obesity may be the root cause of so many health issues. We absolutely understand this, and cover for Bariatric Surgery when it is medically necessary and advised by your doctor. However, we DO NOT cover if hospitalisation for this treatment is for cosmetic reasons.

If You are hospitalized for a Bariatric Surgery which is medically necessary, on the advice of a Medical Practitioner, we will cover the related Medical Expenses subject to the following conditions:

a) The Insured Person undergoing the surgery is minimum 18 Years old.
b) The Medical Practitioner / Bariatric Surgeon confirms that Your Existing Body Mass Index (BMI) and health conditions fall within the below qualification requirements for Bariatric Surgery:
   - Class III Obesity (extreme obesity)- [Body Mass Index (BMI) ≥ 40 kg/m2)];
   - Class II Obesity- (Body Mass Index (BMI) 35-39.9 kg/m2) along with any of the following co-morbidities:
     - Uncontrolled Diabetes Mellitus
     - Cardiovascular Disease
     - History of Coronary Artery Disease with a surgical intervention such as Cardiopulmonary Bypass or Percutaneous Transluminal Coronary Angioplasty;
     - Cardiopulmonary Problems as a result of another disease process, including, though not limited to, a documented severe obstructive sleep apnoea (OSA), confirmed on polysomnography.
c) A claim under this cover is acceptable *only* if it is under any of the below procedures:
   - Gastric Bypass-
     - The Roux-en-Y Gastric Bypass
     - Biliopancreatic Diversion with or without Duodenal Switch (BPD/DS) Gastric Bypass
   - Sleeve Gastrectomy
   - Laparoscopic Gastric Banding
   - Any similar procedures used which qualifies for Bariatric treatment and approved by relevant authority.
d) This particular cover has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" stated in Your Schedule which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break with Bariatric Surgery Cover as a benefit since inception of the first policy.
e) If you are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company where this cover was not there or if you are adding this cover while renewing our health

policy, a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance will be applied.

f) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity.
g) We would need a documented detailed history of your obesity-related health problems, difficulties, and treatment attempts demonstrating that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioural modification), and pharmacological therapy, if appropriate, have been unsuccessful, at least for past 6 months.
h) A prior approval should be taken from us before the Bariatric Surgery is performed.

Bariatric surgery for the following reasons is not covered:

a) For Cosmetic/Aesthetic reasons.
b) For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity.

This section needs your special attention!

✗: Bariatric surgery for treating obesity caused due to hormonal imbalance, psychiatric and bad eating habits is not covered.

😊: Treatment for obesity with an underlying medical condition like uncontrolled diabetes, heart disease etc., is covered.

1.7. Psychiatric Illness

Digit Simplification: Never ignore your mental health. Just breathe. Because we're here to cover you for expenses related to psychiatric disorders and illnesses.

We will pay for the Medical Expenses, related to Psychiatric Illness, provided that:

a) The first diagnosis and Hospitalization, as an inpatient, was during the Policy Period.
b) Waiting period for this cover for the below mentioned ICD codes shall be as per the '"**Specific Waiting Period**'" stated in Your Schedule which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with Psychiatric Illness Cover as a benefit since inception of the first policy.

ICD Code	Psychiatric Illness & Disorders
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F99-F99	Unspecified mental disorder

c) If you are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company where this cover was not there or if you are adding this cover while renewing our health policy, a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance will be applied.
d) Hospitalization under this benefit shall be subject to prior approval from Us, except in cases of emergencies.

This section needs your special attention!

✗: This does not cover psychologist and psychiatric therapy expenses unless you are hospitalized with such a condition.

😊: Hospitalisation related to mental illness is covered.

1.8. Health Check Up

Digit Simplification: We pay for your health check-up expenses up to the amount mentioned in your Plan. No restrictions on the kind of tests! Be it ECG or Thyroid Profile. Make sure you go through your policy schedule to check the claim limit.

If You have continued Your Policy with Us without any break, then at the end of each block of continuous years (as per plan opted), We will pay the expenses incurred towards cost of health check-up up to the Limits Per Policy (excluding any cumulative bonus) as per plan opted and mentioned in Your Policy Schedule. This shall be paid, provided that:

a. This benefit will not be carried forward if not utilized.
b. You submit a duly filled and signed claim form along with original bills and copy of medical reports.
c. In case of Family Floater policy, Health Check-up Sum Insured as mentioned in Policy Schedule is the maximum total cost including taxes which is available for all insured persons put together.

Please Note- Payment under this benefit won't be deducted from Your Sum Insured. It is additional.

This space needs your special attention!

✗: **This benefit will not be carried forward to your next policy year if not utilized.**

😊**: Keep track of your overall health and monitor your health and wellbeing on the right medical parameters. Amount spent towards health check-up is not deducted from your sum insured, it's additional!**

1.9. HOME (DOMICILIARY) HOSPITALIZATION

Digit Simplification: Hospitals can go out of beds, or the patient's condition may be rough to get admitted in a hospital. Don't panic! We cover you for the medical expenses even if you get treatment at home.

We will pay the Medial Expenses incurred by You for any illness or Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization, provided that:

a) The condition of the patient is such that s/he is not in a condition to be moved to a Hospital or
b) The patient takes treatment at home on account of non-availability of room in a Hospital, and
c) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period.
d) No Payment will be made if the condition for which You require medical treatment is due to:
Asthma, Bronchitis, Tonsillitis, Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza, Arthritis, Gout and Rheumatism, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastroenteritis, Diabetes Mellitus and Insipidus, Epilepsy, Hypertension, any kind of rehabilitation or therapy or counselling related to Psychiatric or Psychosomatic Disorders of all kinds, Pyrexia of unknown Origin.
e) Subject to availability of the sum insured under **Section 1- Hospitalization Cover.**

This Cover is subject to terms, conditions, deductible, co-payment, limitations, and exclusions mentioned in the Policy.

This section needs your special attention!

✗***: If you are home hospitalised for a period less than 3 days, then the expenses for your treatment will not be payable.***

😊***: Medical consultation charges, tests and medical expenses can be reimbursed for the treatment taken at home.***

SECTION 2: ORGAN DONOR EXPENSES

Digit Simplification: Your organ donor gets covered in your policy. We also take care of the pre and post hospitalization expenses of the donor. Organ donating is one of the kindest deeds ever and we thought to ourselves, why not be a part of it!

We will pay You for the following incurred Medical Expenses in respect of organ transplantation:

a) For the harvesting of the donated organ subject to plan opted and availability of the Sum Insured under **Section 1. Hospitalization Cover.**
b) There are strict guidelines when it comes to organ transplantation, therefore the organ donor whose organ has been made available should be in accordance and in compliance with the Transplantation of Human Organs Act 1994 (as amended) and the organ is donated for Your use only.
c) We will pay the donor's Pre and Post Hospitalization expenses. This is up to 5% of the claim amount approved in respect of harvesting expenses.
d) We will not pay any other medical treatment for the donor consequent on the harvesting.
e) This also has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" stated in Your Schedule which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with Organ Donor Cover as a benefit since inception of the first policy.
f) If you are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company where this cover was not there or if you are adding this cover while renewing our health policy, a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance will be applied.

Provided that, We have accepted a claim under **Section 1. Hospitalization Cover.**

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

This section needs your special attention!

✗: If the surgery required for the organ transplant is not covered in your policy, then the organ donor expenses for the same treatment will not be payable.

😊: Organ donor expenses include expenses such as cost of surgery, room, nursing, medication, doctor's follow-ups etc.

SECTION 3. EMERGENCY AIR AMBULANCE

Digit Simplification: There may be emergency life-threatening health conditions which may require immediate transportation to hospital. We absolutely understand this and reimburse for expenses incurred for your transportation to a hospital in airplane or helicopter.

We will pay You the expenses incurred for Your transportation to the nearest hospital in an airplane or helicopter (registered Air Ambulance Service Provider) for emergency life threatening health conditions which requires immediate and rapid ambulance transportation.

Provided that,

1. We have accepted a claim under Section 1. Hospitalization Cover.
2. This transportation will be from the location where the illness /accident happened the first time and subject to availability of Sum Insured as mentioned in Your Policy Schedule against Section 1 and as per plan opted by You.
3. Such Transportation in an airplane or helicopter has been prescribed by a Medical Practitioner and/or is Medically Necessary.

Conditions applicable to Emergency Air Ambulance

1. Expenses incurred in return transportation to Insured Person's home by air ambulance is excluded.
2. The insured person should be in India when the emergency life threatening health condition arises.
3. The Air ambulance services will be limited within India only and NOT overseas in any condition whatsoever.
4. For cases where transportation to the hospital is possible through road ambulance then claim should not be admissible under this section unless it is prescribed by Medical Practitioner.
5. Prior approval should be taken from Us for availing Air Ambulance Services.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

This section needs your special attention!

✕: You are not covered for the air ambulance charges in case of a planned hospitalisation and in case your location has the necessary treatment available.

😊: When your health requires immediate attention during an emergency life threatening health condition, don't panic, we are there for you!

SECTION 4. MATERNITY BENEFIT WALLET & NEWBORN COVER

A. Maternity Benefit Wallet

Digit Simplification: Parent-hood is the best-hood! No wonder you get a reduced waiting period of just 9 months. Also, you may include this benefit in your policy before even planning a baby! Because we magically keep on increasing your maternity sum-insured at every renewal, up to a set limit of Rs 1,00,000 if no maternity claim is made. That too at no extra cost of premium!

We will pay the Maternity Expenses incurred towards the delivery of a baby and/or treatment related to any complication of pregnancy or medically necessary and lawful termination. This is up to the Sum Insured as mentioned in Your Policy Schedule against this Section and as per plan opted by You, during the Policy Period provided that:

a) This also has a waiting period. Waiting period of 9 months shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.
Digit Simplification: To start availing the benefits of this cover, you have to wait for a period of 9 months, provided that you have an on-going policy with us without any break.

b) If you are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company where this cover was not there or if you are adding this cover while renewing our health policy, a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance will be applied.

c) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.

d) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit.

e) Sum Insured under this section:

i. Maternity Sum Insured under this section will be INR 15,000 for First Policy Year.
Digit Simplification: For the first year, you are covered for Rs. 15,000. You may utilize this amount after 9 months from the inception of the Policy.

ii. If no claim has been made under this section during the Policy Year, You will be eligible for enhanced Maternity Sum Insured as per table provided below. No extra premium will be charged for this enhanced Maternity Sum Insured.

Policy Year	Maternity Sum Insured	Remarks
1st Policy Year	15,000	If no claim is made in 1st policy year then Sum Insured will be increased by INR 10,000 in 2nd year.
2ndPolicy Year	15,000 + 10,000 = 25,000	Similarly, If no claim is made under this section in 2nd policy year then Sum Insured will further be increased by INR 10,000 in 3rd year.

iii. Third year onwards if no claim has been made under this section, then the Maternity Sum Insured will increase every year by INR 10,000 per policy year, subject to maximum of INR 1,00,000.

iv. In case of a claim under this section, Maternity Sum Insured on renewal/ next policy year will go back to INR 15,000.

We shall not pay for the following under this Section:

a) Expenses for the harvesting and storage of stem cells when carried out as a preventive measure against possible future illness.
b) Medical Expenses for Ectopic Pregnancy will be covered under **Section 1. Hospitalization Cover and** not under the Section 4 – Maternity Benefit Wallet and Newborn Cover.
c) Pre-natal and Post-natal Medical Expenses are not covered.

This space needs your special attention!

✕: Any claim made during the waiting period is not covered.

😊 : Made no claims? Your sum-insured keeps on increasing by ₹ 10,000 every year up to ₹ 1,00,000.

B. New-born Cover

Digit Simplification: ***We treat your new-born as ours and provide all the love & care it needs! Your baby is covered upto 90 days from the date of delivery. This includes vaccinations as per National Immunization Schedule as defined by Government of India.***

Under this cover, we will also pay the Medical Expenses, within the limit of the Sum Insured available under the **Section 4. A Maternity Benefit Wallet Section** of the Policy, provided that We have accepted a claim under **Section 4. A. Maternity Benefit Wallet**, incurred towards:

a) The medical treatment of the Insured Person's New Born Baby while the Insured Person is hospitalised as an inpatient for delivery.
b) The New Born Baby's hospitalisation charges as a result of any medical complications, up to 90 Days from the date of delivery.
c) Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India, up to 90 Days from the date of delivery.
d) If the Policy Expires before 90 days from the date of delivery, the New Born Baby will be covered only if the Policy is Renewed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of any additional premium.

e) After 90 Days from the date of delivery, the New Born Baby will be covered under the existing Policy only if it is Endorsed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of the Pro-Rata Additional Premium, for the balance period.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

This space needs your special attention!

✕: The baby is covered for 90 days up to the amount available in the maternity wallet. Once that amount gets exhausted the expenses under this cover will not be payable.

😊: Get covered for your baby's vaccination expenses up to the age of 90 days from the date of delivery.

SECTION 5: WORLDWIDE COVERAGE

Digit Simplification: Get a world class treatment with the Worldwide Coverage! If your doctor identifies an illness during your health examination in India and you wish to get a treatment abroad, then we're there for you. You're covered!

We will pay You for the Medical Expenses incurred by You outside India. This is up to the Sum Insured as mentioned in your Policy Schedule against this section and as per plan opted by You. The coverage under this section shall be limited to below mentioned covers:

Section 1	Hospitalization Cover
1.1	In-Patient Hospitalization
1.2	Day Care Procedures
Section 2	Organ Donor Expenses

Specific terms and conditions applicable to Section 5 – Worldwide Coverage:

1. Claims will be payable on reimbursement basis only. For Cashless it will be decided on case-to-case basis.
2. Medical expenses under this cover will be payable if diagnosis is made in India and insured travels outside India only for the purpose of treatment.
3. All the payments will be made in Indian Rupees only based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion.
4. Prior approval should be taken from Us for any treatment to be taken Outside India.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

This section needs your special attention!

✕: Claim under this section will not be payable in case your illness is not diagnosed by the doctor in India.

😊: Don't worry if the treatment you need is not available in India, we're there to reimburse your hospitalisation expenses if you get treated from abroad.

SECTION 6. SUM INSURED BACK UP

Digit Simplification: ***We will provide a back-up Sum Insured which will be 100% of your Sum Insured amount.***

We shall provide you 100% of the Sum Insured as a backup under **Section 1. Hospitalization Cover** for that particular Policy Year, provided that:

a) The backup Sum Insured would be utilized if the cause of the Hospitalization is related or not related (as per plan opted) to or arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy year for the same Insured Person.
b) In case of related Hospitalization cooling off period of 45 days will be applicable.
Digit Simplification: Time gap between two related hospitalizations should be minimum 45 days.
c) The maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.**
d) If the first claim amount exceeds the Sum Insured under **Section 1. Hospitalization Cover**, the backup Sum Insured will not be utilized for the same hospitalisation.
e) The number of times the backup Sum Insured may be extended shall be as per the plan opted and mentioned in Your Policy Schedule against this Section during each Policy Period.
f) In case of Floater Policy, the backup Sum Insured will be applicable on family floater basis.
g) The Backup Sum Insured can only be utilized for hospitalization in India only.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

This space needs your special attention!

❌**: Back-up Sum Insured cannot be utilized for hospitalization outside India.**

😊**: You are protected against future hospitalisation expenses unrelated or related to your previous hospitalisation. For related illness hospitalization, in case Sum Insured backup is to be utilised, there should be 45 days gap between the date of discharge of previous hospitalisation and date of admission of current hospitalisation.**

SECTION 7. IN-BUILT PERSONAL ACCIDENT

Digit Simplification: ***Some accidents can result in one's death within 12 months from date of Accident. In such cases, we pay 100% of the sum insured to the nominee.***

If You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your Death within twelve (12) months from the date of accident, then We will pay 100% of the Sum Insured as mentioned in Policy Schedule against this cover and as per plan opted.

Under this section, claim will also be payable for the below mentioned events:
a. Disappearance:, If the Insured Person's full body cannot be located within a period of consecutive twelve (12) months, following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Person was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the Policy Period, where it is reasonable to believe that such Insured Person has died as a result of an Accidental Injury.

Digit Simplification: We will be liable to pay if the insured's full body cannot be located within a period of 12 months consecutively and if we have all the reasons to believe that the person has died due to an accident.

b. Drowning: If the Insured Person's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the Policy Period, where it is reasonable to believe that such Insured Person has died as a result of drowning.

Digit Simplification: We will be liable to pay if the insured's full body cannot be located within a period of 12 months consecutively and if we have all the reasons to believe that the person has died due to drowning.

For both (a) and (b) above, We will only pay, when the nominee or the legal heir provides a legally binding indemnity bond or any other document as required by Us which guarantees, that, if at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, all payments shall be repaid in full to Us.

Digit Simplification: If later, it is found that the insured person is still alive, then all the money that was paid by us will have to be repaid to us in full.

1. This benefit will be applicable only to the proposer of the Policy during the Policy Period. In case if proposer is not covered in the policy this benefit will be applicable to the eldest member of the Policy during the Policy Period. This is applicable for both individual base sum insured as well as floater-based Sum Insured policy.
2. Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Particular Insured Person.

Digit Simplification: This policy will no longer exist for the insured person for whom the claim was made under death.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

This section needs your special attention!

✕: Person other than proposer or the eldest member of the family (as applicable) is not covered under this section.

😊 : This cover is over and above the indemnity sum-insured and expenses incurred in treatment.

SECTION 8. AYUSH HOSPITALIZATION (MANDATORY IN BUILT COVER IN SECTION 01 HOSPITALIZATION COVER)

Digit Simplification: Natural treatment has its own power! That is why, we cover your hospitalization expenses when you choose a registered AYUSH Hospital.

We will pay the Medical Expenses for Your In-patient Treatment, taken under Ayurveda, Unani, Siddha or Homeopathy. This is up to the Sum Insured as mentioned in Your Policy Schedule against **Section 1. Hospitalization Cover**. This is paid provided that treatment has been undergone in an Ayush Hospital.
You should also be aware what We won't pay for:

a) Outpatient Medical Expenses.
b) All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.

Specific Conditions applicable to this cover:
Claim will be payable under this section only if AYUSH Hospitals and AYUSH Day Care Centres have obtained pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

II. Optional Covers

Digit Simplification: True customization means you get an option to add covers that make sense to you!

The covers listed below are optional covers and will be applicable only if you have selected them at the time of purchase and is mentioned in your Policy Schedule.

S.No.	Optional Covers	Section Admissibility
1	Consumables Cover	Section 1- Hospitalization Cover
2	Network Hospital Discount	Section 1- Hospitalization Cover
3	Pre-existing Disease/Specific Disease/Initial Waiting Period Modification	Section 1 – Hospitalization Cover Section 2 – Organ Donor Expenses Section 3 – Emergency Ambulance Section 4 - Maternity Benefit Wallet and New-born Cover Section 5 – Worldwide Coverage

Please note, the below cover is subject to terms, conditions, warranties, deductible, co-payment, limitations and exclusions mentioned in the Policy.

1) Consumables Cover

(Applicable under Section 1 Hospitalization Cover)

***Digit Simplification:* Before, during & after hospitalization, there are many other medical aids & expenditures such as walking aids, crepe bandages, belts, etc., which needs your pocket's attention... This cover takes care of these expenses that are otherwise excluded from the policy.**

If you have opted for this optional cover and on payment of additional premium and if Your claim is approved under **Section 1- Hospitalization Cover**, we will compensate for non-medical expenses incurred by You (You can check them under Annexure A below) during the Policy period directly related to the Your medical or surgical treatment of illness/disease/injury. The compensation will be maximum upto a Sum Insured as mentioned in Policy Schedule against Section 1 – Hospitalization Cover.

Please note:

i. Coverage will be limited to the actual expenses incurred during the Hospitalisation but not paid under **Section 1 – Hospitalisation Cover** as Non-Medical expenses.
ii. In the General Exclusions section, 'Non-medical Expenses' as exclusion no. 25 will not be applicable if you have opted for this optional cover.

2) Network Hospital Discount

(Applicable under Section 1 Hospitalization Cover)

Digit Simplification: Well, if you choose to be treated at our Network hospital, we have something for you. A discount! Add this cover for a discount on your policy!

Please note: After opting this cover, if you get treatment in a hospital that does not fall under our network hospitals, you'll be liable to pay a percentage of amount [Co-pay] as mentioned in your policy schedule.

If you have opted for this optional cover, You will be eligible for premium discount of 10% as You agree for hospitalization* in Our network hospitals only. In case, You are hospitalized in any of the non-network hospital, then you shall bear a co-payment of 20% on each and every admissible claim under Section 1.

*(under Section 1 Hospitalization Cover)

Specific Conditions applicable to this cover:

i. Co-payment will be applicable if Insured Person is hospitalized in non-network hospital and on admissible claim amount under Section 1.
ii. Co-payment will not be applicable in case of an accidental hospitalization and on capped ailments.
iii. For complete list of Network Hospitals, kindly refer Company's Website.

3) Pre-existing Disease /Specific Disease /Initial Waiting Period modification:

***Digit Simplification:** Restrictions on waiting period, pre-existing or specific diseases can be modified with this optional cover!*

If You have opted for this cover then the waiting period as mentioned under exclusion D.I.1, D.I.2 and D.I.3 shall stand modified as mentioned in Policy Schedule.

III. Cumulative Bonus

***Digit Simplification:** No claims in the Policy year? You get a bonus - an additional amount in your total sum-insured for staying healthy & claim free!*

If You've been safe and healthy and have had No Claims made under the **Section 1. Hospitalization Cover** in the expiring Policy Period, you would be eligible for Cumulative Bonus at the time of renewal/or policy year completion in case of term more than one year as per plan opted and mentioned in Your Policy Schedule, provided that:

1. There is an upper limit to the Cumulative Bonus You can earn. In any Policy period, the accrued Cumulative Bonus (including any carried forward Cumulative Bonuses from the previous policy) shall not exceed the limit mentioned in Your Policy Schedule.
2. For a Floater Policy, the Cumulative Bonus shall be available only on Floater Basis. It shall accrue only if no claim has been made for any of the Insured Members during the expiring Policy Period.
3. In the event of a claim in the expiring policy period, the Cumulative Bonus will reduce in the same way as it was accrued in the policy at the time of renewal.
4. If You discontinue the Policy or fail to renew the Policy within the Grace Period of 30 days from the due date of renewal, the entire Cumulative Bonus will be lost.
5. The Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy with Us.
6. For an individual Sum Insured policy, the Cumulative Bonus shall only be accrued for a member, if he/she has completed at least 12 months at the time of policy renewal.
7. In policies with a tenure of more than one year, the above guidelines of Cumulative Bonus shall be applicable post completion of each policy year
8. The Cumulative Bonus will be Calculated on the Sum Insured as opted by You under **Section 1. Hospitalization Cover.**

***Note:** Cumulative bonus opted at the inception of the first policy with us can't be changed during the policy period and subsequent renewals.*

This section needs your special attention!

X: You will not be able to use this benefit if there is a claim in expiring policy.

😊: If there is no claim under the policy you will be rewarded with some bonus

CARRY FORWARD SUM INSURED

***Digit Simplification:** Used a portion of your sum-insured or didn't use it at all? Then carry it to your next policy year with a maximum limit of 100% base sum-insured! No strings attached.*

At the time of renewal/or policy year completion in case of term more than one year of the policy, sum insured under Section 1 -Hospitalization Cover of the renewed policy will be increased based on the unused base sum insured of Section 1 – Hospitalization Cover of the expiring policy, subject to the following:

i. Maximum 100% of the unused Base Sum Insured (i.e sum insured less any carry forward Sum Insured) will be carried forward at the time of renewal.
ii. Maximum carried forward of unused Base Sum Insured, year on year, will be limited to 100% of Base Sum Insured of the expiring policy.
iii. No cumulative bonus benefit will be provided under the product if this cover is opted.

For this cover, unused base sum insured will mean total sum insured minus any claim amount under the policy during the policy period.

This section needs your special attention!

✕: **This cover is not available if you have opted for Cumulative Bonus.**

😊 **: The less sum-insured you use, the more Sum Insured you get in the next Policy Year.**

D. EXCLUSIONS

Digit Simplification: We have always been transparent. Time to discuss what you're not covered for or when you do not get a claim.

We shall not be liable to make any claim payment under this Policy caused by, based on, arising out of or howsoever attributable to any of the following unless specifically agreed and mentioned elsewhere in the Policy Schedule:

I. STANDARD EXCLUSIONS

1. Pre-Existing Diseases - Code- Excl01

Digit Simplification: The disease or condition that you are already suffering with and have disclosed to us before taking the policy and has been accepted by us has a waiting period as per plan opted and mentioned in your Policy Schedule.

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of number of months, as per plan opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with insurer.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   Digit Simplification: For instance, if you opt for ₹ 3,00,000 sum-insured at the start of your policy and after 2 years increases it to ₹ 5,00,000. Then, waiting period will be applicable on the enhanced sum-insured i.e., ₹ 2,00,000.
c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of number of months, as specified in the Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified disease/procedure waiting period- Code- Excl02

Digit Simplification: There are certain disease or procedures which has a specific waiting period as per plan opted by You.

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months, as per plan opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable

norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage

f. List of specific diseases/procedures

i. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)

ii. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.

iii. Cataract, Glaucoma and Disorder of retina

iv. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele

v. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease

vi. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.

vii. Hernia of all sites,

viii. Varicose veins of lower extremities,

ix. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa,

x. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump including breast lumps (each of any kind unless malignant),

xi. Internal Congenital Anomaly (not applicable for new-born baby),

xii. Psychiatric illness and Disorders listed below:

ICD Code	Psychiatric Illness & Disorders
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F99-F99	Unspecified mental disorder

xiii. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease

xiv. **Joint Replacement, Bariatric Surgery and Organ Transplant**

Any Medical Expenses incurred as a result of Joint Replacement, Bariatric Surgery and Organ Transplant Surgery will be covered subject to a waiting period as opted by You and mentioned in Your Policy Schedule as long as the Insured Person has been insured continuously under the Policy without any break, unless due to an accident.

3. Initial Waiting Period- Code- Excl03

Digit Simplification – You need to wait for a defined period from the first day of your policy to get covered for treatment related to any non-accidental illness.

a. Expenses related to the treatment of any illness within number of days as per plan opted and from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. If you have opted for a plan which provides coverage outside India, then the waiting period for hospitalization outside India shall be 30 days.

c. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

d. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

e. The waiting period for Critical illness irrespective of plan opted shall be 30 days.

f. List of critical illnesses in which this waiting period is applicable is mentioned below:

Sr. No.	Category	Critical Illness
1	**Malignancy**	Cancer of Specified Severity

2	**Cardiovascular system**	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	**Major Organ Transplant**	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	**Nervous System**	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

4. Investigation & Evaluation- Code- Excl04

Digit Simplification: You are not covered in case you get hospitalised only for investigation and evaluation purposes.

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

5. Rest Cure, rehabilitation and respite care- Code- Excl05

Digit Simplification: If you get hospitalised only for the purpose of bed rest and not to receive treatment, you do not get covered.

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
    ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

except to the extent covered under **SECTION 1.9 HOME (DOMICILIARY) HOSPITALIZATION** if opted by You.

6. Obesity/ Weight Control: Code- Excl06

Digit Simplification: Surgery related to weight loss is not covered until and unless it is advised by your doctor and is totally on medical grounds. Any surgery done just to enhance your outer appearance is not covered.

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
    a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnoea
   iv. Uncontrolled Type2 Diabetes

7. Change-of-Gender treatments: Code- Excl07

Digit Simplification: Medical expenses related to treatment for changing characteristics of the body in order to change one's gender is not covered under your policy.

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. Cosmetic or plastic Surgery: Code- Excl08

Digit Simplification: You are covered for plastic surgery only if it is medically necessary due to Accident, Burn or Cancer.

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

9. Hazardous or Adventure sports: Code- Excl09

Digit Simplification: You are covered for hazardous or adventure sports only if you are not a professional in this field and have met with an accident under the supervision of a trained personnel.

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

However, You would be covered if you participate in a non-professional capacity for any recreational sport which may be under the supervision of a trained professional

10. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

11. Excluded Providers: Code- Excl11

Digit Simplification – Any claim reported from non-preferred hospital will not be considered. Please refer here for the list of the non-preferred hospitals:
https://d2h44aw7l5xdvz.cloudfront.net/policyDocuments/hospital-list-one-pager.pdf

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

12. Substance Abuse – Code- Excl12-

Digit Simplification – Any illness or injury arising while under the influence of drinking alcohol, taking drugs or any other type of addictive substance will not be covered.

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

13. Domestic Treatment- Code- Excl13-

Digit Simplification – Any treatment taken at a place which qualifies as a domestic treatment such as in spas, nature cure clinics etc, is not covered in your policy.

Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

14. Non-prescribed Medicine – Code- Excl14 –

Digit Simplification – Medicines and supplements such as vitamins, organic substances, minerals etc. which can be bought without doctor's prescription are not covered. P.S. – These are only covered if they're part of your hospitalization claim and prescribed by the doctor.

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

15. Refractive Error: Code- Excl15

Digit Simplification – Only surgery for Refractive error more than 7.5 dioptres will be covered but expenses toward Implantable collamer lens will not be payable.

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

16. Unproven Treatments: Code- Excl16

Digit Simplification: Any treatment which is not approved/authorized by Medical Council of India or any other regulatory body within India is not covered.

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. Sterility and Infertility: Code- Excl17

Digit Simplification: Any treatment or medical expenses arising from Sterility or Infertility (a condition where a person is not able to produce offspring) is not covered.

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

18. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

Please note: This exclusion stands deleted to the extent of the coverage provided under **SECTION 4. MATERNITY BENEFIT WALLET & NEWBORN COVER**, if opted by You.

II. SPECIFIC EXCLUSIONS

19. Artificial Life Maintenance

Digit Simplification: Artificial life maintenance means ventilator support to someone who is in a vegetative state with an irreversible condition due to permanent damage.

Artificial Life Maintenance, including life support machine used, where such treatment is used to maintain the Insured/Patient in a vegetative state. However, expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the Policy.

20. Suicide and Self-Injury

Digit Simplification: We do not cover for hospitalisation arising due to intentionally harming yourself. Take care! Suicide is not the solution.

We do not cover treatment arising from or contributed or aggravated or accelerated by any of the following:

a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
b. Intentional self-injury
c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

21. Circumcision, Aesthetic reasons

Digit Simplification – Aesthetic surgeries that are done to alter ones physical appearance not due to any illness but to enhance ones beauty or physical appeal are not covered.

a. Circumcision unless necessary for the treatment of a disease or necessitated by an Accident;
b. Treatment for alopecia, baldness, wigs, or toupees and all treatment related to the same.
c. Aesthetic Surgeries of any description.

22. External Congenital Anomaly

Digit Simplification – Any condition that is since birth and is visible externally is not covered.

Screening, Counselling or treatment related to external Congenital Anomaly.

23. Geographical Limits

This Policy covers all treatments received within India. However, based on the plan opted, the Geographical limits will be extended to places outside India. Our liability will be to make Payment in Indian Rupees Only.

24. Defence Operation

We will not pay any claim under this Policy, whilst You are Involved in naval, military, air force operation

25. Non-Medical Expenses

Digit Simplification – Expenses incurred on personal comfort during and related to hospitalisation as mentioned in Annexure A are covered only if the optional cover "Consumables Cover" is opted.

Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies including but not limited to charges for admission, discharge, administration, registration, documentation and filing. (Please refer Annexure A provided in the policy document or visit our website for complete list of non-medical items)

26. Preventive Treatment

Digit Simplification – Any treatment/therapy for example vaccination given to prevent any possible condition is not covered.

We do not cover inoculations, vaccinations, or other treatment, for example drugs or Surgery, which aims to prevent a disease or Illness except:

a. For an active vaccination for dog or animal bite;
b. To the extent covered under **SECTION 4. MATERNITY BENEFIT WALLET & NEWBORN BABY COVER** if opted by You.

27. Spectacles, Hearing aids & other Expenses

Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

28. Unjustified or Unwarranted Hospitalization

Digit Simplification – Hospitalisation only for investigations, diagnosis is not covered.

Admission solely for Physiotherapy, evaluation, investigations, diagnosis or observation service unless a claim is accepted under **Section1 – Hospitalization Cover.**

29. War and hazardous substances

We do not cover treatment directly or indirectly arising from or required as a consequence of:
War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government or any acts of terrorism.
Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel.

30. Legal Liability

Digit Simplification – Any legal expenses incurred due to any fault or error at hospital's end is not covered.
Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

31. Substance abuse and Addictions by the Insured

Digit Simplification – Any expenses incurred on the hospitalisation caused due to the influence of substances such as drugs, alcohol etc. are not covered.

a. Expenses incurred for the treatment of any Illness or accidental Injury caused due to:
   (i) Use/misuse/abuse of Alcohol, opioids or nicotine or drugs (whether prescribed or not) by the Insured unless associated with Psychiatric Illness.
   (ii) Withdrawal and de-addiction treatment taken by the Insured.
b. Any claim in respect of Cancer of Oral, Oropharynx and respiratory system is specifically excluded in cases where Insured is a tobacco user.

SPECIFIC ONES (CAN'T BE WAIVED)

32. Ear, Eyesight & Optical Services

a) We do not cover treatment for Correction of refractive errors of the eye including but not limited to short-sight or long-sight, such as glasses, contact lenses or laser eyesight correction Surgery
b) We do not cover Femto Laser Procedure and multifocal lenses.
c) Our Maximum Liability in respect of Cochlear Implant Procedure will be restricted to 50% of the Sum Insured opted under **Section 1. Hospitalization Cover**

33. Prosthetics and other devices

Digit Simplification – Expenses related to supporting devices such as wheelchair, artificial limbs etc. which can be removed and can be reusable are not covered.
Prosthetics and other devices NOT implanted internally by surgery.

34. Specific Treatments

1. We will not pay for expenses related to administration of below medications or procedures in excess of 5% of Sum Insured opted under **Section 1. Hospitalization Cover**:
   a. Hyaluronic acid, Remicade or similar medications
   b. Intra-articular/intra thecal or cortico-steroid injections.
2. We will not pay for expenses related to administration of medications or procedures including but not limited to expense related to:
   a. Predictive Genome testing
      Digit Simplification - The tests that confirm only the possibility of severity of disease is not covered.

35. New Age Treatment

Digit Simplification - New age treatments such as Oral Chemotherapy, Stem Cell Therapy etc. can be covered only upto 50% of the Sum Insured.

Our Maximum Liability in respect of the following procedures or new age treatments will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured opted under Section **1. Hospitalization Cover**:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy – Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchial Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM – (Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

36. Dental Treatment

Digit Simplification: We only cover for the dental treatment expenses if you require hospitalisation due to accident.

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva, unless requiring Hospitalisation due to Accident**.**

37. Organ Donor

The Expenses incurred by You on organ donation, except for those covered under **SECTION 2. ORGAN DONOR EXPENSES.**

38. Weight loss Surgery

Digit Simplification: Any treatment that is related to your Bariatric Surgery is not covered unless covered under Section 1 – Hospitalization Cover.

We do not cover treatment that is directly or indirectly related to:
Bariatric Surgery (weight loss Surgery), such as gastric banding or a gastric bypass, or the removal of surplus or fat tissue, unless You have specifically opted for **SECTION 1. Hospitalization Cover** which covers Bariatric Surgery.

39. Any loss arising out of the **Insured Person**'s actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

E. GENERAL TERMS AND CLAUSES

I. STANDARD GENERAL TERMS AND CLAUSES

Digit Simplification: Time to remind you some basic conditions that were taken up before we issued the policy.

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
"Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

2. **Condition Precedent to admission of Liability**

The terms and conditions of the policy must be fulfilled by the insured person for the company to make any payment for claim(s) arising under the policy.

3. Nomination in case of death –

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination during the term of the Policy shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee, as named in the Policy Schedule/Policy Certificate/Endorsement (if any), and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

4. Special Conditions Applicable for Policies issued with premium Payment on Instalment basis

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
ii. During such Grace Period, Coverage will be available from the instalment premium payment due date till the date of receipt of premium by company.
iii. The insured person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy

5. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

6. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the Policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

7. **Moratorium Period**

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

8. Cancellation

A. Cancellation by You

You may cancel your policy at any time during the term, by giving 7 days notice to us in writing. We shall

a) Refund proportionate premium for unexpired policy period, if the term of policy is upto one year and there is no claim (s) made during the policy period.
b) Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

B. Cancellation By Company

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

C. In case of Death of Insured Person

i. Individual Policy

In case, no claim has been made, and termination takes place on account of death of the insured person, We shall refund proportionate premium for unexpired policy period, subject to the terms and conditions of the Policy.There will be no change in premium for other family members covered under the policy for the remaining duration of the policy.

ii. Family Floater Policy.

In case of death of Insured Family Member, cover shall continue for the remaining family members till the end of Policy Period. Provided no claim has been made, revised premium would be calculated basis new family composition and revised premium would be calculated on proportionate basis for unexpired policy, subject to the terms and conditions of the Policy. Difference between proportionate premium of new family composition with old family composition shall be considered for refund.

9. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty (30) days from date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;
iv. The request received for cancellation of the policy during free look period shall be processed and the premium shall be refunded within 7 days of receipt of such request.

Please note KYC documents (Photo ID card) shall be required at the premium refund to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per premium refund.

10.Multiple Policies

a. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
b. Indemnity based Insurance Sections:
A policyholder can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

c. Benefit based Insurance Sections:
On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.

11.Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means, or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/Policyholder(s), who has made that particular claim, who shall be jointly and severely liable for such repayment to the insurer

For the purpose of this clause, the expression "Fraud" means any of the following acts committed by the insured person or by his agents or the hospital/Doctors/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) The suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) The active concealment of a fact by the insured person having knowledge or belief of the fact;
c) Any other act fitted to deceive; and
d) Any such act or omission as the law specially declares to be fraudulent.

The company shall not repudiate the claim and/or forfeit the policy benefits on the grounds of Fraud, if the insured person/beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intension to supress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

12.Claim Settlement (provision for Penal Interest)

a. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
b. In case the claim is not settled within the specified timelines, then the claimant is entitled for interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment.
"Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

13.Complete Discharge

Any payment to the Policyholder, insured person or his/ her nominee or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

14.Renewal

i. The policy shall ordinarily be renewable provided the product is not withdrawn except on grounds of established fraud, or non-disclosure or misrepresentation by the insured person.
ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
vi. No loading shall apply on renewals based on individual claims experience.
vii. No fresh underwriting unless there is an increase in sum insured.
viii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected and shall be applicable for both Indemnity based and Benefit based sections.

15.Portability

In case of Indemnity based Insurance sections:

a. A Policyholder has the choice to port his/ her policies from one Insurer to another. The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred.

b. The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.

c. The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.

d. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy

16.Migration

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

17.Customer Grievance Redressal Policy:

In case of any grievance the insured person may contact the company through

Website: https://www.godigit.com

Toll Free: 1-800-258- 4242

Email: hello@godigit.com

Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievance@godigit.com

For updated details of grievance officer, kindly refer the link: →

https://www.godigit.com/claim/grievance-redressal-procedure

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017

Grievance may also be lodged at IRDAI Integrated Grievance Management System- https://igms.irda.gov.in/

The contact details of the Insurance Ombudsman Centres are mentioned in Annexure B.

II. SPECIFIC TERMS AND CLAUSES

18.Zone wise Classification

Based on your city of residence, we have classified you within two Zones. In case of family floater policies, a single zone shall be applied to all the members covered under the policy. The two Zones are defined below: -

Zone 1 Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan), Greater Hyderabad Area

Zone 2 Rest of India apart from Zone 1 cities are classified as Zone 2.

- Zone opted by you is mentioned in your Policy Schedule.
- At the time of claim, Insured needs to provide address proof as per the declaration in proposal form.

- In the absence of Address proof provided which validates the pricing zone opted, and if the place of hospitalization belongs to Higher Zone Category – then Co-pay of 10% would be applicable on admissible claim amount.
- If address proof as per declaration in Proposal form and Address proof provided at the time of claim is same, Zone based Co-pay will not be applicable.
- Zone based Co-Pay, as mentioned above, will not be applicable in case of Accidental Injury.

19.Alterations to the Policy

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or edited by anyone (including an insurance agent or intermediary) except Us (subject to necessary approval from the Insurance Regulatory and Development Authority of India), and any change We make will be through a written endorsement signed and stamped by Us, only on the request from Proposer/Insured Member.

20.Non-Disclosure or Misrepresentation:

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form either physically or electronically or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

a) cancelled ab initio i.e. from the inception date or the renewal date (as the case may be),
b) or the Policy may be modified by Us, at Our sole discretion, upon 30 days' notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance;
c) the claim under such Policy if any, shall be rejected/repudiated forthwith.

21.Insured Person

a. Only those persons named as an Insured Person in the Policy Schedule shall be covered under this Policy.
b. You can add more persons during the Policy Period but only after payment of an additional premium and subject to acceptance of Proposal by Us (wherever necessary) and after We have issued an endorsement confirming the addition of such person as an Insured Person.

22.Arbitration

If we have any differences with respect to the claim amount to be paid under this policy, it will be referred to arbitration in accordance with the Indian Arbitration and conciliation act 1996, as amended. The making of an award under such arbitration proceedings shall be a condition precedent for the Company to be liable to make any payment under this policy.

23.Claims Notification and Procedure

In the event of any accidental injury or illness or condition that may result in a claim under this policy, it is a condition precedent to Our liability under the Policy that below procedure should be followed depending on the type of claim:

A. Cashless Claim Process:

Cashless Facility can be availed from our network hospitals only. This is facilitated by our Service Provider / Third Party Administrator (TPA) and we would make a direct payment to the Network Hospital to the extent of Our Liability provided that:

1. We are given a notice at least 72 hours before any planned hospitalization or within 24 Hours of hospitalization in case of an emergency situation.
2. For Cashless Facility You shall follow the below Procedure:
   a. Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.
   b. Submit Duly filled & Signed Pre-Authorization Form to the Hospital Counter.
   c. Ensure that the Hospital shares the Duly filled & Signed Pre-Authorization Form to Service Provider / Third Party Administrator (TPA) for further Processing.
   d. Service Provider / Third Party Administrator (TPA) will inform the decision and may issue authorization letter depending on the Policy Terms and Conditions to the Hospital directly.

e. Once the request for Pre-Authorization has been granted, the treatment must take place within 15 days of the Pre-Authorization Approval Date or the Policy Expiry Date whichever is earlier and shall be valid only if all the details of the Authorised details, Hospital and Location including Dates match with the details of the Actual Treatment Received.
f. We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.
g. For any queries designated Service Provider / Third Party Administrator (TPA) may be contacted on the contact details mentioned on the Health Card/Copy of E-Cards issued to You.

B. Reimbursement Claim Process:

Reimbursement Facility can be availed from any hospital within India (except for Section 5 – Worldwide coverage where treatment can be taken outside India) of Your Choice Wherein You will have to make payment directly to the Hospital and submit the documents to Service Provider / Third Party Administrator (TPA) for processing the reimbursement of the claim amount provided that:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
   a. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
   b. In case the claim is not settled within the specified timelines, then the claimant is entitled for interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment.
   "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
   c. In case of Your Death, We shall reimburse the claim amount to Your Nominee as named in Your Policy Schedule or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information	Hospitalization Claim	Personal Accident
1	Duly Filled and Signed Claim form	√	√
2	Discharge Summary	√	×
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	×
4	Original Hospital Main Bill	√	×
5	Original Hospital Bill Break Up	√	×
6	Original payment receipt		
7	Original Pharmacy Bills	√	×
8	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	×
9	Consultation Papers	√	×
10	Investigation Reports	√	×
11	Digital Images/CDs of the Investigation Procedures (if required)	√	×
12	MLC/FIR Report (If applicable)	√	×
13	Original Invoice/Sticker (If applicable)	√	×
14	Post Mortem Report (If applicable)	√	√
15	Disability Certificate (If applicable)	√	×
16	Attending Physician Certificate (If applicable)	√	×

17	Ante-natal Record (If applicable)	√	×
18	Birth discharge Summary (If applicable)	√	×
19	Death Certificate (If applicable)	√	√
20	Burial Certificate	×	√
21	Attested Copy of Statement of Witness, if any lodged with police authorities	×	√
22	Attested Copy of FIR / Panchnama / Inquest Panchnama	×	√
23	Attested Copy of Viscera report if any (Only if Post-mortem is conducted)	×	√
24	*KYC (Photo ID card) (If applicable)	√	√
25	Address Proof		
26	Bank Details with Cancelled Cheque	√	√

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions A.1, B.1 and B.2.a may be considered where the reason for delay is proved to our satisfaction.

Insufficient Document

We have tried to reduce the number of documents you need to share but we shall not be liable to pay any claim in case all the necessary mandatory documents as mentioned in Our claims process are not submitted to Us.

*KYC documents shall be required at the claim settlement stage, where claims pay-out to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per claim, address and ID proof is required

24.Sum Insured Enhancement/Plan Change

a. Sum Insured enhancement/Plan Change can be done only at the time of renewal. You need to submit fresh proposal for Sum Insured Enhancement.
b. The acceptance of enhancement of Sum Insured or plan change would be at Our discretion, based on the health condition of the insured members & claim history of the policy.
c. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

25.Continuity Benefits

We will grant continuity of benefits which were available to the Insured Members under a health insurance policy which provides same coverage in the immediately preceding Cover Year provided that:

i. We shall be liable to provide continuity of only those benefits (for e.g.: Initial wait period, wait period of Specific Diseases pre-existing disease etc) which are applicable under this Policy;
ii. Any other waiting period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.

Annexure -A

List I – Optional Items

Sl No	Item
1.	BABY FOOD *(Not Payable)*
2.	BABY UTILITIES CHARGES *(Not Payable)*
3.	BEAUTY SERVICES *(Not Payable)*
4.	BELTS/BRACES *(Payable in cases where insured has undergone Surgery of thoracic or lumbar spine)*

5.	BUDS *(Not Payable)*
6.	COLD PACK/HOT PACK *(Not Payable)*
7.	CARRY BAGS *(Not Payable)*
8.	EMAIL/ INTERNET CHARGES *(Not Payable)*
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) *(Not Payable)*
10.	LEGGINGS *(Payable in Bariatric and Varicose Vein Surgery and may be considered for at least these conditions where Surgery itself is Payable)*
11.	LAUNDRY CHARGES *(Not Payable)*
12.	MINERAL WATER *(Not Payable)*
13.	SANITARY PAD *(Not Payable)*
14.	TELEPHONE CHARGES *(Not Payable)*
15.	GUEST SERVICES *(Not Payable)*
16.	CREPE BANDAGE *(Not Payable)*
17.	DIAPER OF ANY TYPE *(Not Payable)*
18.	EYELET COLLAR *(Not Payable)*
19.	SLINGS *(Reasonable costs for one sling in case of upper arm fractures should be considered)*
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES *(Part Of Cost Of Blood, Not Payable)*
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	Television Charges *(Payable Under Room Charges Not if separately levied)*
23.	SURCHARGES *(Part of Room Charge Not Payable Separately)*
24.	ATTENDANT CHARGES *(Part of Room Charge Not Payable Separately)*
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) *(Patient Diet provided by hospital is Payable)*
26.	BIRTH CERTIFICATE *(Not Payable)*
27.	CERTIFICATE CHARGES *(Not Payable)*
28.	COURIER CHARGES *(Not Payable)*
29.	CONVEYANCE CHARGES *(Not Payable)*
30.	MEDICAL CERTIFICATE *(Not Payable)*
31.	MEDICAL RECORDS *(Not Payable)*
32.	PHOTOCOPIES CHARGES *(Not Payable)*
33.	MORTUARY CHARGES *(Payable upto 24 Hours. Shifting charges not Payable)*
34.	WALKING AIDS CHARGES *(Not Payable)*
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) *(Not Payable)*
36.	SPACER *(Not Payable)*
37.	SPIROMETRE *(Device Not Payable)*
38.	NEBULIZER KIT *(Not Payable)*
39.	STEAM INHALER *(Not Payable)*
40.	ARMSLING *(Not Payable)*
41.	THERMOMETER *(Not Payable)*
42.	CERVICAL COLLAR *(Not Payable)*
43.	SPLINT *(Not Payable)*
44.	DIABETIC FOOTWEAR *(Not Payable)*
45.	KNEE BRACES (LONG/ SHORT/ HINGED) *(Not Payable)*
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER *(Not Payable)*
47.	LUMBO SACRAL BELT *(Payable only where Insured has undergone Surgery of Lumbar Spine)*
48.	NIMBUS BED OR WATER OR AIR BED CHARGES *(Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadriplegia for any reason and at reasonable cost of approximately Rs. 200 / day*
49.	AMBULANCE COLLAR *(Not Payable)*
50.	AMBULANCE EQUIPMENT *(Not Payable)*

51.	ABDOMINAL BINDER *(Not Payable)*
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES *(Post hospitalization nursing charges not Payable)*
53.	SUGAR FREE Tablets *(Payable. Sugar free variants of admissible medicines are Not excluded)*
54.	CREAMS POWDERS LOTIONS *(Toiletries are not payable, only prescribed medical pharmaceuticals payable)*
55.	ECG ELECTRODES *(Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be Payable)*
56.	GLOVES *(Sterilized Gloves Payable / Unsterilized Gloves not payable)*
57.	NEBULISATION KIT *(Payable Reasonably only if used during Hospitalization)*
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, etc.]
59.	KIDNEY TRAY *(Not Payable)*
60.	MASK *(Not Payable)*
61.	OUNCE GLASS *(Not Payable)*
62.	OXYGEN MASK *(Not Payable)*
63.	PELVIC TRACTION BELT *(Not Payable)*
64.	PAN CAN *(Not Payable)*
65.	TROLLY COVER *(Not Payable)*
66.	UROMETER, URINE JUG *(Not Payable)*
67.	AMBULANCE *(Payable Reasonably only if used during Hospitalization upto sub-limit mentioned in the policy schedule)*
68.	VASOFIX SAFETY *(Not Payable)*

List II - Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED) *(Not Payable)*
2	HAND WASH *(Not Payable)*
3	SHOE COVER *(Not Payable)*
4	CAPS *(Not Payable)*
5	CRADLE CHARGES *(Not Payable)*
6	COMB *(Not Payable)*
7	EAU-DE-COLOGNE/ ROOM FRESHNERS *(Not Payable)*
8	FOOT COVER *(Not Payable)*
9	GOWN *(Not Payable)*
10	SLIPPERS *(Not Payable)*
11	TISSUE PAPER *(Not Payable)*
12	TOOTHPASTE *(Not Payable)*
13	TOOTHBRUSH *(Not Payable)*
14	BED PAN *(Not Payable)*
15	FACE MASK *(Not Payable)*
16	FLEXI MASK *(Not Payable)*
17	HAND HOLDER *(Not Payable)*
18	SPUTUM CUP *(Payable Under Investigation Charges, Not as Consumable)*
19	DISINFECTANT LOTIONS *(Not Payable-Part of Dressing Charges)*
20	LUXURY TAX *(Only Actual Tax Levied by Government is Payable - Part of Room Charge for Sub Limits)*
21	HVAC *(Part of Room Charge Not Payable Separately)*
22	HOUSE KEEPING CHARGES *(Part of Room Charge Not Payable Separately)*
23	AIR CONDITIONER CHARGES *(Payable Under Room Charges Not if separately levied)*
24	IM IV INJECTION CHARGES *(Part of Nursing Charges, Not Payable)*
25	CLEAN SHEET *(Part of Laundry/housekeeping Not Payable Separately)*

26	BLANKET/WARMER BLANKET *(Not Payable- Part of Room Charges)*
27	ADMISSION KIT *(Not Payable)*
28	DIABETIC CHART CHARGES *(Not Payable)*
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES *(Not Payable)*
30	DISCHARGE PROCEDURE CHARGES *(Not Payable)*
31	DAILY CHART CHARGES *(Not Payable)*
32	ENTRANCE PASS/ VISITORS PASS CHARGES *(Not Payable)*
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE *(To be Claimed by Patient under Post -Hospitalization where admissible)*
34	FILE OPENING CHARGES *(Not Payable)*
35	INCIDENTAL EXPENSES/ MISC. CHARGES (NOT EXPLAINED) *(Not Payable)*
36	PATIENT IDENTIFICATION BAND/ NAME TAG *(Not Payable)*
37	PULSEOXYMETER CHARGES *(Not Payable)*
38	Nursing, DMO/ RMO charges included in room rent under associated medical expenses *(Not Payable)*

List III - Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM *(Not Payable)*
2	DISPOSABLES RAZORS CHARGES (for site preparations) *(Payable for site preparations)*
3	EYE PAD *(Not Payable)*
4	EYE SHIELD *(Not Payable)*
5	CAMERA COVER *(Not Payable)*
6	DVD, CD CHARGES *(Payable only if CD is specifically sought by Insurer/TPA)*
7	GAUSE SOFT *(Not Payable)*
8	GAUZE *(Not Payable)*
9	WARD AND THEATRE BOOKING CHARGE *(Payable Under OT Charges, Not Payable Separately)*
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS *(Rental Charged By The Hospital Payable. Purchase of Instruments Not Payable.)*
11	MICROSCOPE COVER *(Payable Under OT Charges, Not Payable Separately)*
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER *(Payable Under OT Charges, Not Payable Separately)*
13	SURGICAL DRILL *(Payable Under OT Charges, Not Payable Separately)*
14	EYE KIT *(Payable Under OT Charges, Not Payable Separately)*
15	EYE DRAPE *(Payable Under OT Charges, Not Payable Separately)*
16	X-RAY FILM *(Payable Under Radiology Charges, Not as Consumable)*
17	BOYLES APPARATUS CHARGES *(Part Of OT Charges, Not Separately)*
18	COTTON *(Not Payable-Part of Dressing Charges)*
19	COTTON BANDAGE *(Not Payable-Part of Dressing Charges)*
20	SURGICAL TAPE *(Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges)*
21	APRON *(Not Payable -Part of Hospital Services/Disposable Linen to be Part of OT/ICU Charges)*
22	TORNIQUET *Not payable (service is charged by hospital, consumables cannot be separately charged.*
23	ORTHOBUNDLE, GYNAEC BUNDLE (Part of Dressing Charges)

List IV - Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES *(Not Payable)*
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE *Unless A Claim Is Accepted Under Section1 - A. Accidental Hospitalization Cover And/Or B. Accidental & Illness Hospitalization Cover*
3	URINE CONTAINER *(Not Payable)*
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES *(Not Payable)*
5	BIPAP MACHINE *(Not Payable)*
6	CPAP/ CAPD EQUIPMENTS *(Device Not Payable)*
7	INFUSION PUMP- COST *(Device Not Payable)*
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC (May be Payable when prescribed for patient, not Payable for hospital use in OT or ward or for dressings in hospital)
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES *(Patient diet provided by hospital is payable)*
10	HIV KIT *(Payable Only as Pre-Operative Screening)*
11	ANTISEPTIC MOUTHWASH *(Payable when prescribed)*
12	LOZENGES *(Payable when prescribed)*
13	MOUTH PAINT *(Payable when prescribed)*
14	VACCINATION CHARGES *(Except to the extent covered under SECTION 4. MATERNITY BENEFIT WALLET & NEW BORN BABY COVER if opted & For dog or animal bite)*
15	ALCOHOL SWABES *(Not Payable. Part of hospital's own internal cost)*
16	SCRUB SOLUTIONISTERILLIUM *(Not Payable. Part of hospital's own internal cost)*
17	Glucometer& Strips *(Not Payable pre hospitalization or post hospitalization / Reports and Charts required/ Device not payable)*
18	URINE BAG *(Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs)*

List V – Additional Non-Payable Items

Sr. No	List of Expenses Generally Excluded ("Non-medical")
1.	Brush
2.	Cosy Towel
3.	Moisturiser Paste Brush
4.	Powder
5.	Barber Charges
6.	Oil Charges
7.	Bed Under Pad Charges
8.	Cost Of Spectacles/ Contact Lenses/ Hearing Aids, Etc.,
9.	Dental Treatment Expenses That Do Not Require Hospitalisation
10.	Home Visit Charges
11.	Donor Screening Charges
12.	Band Aids, Bandages, Sterile Injections, Needles, Syringes
13.	Blade
14.	Maintenance Charges
15.	Preparation Charges
16.	Washing Charges
17.	Medicine Box
18.	Commode
19.	Digestion Gels
20.	Novarapid
21.	Volini Gel/ Analgesic Gel
22.	Zytee Gel

23.	AHD (Ancillary And Hospital Disinfection (Eg.,Biomedical Waste Disposal/Management, Sanitation, Sanitization/Fumigation Charges Etc.)
24.	Visco Belt Charges
25.	Examination Gloves
26.	Outstation Consultant's/ Surgeon's Fees
27.	Paper Gloves
28.	Referral Doctor's Fees
29.	Sofnet
30.	Softovac
31.	Stockings

Annexure B

Address and contact number of Council For Insurance Ombudsman

Office Location	Contact Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 – 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: COUNCIL FOR INSURANCE OMBUDSMAN ,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.Tel.: 022 – 69038801/03/04/05/06/07/08/09 Email: inscoun@cioins.co.in

Plan Chart

(Digit Health Insurance Policy)

Sections	Coverages	Double Wallet Plan	Infinity Wallet Plan	Carry Forward Sum Insured Plan	Worldwide Treatment Plan	Early Start Plan	Senior Priority Plan
BASE COVERAGES							
	Sum Insured Options	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores	Upto INR 3 Crores
I	**Hospitalization Cover**						

i	Inpatient Hospitalization Cover	No Restriction or Room Rent	No Restriction on Room Rent	No Restriction on Room Rent	No Restriction on Room Rent	No Restriction on Room Rent	No Restriction on Room Rent
ii	Day Care Procedures	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
iii	Pre-Hospitalization	30 days	60 days	90 days	60 days	30 days	30 days
iv	Post Hospitalization	60 days	180 days	180 days	180 days	60 days	60 days
v	Road Ambulance	1% of Sum Insured max upto INR 10,000	1% of Sum Insured max upto INR 15,000	1% of Sum Insured max upto INR 20,000	1% of Sum Insured max upto INR 10,000	1% of Sum Insured max upto INR 10,000	1% of Sum Insured max upto INR 10,000
vi	Bariatric Surgery	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
vii	Psychiatric Illness	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
viii	Health Check-up	0.25% of Sum Insured max upto INR 1,000 after every two year	0.25% of Sum Insured max upto INR 1,500 after every year	0.25% of Sum Insured max upto INR 2,000 after every year	0.25% of Sum Insured max upto INR 2,000 after every year	0.25% of Sum Insured max upto INR 1,500 after every year	0.25% of Sum Insured max upto INR 1,500 after every year
x	Home (Domiciliary) Expenses	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
II	**Organ Donor Expenses**	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Not Applicable
III	**Emergency Air Ambulance**	Not Applicable	Upto B Sum Insured	Upto Sum Insured	Upto Sum Insured	Not Applicable	Not Applicable
IV	**Maternity Benefit Wallet and New-born Cover**	Not Applicable	Not Applicable	Not Applicable	Not Applicable	INR 15,000 it will increase by INR 10,000 per year maximum upto INR 1,00,000	Not Applicable
V	**Worldwide Coverage**	Not Applicable	Not Applicable	Not Applicable	Upto Sum Insured	Not Applicable	Not Applicable
VI	**Sum Insured Back-up**	Upto Sum Insured Once in a policy period - related and unrelated illness	Upto Sum Insured Unlimited Reinstatement in a policy period - related and unrelated illness	Upto Sum Insured Unlimited Reinstatement in a policy period - related and unrelated illness	Upto Sum Insured Once in a policy period - related and unrelated illness	Upto Sum Insured Once in a policy period - related and unrelated illness	Upto Sum Insured Once in a policy period - Unrelated illness
VII	**In-built Personal Accident**	INR 50,000	INR 1,00,000	INR 1,00,000	INR 1,00,000	INR 1,00,000	Not Applicable
VIII	**AYUSH Hospitalization (Mandatory In-Built cover in Section-1 Hospitalization Cover)**	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
OPTIONAL COVERAGES							
1	**Consumables Cover**	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured	Upto Sum Insured
2	**Network Hospital Discount**	Available	Available	Available	Available	Available	Available
3	**Pre-existing Disease/Specific Disease/Initial Waiting Period Modification**	Available	Available	Available	Available	Available	Available

II. Digit Glow Term Life Insurance

PART – B

Important Terms and Definitions

DEFINITIONS

In this Policy, unless the context requires otherwise, the following words and expressions shall have the meaning assigned to them respectively herein below:

1. **Accident, Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Accidental Death** The Accident shall result in Bodily Injury or injuries to the Life Assured independently of any other means. Such Injury or injuries shall, within 180 days of the occurrence of the Accident directly and independently of any other means, cause the death of the Life Assured. Such a death is defined as "Accidental Death".
3. **Accelerated Terminal Illness Benefit** means the absolute amount of Benefit payable on diagnosis of Terminal Illness to the Insured Person after the Risk Commencement date and during the Policy Term and in accordance with terms and conditions of the Policy and is specified as such in the Policy Schedule.
4. **Accidental Total & Permanent Disability (ATPD)** refers to a disability, which:
   a) Is caused by Bodily Injury resulting from an Accident; and
   b) Occurs solely and directly due to the said Bodily Injury and shall be independent of any other cause; and
   c) Occurs within 180 days of the occurrence of such Accident; and
   d) Results in (i) Total and irrecoverable loss of sight of both eyes, or; (ii) Physical separation or loss of use of both hands or feet, or; (iii) Physical separation or loss of use of one hand and one foot, or; (iv) loss of sight of one eye and Physical separation or loss of use of hand or foot; (v) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Life Assured from engaging in any employment or occupation of any description whatsoever. .

   The above is exclusive of and without prejudice to the other causes of total and permanent disability.

   Where, Physical separation shall mean physical severance of the hand at or above the wrist or physical severance of the foot at or above the ankle.

   The date of the Accident should be after the Risk Commencement Date and before Policy End Date.
5. **Additional Accidental Death Benefit (ADB)** means the absolute amount of Benefit in addition to Death Benefit and which is guaranteed to become payable on occurrence of the event of Accidental Death of the Life Assured, where such Accident occurs after the Risk Commencement Date but occurs before the Policy End Date. This Benefit shall be payable in accordance with the terms and conditions of the Policy and is specified as such in the Policy Schedule.
6. **Additional Accidental Total and Permanent Disability (ATPD) Benefit** means the absolute amount of Benefit which is guaranteed to become payable on occurrence of the event of Accidental Total and Permanent Disability of the Life Assured, where such Accident occurs after the Risk Commencement Date but occurs before the Policy End Date. This Benefit shall be payable in accordance with the terms and conditions of the Policy and is specified as such in the Policy Schedule.
7. **Act** refers to the Insurance Act 1938 as amended from time to time and shall include the Insurance Laws (Amendment) Act 2015.

8. **Age at Entry or Entry Age** shall be Age of the Life Assured at Policy Commencement Date as at last birthday i.e. the Age in completed years and is recorded in the Policy Schedule based on the details provided by the Policyholder.
9. **Annualized Premium** shall be the Premium amount payable in a year chosen by the Policyholder excluding the taxes, rider Premiums, underwriting extra premiums and loadings for modal Premiums, if any.
10. **Appointee** shall mean a person who is appointed by the Life Assured to receive the Benefits on behalf of the Nominee/(s), if the Nominee/(s) is a/are minor on the date of the payment of such Benefit on the happening of the death of Life Assured.
11. **Assignee** is the person to whom the rights and Benefits under this Policy are transferred by virtue of an Assignment.
12. **Assignment** is the process of transferring the rights and Benefits to an "Assignee," in accordance with the provisions of Section 38 of Insurance Act, 1938, as amended from time to time.
13. **Assignor** means the person who transfers the rights and Benefits under this Policy to the Assignee by virtue of an Assignment.
14. **Authority** means Insurance Regulatory and Development Authority of India (IRDAI).
15. **Benefit/s** means the Death Benefit, Inbuilt Optional Benefits which are Additional Accidental Death Benefit, Additional Accidental Total and Permanent Disability Benefit, Accelerated Terminal Illness Benefit or any other Benefit as applicable under the terms of this Policy.
16. **Beneficiary** means the Policyholder or the Life Assured or Nominee/(s) or the Assignees, as the case may be.
17. **Claimant** means the Policyholder or the Life Assured or the Nominee (under Section 39 of the Insurance Act, 1938 as amended from time to time) who is entitled to register a claim for the insured event under the Policy; or Assignees under Section 38 of the Insurance Act 1938 as amended from time to time or where there is no Beneficiary(s), then the Life Assured's legal heir or legal representative or the holder of a succession certificate, as the case may be.
18. **Early Termination** means complete withdrawal/ termination of the Policy before completion of Policy Term at the request of the Policyholder and in accordance with terms and conditions of this Policy.
19. **Grace Period (for other than Single Pay Policies)** means the time granted by the Company from the due date for the payment of Premium without any penalty or late fee, during which time the Policy is considered to be In Force with the risk cover without any interruption, as per the terms and conditions of the Policy. The Grace Period so granted is fifteen (15) days for monthly Premium payment frequency and thirty (30) days for other available Premium payment frequencies from the respective due date of first unpaid Premium.
20. **Inbuilt Optional Benefits** means Accelerated Terminal Illness Benefit, Additional Accidental Death Benefit and Additional Accidental Total and Permanent Disability Benefit as described in Clause 2 of Part C of this Policy Document. These are optional Benefits being offered under Digit Glow Term Life Insurance and any one or more of these Benefits can be chosen by the Policyholder by paying additional Premium for each one of them at the Date of the Inception of Policy.
21. **Indebtedness** means any unpaid Premiums, deductibles and any other amounts owed to the Company.
22. **In Force** means status of the Policy being active, all due Premiums have been paid and the Policy is not terminated or in lapsed status.

23. **Injury / Bodily Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

24. **Lapsation** means state of a non-active life insurance contract on account of non-payment of Premium within the Grace Period.
25. **Life Assured / Insured Person** means the person named as such in the Policy Schedule, on whose life the Policy has been taken in terms hereof.

26. **Limited Pay Policy** means the Policy other than Single Pay Policy, where the Premium is paid for a limited period, which shall be less than the Policy Term, and Premiums are payable at regular intervals like annually, half yearly, quarterly or monthly.

27. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The person shall not be

    • The Policyholder/ Life Assured himself/herself; or
    • An authorized Insurance Intermediary (or related persons) involved with selling or servicing the insurance contract in question; or
    • Employed by or under contractual engagement with the Policyholder / Life Assured;
    • Related to the Policyholder/ Insured person by blood or marriage.

28. **Nomination** is the process of nominating a person(s) in accordance with provisions of Section 39 of the Insurance Act, 1938 as amended from time to time.

29. **Nominee/s** means a person / persons nominated by the Policyholder to receive the applicable Benefit/(s) under this Policy in case of death of the Life Assured and whose name/(s) is/are mentioned in Policy Schedule.

30. **Policy** means the contract of insurance entered into between the Policyholder and the Insurer as evidenced by the Policy Document.

31. **Policy Document** means this Digit Glow Term Life Insurance Policy comprising the necessary documents including terms and conditions, Policy Schedule, the signed Proposal Form, any endorsements in this document issued by Us from time to time and the annexures, if any.

32. **Policyholder** shall mean the owner of this Policy and is referred to as the proposer in the Proposal form and is named as such in the Policy Schedule.

33. **Policy Schedule** means the Policy Schedule set out above in Part A that We have issued, along with any annexures, tables and/or endorsements, attached to it from time to time and forming part of this Policy and if any updated Schedule is issued, then the Schedule which is latest in time.

34. **Policy End Date** means the date of completion of the Policy Term as specified in the Policy Schedule.

35. **Policy Commencement Date / Date of Inception of the Policy** is the Date, Month and Year the Policy comes into effect and is as specified in the Policy Schedule.

36. **Policy Term** means the tenure of this Policy as specified in the Policy Schedule.

37. **Policy Year** means a period of twelve (12) consecutive months starting from the Policy Commencement Date and ending on the day immediately preceding the following Policy anniversary date and each subsequent period of twelve (12) consecutive months thereafter.

38. **Premium Payment Term (PPT)** means the period in years during the Policy Term in which Premiums are payable by the Policyholder under the Policy, as specified in the Policy Schedule.

39. **Premium/s** means the contractual amount payable by the Policyholder in a Policy Year on the due date as set out in the Policy Schedule to secure the Benefits under this Policy. Applicable tax, cess and other levies if any are payable in addition.

40. **Proposal** means the proposal form filled in and submitted by You to the Company for issuance of this Policy.

41. **Renewal Premium** means the Premium payable in second Policy Year and onwards during the Premium Payment Term under Limited Pay and Regular Pay Policies.

42. **Regular Pay Policy** means the Policy, where the Premium payment is throughout the Policy Term with Premium Payment Term and Policy Term being equal and Premiums are payable at regular intervals like annually, half yearly, quarterly, monthly or any other interval as approved by the Authority.

43. **Regulations** mean the laws and Regulations in effect as amended from time to time and applicable to this Policy, including without limitation the Regulations and directions issued by the Insurance Regulatory and Development Authority of India (IRDAI) from time to time. The applicable Regulation shall form a part and parcel of the terms and conditions, and the terms and conditions shall be read along with the Regulation.

44. **Revival** means restoration of the Policy, which is in lapsed status due to non-payment of the Premium (as stated in Part D in this Policy Document), by the Company with all the Benefits mentioned in the terms and conditions, with or without Rider Benefits, if any upon receipt of all the Premiums due and other charge/late fee if any, as per the terms and conditions of the Policy, upon being satisfied as to the continued insurability of the Life Assured/Policyholder on the basis of the information, documents and reports furnished by the Policyholder, in accordance with the board approved underwriting guidelines.

45. **Revival Period** shall mean the period of five years (during the Policy Term) from the due date for payment of the first unpaid Premium during which the Policyholder is entitled to revive the Policy for full Benefits, as provided in terms of Part D of this Policy Document.

46. **Risk Commencement Date** means the date from which risk is assumed by the Company and as specified in the Policy Schedule.

47. **Single Pay Policy** means the Policy, where the Premium payment is made only one time in lump sum at the Date of Inception of the Policy.

48. **Sum Assured on Death** means an absolute amount of Benefit which is agreed to be paid by Us on occurrence of death of Life Assured as per the terms and conditions of this Policy and as specified in Policy Schedule or such amount as may be endorsed on the Policy.

49. **Terminal Illness** means an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two independent Medical Practitioners specializing in treatment of such illness, certifies that the illness is expected to lead to death of the Life Assured within 6 months of the date of diagnosis of the Terminal Illness.
    The Company reserves the right for an independent assessment by two different Medical Practitioners other than the Medical Practitioner whose diagnosis has been provided by the Life Assured.

50. **Unexpired Risk Premium Value** means an amount, if any, that becomes payable in case of Early Termination of the Policy, in accordance with the terms and conditions of the Policy as mentioned in Part D of this Policy Document.

51. **Total Premiums Paid** means total of all the Premiums received, excluding any extra Premium, any rider premium and taxes.

52. **"We", "Us", "Our" "Ours", "Digit" "Digit Life" "Digit Life Insurance", "Insurer" and "Company"** refers to Go Digit Life Insurance Limited.

53. **"You", "Your", "Yours"** refers to the Policyholder named in Policy Schedule.

PART – C
Product Core Benefits (Benefits Payable Under This Policy)

1. **Death Benefit:** Subject to terms and conditions of this Policy and the Policy remaining In-Force as on the date of the death of the Life Assured (after the Risk Commencement Date but before the Policy End Date), the Company shall pay the lumpsum Death Benefit as mentioned below to the Claimant after deducting the Premiums, if any due for the Policy Year in which the death has occurred. In the event of death claim during the Grace Period, the Company shall pay Death Benefit in lumpsum as follows, subject to the deduction of any Premium which is unpaid as on the date of death.

   Death Benefit payable shall be the highest of the following:

   i. 105% (One Hundred Five percent) of Total Premiums Paid as on the date of death of the Life Assured, OR

   ii. 10 times the Annualized Premium, OR

   iii. Sum Assured on Death

   The Policy shall terminate on payment of Death Benefit.

2. **Inbuilt Optional Benefits**

   One or more of the following Inbuilt Optional Benefits can be chosen at the Date of Inception of the Policy subject to Our acceptance, prevailing underwriting policy of the Company and terms and conditions of this Policy. Subject to terms and conditions of this Policy and Policy remaining In-Force at the time of insured event, the Company shall pay the chosen Inbuilt Optional Benefit/s in lumpsum as specified in the Policy Schedule and as described below. Once chosen at the Date of the Inception of Policy, Inbuilt Optional Benefit/s cannot be changed later.

   Inbuilt Optional Benefits are not applicable for Point-of-Sale Policies.

2.1. Additional Accidental Death Benefit (Additional ADB):

If this Inbuilt Optional Benefit is chosen, then in the event of death of the Life Assured due to an Accident, provided that the Accident has occurred during the Policy Term and the Policy is In-Force, in addition to the Death Benefit, the Accidental Death Benefit as specified in the Policy Schedule shall be payable in lumpsum. Additional Accidental Death Benefit payable shall be equal to 100% of Sum Assured on Death. A claim under this Benefit Option shall be admitted provided that the death:

i. is caused by Injury resulting from an Accident,
ii. occurs solely and directly due to the Injury, and independent of any other causes,
iii. occurs within 180 days of the occurrence of Accident and
iv. is not a result from any of the causes listed in the exclusions for Accidental Death Benefit specified in Annexure.

In case, the Accident occurs while the Life Assured's Additional Accidental Death Benefit is In-force, but the Accidental Death occurs after the Policy End Date and within 180 days of the Accident, Additional Accidental Death Benefit shall be payable to the Claimant.

The Policy shall terminate on payment of the Additional Accidental Death Benefit.

Definitions and exclusions pertaining to Additional Accidental Death Benefit are provided in Annexure IV in this Policy Document.

2.2. Additional Accidental Total and Permanent Disability (ATPD) Benefit:

If this Inbuilt Optional Benefit is chosen, then upon occurrence of total and permanent disability due to an Accident, provided that the Accident has occurred during the Policy Term and the Policy-is In-Force, Additional Accidental Total and Permanent Disability Benefit as specified in Policy Schedule shall be payable in lumpsum. Additional Accidental Total and Permanent Disability Benefit payable shall be equal to 100% of Sum Assured on Death and shall be in addition to Death Benefit and other Inbuilt Optional Benefit/(s) (if any).

In case, the Accident occurs while the Life Assured's Additional Accidental Total and Permanent Disability Benefit is In-Force, but the Accidental Total and Permanent Disability (ATPD) occurs after the Policy End Date and within

180 days of the Accident, Additional Accidental Total and Permanent Disability Benefit shall be payable to the Claimant.

On payment of the Additional ATPD Benefit, insurance cover for this Benefit under Policy terminates, however, the Policy shall continue for In-Force Death Benefit and other In-Force Inbuilt Optional Benefits (if any) for the remaining Policy Term.

Definitions and exclusions pertaining to Additional Accidental Total and Permanent Disability Benefit are provided in Annexure V in this Policy Document.

2.3. Accelerated Terminal Illness Benefit

If this Inbuilt Optional Benefit is chosen, Accelerated Terminal Illness Benefit as specified in Policy Schedule shall be payable as lump sum upon the occurrence of Terminal Illness condition in respect of Life Assured during the Policy Term, where such an occurrence happens while the Policy is In Force.

This is an accelerated Benefit, which means it only facilitates an earlier payment of Death Benefit on prior occurrence of the Terminal Illness. It is payable only once during the lifetime of the Life Assured and shall be equal to the Death Benefit under the Policy.

The Terminal Illness must be diagnosed and confirmed by Medical Practitioners. We reserve the right for an independent assessment by two different Medical Practitioners other than the Medical Practitioner whose diagnosis has been provided by Life Assured.

The Policy shall terminate upon payment of Accelerated Terminal Illness Benefit.

3. Survival / Maturity Benefit

This Policy does not provide any Survival or Maturity Benefit on survival of the Life Assured.

4. Wellness Benefit – Through this program, We intend to incentivize the Life Assured for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services.
The applicability of the wellness benefit program and its features may be amended from time to time as per the availability of suitable service providers. The list of services under this program and terms and conditions applicable to them are provided in Annexure VI in this Policy Document.

5. Premium under this Policy:

5.1. Payment of Premiums: This Policy is issued subject to the Policyholder making prompt and regular payment of Premium as and when due during the Premium Payment Term as mentioned in the Policy Schedule and it shall be the responsibility of the Policyholder to ensure regular payment of the Premium. Any Premium paid by You will be deemed to have been received by Us only after the same has been realized and credited to Our bank account.

Except in case of Single Pay Policy, Premiums under the Policy can be paid on annual, half-yearly, quarterly or monthly basis as per the chosen Premium payment frequency and as set out in the Policy Schedule or as amended subsequently. The method of Premium collection will be subject to board approved underwriting policy of the Company.

For Premium payment frequency other than annual, instalment Premiums payable are calculated by applying the loading factor as given below on annual premium:

Premium paying frequency	Loading factor
Half-yearly	2%
Quarterly	3%
Monthly	4%

Policyholder will have an option to change the Premium payment frequency during Premium Payment Term by submitting a written request to Us, provided the limits of minimum Premium for the chosen Premium payment

frequency are adhered to and the Benefits remains unchanged. Any change in the Premium payment frequency will result in a change in the Premium amount basis the applicable loading factors. A change in Premium payment frequency will be effective only on the Policy anniversary following the receipt of such request, subject to the Policy being In Force

5.2. Payment of Advance Premiums: Collection of advance Premium shall be allowed within the same financial year for the Premium due in that financial year. However, where the Premium due in one financial year is being collected in advance in earlier financial year, Premium for maximum period of three months in advance of the due date shall be collected or as may be permitted by IRDAI. The Premium so collected in advance shall only be adjusted on the due date of the Premium. These advance premiums shall be non-refundable, except in case of Free Look Cancellation of this Policy.

Any Premiums paid before the due date will be deemed to have been received on the due date for that Premium.

6. Grace Period

Except for Single Pay Policies, a` Grace Period of fifteen (15) days from the due date of the first unpaid Premium for Policies with monthly Premium payment frequency and thirty (30) days from the due date of the first unpaid Premium for all other available Premium payment frequencies will be allowed for the payment of each due Premium instalment. Instalment Premium Payment in parts shall not be accepted. During the Grace Period, the Policy shall continue to be In Force for availing the Benefit/(s) as applicable. Any unpaid due Premium is deductible from the Benefits that may arise during the Grace Period. The Company shall pay the applicable Benefit during Grace Period, subject to the deduction of the Premiums due as well as balance Premiums for the Policy Year, if any under the Policy.

A Premium will be deemed to remain unpaid if the Premium amount has not been realized by Us.

PART – D
Policy Servicing Related Aspects

1. **Free Look Provisions:**
   If You do not agree with the terms and conditions of the Policy, You have the option to request for cancellation of the Policy by returning the original Policy Document (in case the physical copy of Policy Document was sent to the Policyholder) along with a written request stating the reasons for objection to Us within 30 days from the date of receipt of Policy Document. Upon such Free-Look cancellation, the Company shall refund the Premiums received after deducting proportionate risk premium for the period of insurance coverage and expenses incurred on medical examination of Life Assured, if any and applicable stamp duty. The Policy and all the Benefits, rights under it shall immediately stand terminated on the cancellation of the Policy.

2. **Lapsation of the Policy (applicable for Limited Pay and Regular Pay Policies only):**
   If the due Premium is not paid by the end of Grace Period, the Policy will lapse on the expiry of Grace Period until the Policy is revived for full Benefits within the Revival Period. No Benefit shall be payable if the Policy is in lapsed status.

   However, for Limited Pay Policies, if at least three full year's Premiums are paid and no further Premium is paid, then only in case of event of death of Life Assured after the Grace Period, Death Benefit equal to prevailing Unexpired Risk Premium Value payable on Early Termination as applicable on the date of death shall be payable to the Claimant.

   In any case, Inbuilt Optional Benefits (if chosen) shall not be payable for the Policy in lapsed status.

3. **Reduced Paid-up Benefit**
   This Policy does not have any reduced paid-up benefit.

4. **Early Termination of Policy**

   For Single Pay Policies, Policy can be terminated any time before the completion of Policy Term and Unexpired Risk Premium Value, if any, shall be payable on such Early Termination of the Policy.

   Unexpired Risk Premium Value on Early Termination of Single Pay Policies = 60% x Single Premium amount x (Outstanding Policy Term/Policy Term)

   For Limited Pay Policies, Policy can be terminated any time before the completion of Policy Term and Unexpired Risk Premium Value, if any, shall be payable on such Early Termination of the Policy, provided three full years' Premiums are received by Us before such termination.

   Unexpired Risk Premium Value on Early Termination of Limited Pay Policies = 60% x Total Premiums Paid x (Outstanding Policy Term/Policy Term) x (1 – Premium Payment Term / Policy Term)

   In case, any Limited Pay Policy is terminated where three full years' Premiums are not paid, the Unexpired Risk Premium Value shall not be applicable.

   For Regular Pay Policies: No Unexpired Risk Premium Value is payable for Regular Pay Policies.
   Any change to the above-mentioned formula for deriving Unexpired Risk Premium Value shall be subject to the prior approval of the Authority.

   All the rights / title and interest under the policy shall stand extinguished upon Early Termination of the Policy.

5. **Revival**
   5.1. Subject to the approval of the Company and the prevailing board approved underwriting policy, this Policy, if lapsed may be revived for full Benefits before the Policy Maturity Date but within five years from the due date for payment of the first unpaid Premium provided that;

5.1.1. This Policy has not been surrendered for cash;
5.1.2. No claim has arisen under this Policy;
5.1.3. Where required by the Company, a written application for Revival/ is received from the Policyholder by the Company, together with evidence of insurability and health of the Life Assured, to the satisfaction of the Company; and
5.1.4. All amounts necessary to revive this Policy including all arrears Premiums with interest for late payment of Premiums /Revival charge set as per the formula below and is subject to IRDAI's approval: (10-year benchmark G-Sec Yield + 1.5%) rounded up to multiple of 25 bps. The Revival interest rate will be reviewed on 31st March of every year and any change in Revival interest rate will be applicable from the following 1st July to 30th June period.

The current rate of interest for Revival is 9.00% p.a. Interest rate will be as prevailing from time to time.
Any change on basis of determination of interest rate for Revival can be done only after prior approval of the Authority.

5.2. Notwithstanding anything to the contrary contained elsewhere in this Policy, the Company reserves the right to revive the lapsed Policy either on its original terms and conditions or on such other or modified terms and conditions as the Company may specify or to reject the Revival. If needed the Company may refer it to its medical examiner in deciding on Revival of lapsed Policy. Subject to the provisions of Part D.5.1 above, the Revival shall come into effect on the date when the Company specifically communicates it in writing to the Policyholder.

5.3. If the Policy in lapsed status is not revived for full Benefits before the Policy End Date but within five years from the due date for payment of the first unpaid Premium, then the Policy will terminate and no Benefit shall be payable to the Claimant.

6. Policy Loan: Policy loan is not available under this Policy.

7. Payment of Benefits:

7.1. Payment of the Benefits under this Policy shall be subject to deduction of any unpaid Premium due, balance Premiums for the Policy Year of death and deduction of any Indebtedness.
7.2. Payment of all the Benefits as shown in the Policy Schedule shall be subject to receipt of proof by the Company to its satisfaction:
7.2.1. of the Benefits having become payable as set out in this Policy and as per the terms and conditions of this Policy; and
7.2.2. of the title of the person or persons claiming the Benefits; and
7.2.3. of the correctness of the Age of the Life Assured as stated in the Proposal, if not previously admitted.
7.3. All Benefits and other sums under this Policy shall be payable in the manner and currency allowed/permitted under the Regulations and shall be payable by NEFT, account payee cheque or other permissible modes.
7.4. The Company shall pay the applicable Benefits and other sums payable under this Policy to the Policyholder / Claimant as the case may be. Once the applicable Benefits under this Policy are paid to the Policyholder / Claimant as the case may be, the same will constitute a valid discharge of Our liability under this Policy.
7.5. Apart from the Benefits mentioned hereinabove in part C, and if applicable as per the Policy Schedule, the Company shall not be liable to pay any other Benefits to the Claimant.

8. Termination

a) Termination of Policy: All the rights and Benefits under the Policy shall terminate upon the occurrence of the earliest of the following:
i) On the date on which We receive a Freelook cancellation request from the Policyholder;
ii) On the date of payment of Death Benefit on death of Life Assured
iii) On the date of payment of Accelerated Terminal Illness Benefit.

iv) On Policy End Date
v) On lapsed Policy not being revived during the Revival Period;
vi) On the date of Early Termination;
vii) On the date of payment of dues as per suicide clause (as mentioned in Part F)
viii) On cancellation / termination of the Policy by Company on grounds of fraud, misstatement and suppression of a material fact in accordance with Section 45 of Insurance Act, 1938 as amended from time to time.

9. **Loss of Policy Document & Issuance of duplicate Policy Document:** In the event, if the physical Policy Document received by You is lost or destroyed, You may make a written request for a duplicate Policy Document, which We will issue duly endorsed to show that it is in place of the original document, provided that, We receive the fee not exceeding Rs. 250 for issuing the duplicate Policy Document. Upon the issue of a duplicate Policy Document,
   a) the original one shall cease to have any legal force or effect.
   b) You agree that You shall indemnify and hold Us free and harmless from and against any and all claims, losses, costs expenses, awards, judgements, demands or damages that may arise under or in relation to the original Policy document.
   c) You will not be entitled to any free-look period cancellation on duplicate Policy document issued. However, we may permit free-look period cancellation in cases where after investigation, it is evident that You did not receive the original Policy document, either in physical or the soft copy.

PART – E

All the Applicable Charges, Fund Name, Fund Options, etc. (Applicable especially for ULIP Policies)

1) Not Applicable as this is a non-linked product.

PART - F

General Terms and Conditions

1) **Fraud, Misstatement and forfeiture:** In issuing this Policy, the Company has relied on, and would rely on, accuracy and completeness of the information provided by the Policyholder/Life Assured and any other declarations or statements made or as may be made hereafter, by the Policyholder/Life Assured.

   In case of fraud or misstatement or forfeiture, the Policy shall be treated in accordance with the provisions of Section 45 of the Insurance Act, 1938 as amended from time to time.

   [A Leaflet containing the simplified version of the provisions of Section 45 is enclosed as Annexure I for reference]

2) **Misstatement of Age:** The Age of the Life Assured has been admitted on the basis of the declaration made by the Policyholder / Life Assured in the Proposal Form and/or in any document/statement based on which this Policy has been issued. If the Age of the Life Assured is found to be different from that declared, the Company may adjust the Premiums and/or the Benefits under this Policy and/or recover the applicable balance amounts, if any, along with interest thereon, as it deems fit. This Policy shall however become void from Risk Commencement Date and We may refund the Premiums paid (excluding applicable taxes) subject to deduction of proportionate risk premium for the period of insurance cover in addition to the expenses incurred on medical examination (if any), stamp duty charges and Benefits already paid, if any, if at any time the Age of the Life Assured is found to be higher than the maximum Entry Age or lower than the minimum Entry Age that was permissible under this Policy at the time of Risk Commencement Date. The provisions of Section 45 of the Insurance Act 1938 as amended from time to time shall be applicable.

3) **Assignment:** Assignment should be in accordance with provisions of Section 38 of the Insurance Act 1938 as amended from time to time.

   [A Leaflet containing the simplified version of the provisions of Section 38 is enclosed as Annexure II for reference].

4) **Nomination:** Nomination should be in accordance with provisions of Section 39 of the Insurance Act 1938 as amended from time to time.

   [A Leaflet containing the simplified version of the provisions of Section 39 is enclosed as Annexure III for reference]

5) **Review, revision**: The Company reserves the right to review, revise, delete and/ or alter any of the terms and conditions of this Policy, including without limitation the Benefits, the Premiums with the prior approval of IRDAI.

6) **Release and discharge:** The Policy will terminate automatically on payment of the refund from Free Look cancellation, Unexpired Risk Premium Value, Death Benefit, on lapse of the Policy if not revived in accordance with terms and conditions of this Policy or on happening of events that the Policy states specifically that the Policy shall terminate, as the case may be, and the Company will be relieved and discharged from all obligations under this Policy thereafter.

7) **Taxes, duties and levies and disclosure of information:**

   Taxes, duties and levies: It shall be the sole responsibility of the Policyholder/Claimant to ensure compliance with all applicable laws including Regulations, taxation laws, and payment of all applicable taxes in respect of the Premiums and Benefits or other payouts made or received by the Policyholder/Claimant under this Policy and the Company does not accept any liability or responsibility in this regard. Except as may be specifically required by the Regulations, the Company shall not be responsible for any tax liability arising in relation to this Policy, the Premiums payable or the Benefits or other payouts made in terms of this Policy.The Company shall be entitled to deduct such amounts towards taxes, duties or such other levies as may be required from any sum received by it or payable under this Policy, and deposit the amount so deducted with the appropriate

government or regulatory authorities. Policyholder/Claimant acknowledge that they are solely responsible for understanding and complying with their respective tax obligations (including but not limited to,tax payment or filing of returns or other required documentation relating to the payment of all relevant taxes in all jurisdictions in which Your tax obligations arise and relating to the Services provided by Us.
We do not provide any tax advice. Policyholder/Claimant is advised to seek independent legal and/or tax advice. We have no responsibility in respect of Policyholder/Claimant's tax obligations in any jurisdiction including but not limited to those that relate specifically to the Services provided by Us. Tax benefits, if any, may be available as per extant tax laws.

8) **Notice by the Company under the Policy:** We will send you the Policy Document in accordance with the applicable laws. We will send the communication or notices to You either in physical at Your registered address or in electronic mode (including sms) at registered e-mail id or registered mobile number and / or through facsimile provided by You in Proposal Form or otherwise notified to Us, or by issuing general notice, including by publishing such notices in newspapers and / or on Company's website. Any change in the mailing address or any other communication details /email or registered mobile number of Policyholder/Life Assured or Claimant must be notified to Us immediately. This will help Us to serve You better.

9) **Electronic Transactions:** All transactions carried out by the Policyholder through Internet, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication will be valid and legally binding on the Policyholder / Life Assured / Claimants as well as the Company. This will be subject to the relevant guidelines and terms and conditions as may be made applicable by the Company.

10) **Governing Law and Jurisdiction:** This Policy shall be governed by and interpreted in accordance with the laws of India. All actions, suits and proceedings under this Policy shall be subject to the exclusive jurisdiction of the courts in India.

11) **Entire Contract:** This Policy comprises of the terms and conditions set forth in this Policy Document, the Policy Schedule, and the endorsements, if any, made on or applicable to this Policy, which shall form an integral part and the entire contract evidenced by this Policy. The liability of the Company is at all times subject to the terms and conditions of this Policy and the endorsements made from time to time.

12) **Recovery:** We reserve the right to recover the amount from the Policyholder or the Claimant or any other person, if it is found that the Benefits are erroneously paid due to the fault of the Policyholder or the Claimant. However, the Policyholder will not be liable or responsible for any wrong payments made by the Company without any fault on the part of the Policyholder, however the Company shall be entitled to recover the amount paid erroneously from the Policyholder or any other person deriving the Benefit of the said error.

13) **Policy Currency:** All Contributions/Premiums and Benefits payable shall be paid in Indian Rupees only.

14) **Suicide Exclusion:** In case of death of the Life Assured due to suicide within 12 months from the Risk Commencement Date under the Policy or from the date of Revival of the Policy, as applicable, Claimant shall be entitled to at least 80% of the Total Premiums Paid till the date of death or Unexpired Risk Premium Value available as on the date of death whichever is higher, provided the Policy is In Force.

15) **Requirements for claims /Claim Procedure:** In order to register a claim under the Policy, the Claimant shall endeavor to inform Us in writing with the following documents (as applicable) along with bank account details (Cancelled Cheque/copy of passbook with IFSC code) of the Claimant:
   a) **For Death Claim, except death claims arising out of accidents or unnatural deaths**
      i) Duly completed Claim Form signed by Claimant.
      ii) Original Policy Document
      iii) KYC document of Life Assured and Claimant

iv) Attested copy of Death Certificate of the Life Assured issued by Indian Government Authority.
v) Medical treatment records (discharge summary / death summary, investigation and treatment reports, post mortem report, etc) if Life Assured has taken treatment for illness leading to his/her death

b) In case of Death Benefit claim arising out of Accident or unnatural death, the following documents need to be submitted, in addition to above requested documents:
i) Police Records – Attested copy of First Information Report, Panchnama / Inquest Panchnama
ii) Newspaper cutting/Photograph of the accident, in case of Accidental Deaths.
iii) Attested Copy of Postmortem Report (Only if conducted).
iv) Attested Copy of Viscera report if any (Only if Postmortem is conducted)

c) For Accidental Total and Permanent Disability Benefit Claim:
i) Claimants Statement for Disability Claim,
ii) Attested copy of disability certificate from relevant Government Medical authority.
iii) All investigation including Medical Records, Indoor Case papers, Lab tests reports confirming the disability
iv) Complete treatment record with follow-up documentation
v) Attested copy of FIR (if required)
vi) Disability assessment report from Digit empanelled medical specialist (if required)
vii) KYC document of Claimant

d) For Accelerated Terminal Illness Benefit claim:
i) Duly completed Claim Form signed by Claimant.
ii) Medical Report(s) including Investigation report(s), indoor case papers, Hospital Summary/Discharge Card
iii) Medical Practitioner's Certificate confirming the Illness/Treatment advise/Medical Reference
iv) KYC document of Claimant

Notwithstanding anything contained in Clause 15 above of this Part F, depending upon the cause or nature of the claim, the Company reserves the right to call for any other and/or additional documents or information, including documents/information concerning the title of the person claiming the Benefit/(s) under this Policy, to the satisfaction of the Company, for processing of the claim.

The claim should be intimated to the Company within a period of 90 days from the date of insured event, to treat the same as a valid claim. However, delay in intimation of claim or submission of documents should be supported by valid reasons for the Company to condone such delay.

16) Claims Intimation

a) The claim can be notified with proof of claim to the Claims Department' at lifeclaims@godigit.com, and the claim documents to be simultaneously sent at Go Digit Life Insurance Limited, Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095.
b) Claims can also be intimated at Our helpline number – 9960126126 and claim documents to be simultaneously sent at Digit Life Office address as mentioned above in (a) and (b).
c) Claim intimation to the Company can also be made in writing and delivered to the nearest branch office or Corporate Office address, which is currently as:

Claims department

Go Digit Life Insurance Limited
Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095
Helpline Number: 9960126126
Email id: lifeclaims@godigit.com

Any change in the address or details above will be communicated by the Company to the Policyholder. Our liability under the Policy will be automatically discharged on payment to the Claimant.

PART – G
Grievance Redressal Mechanism and Ombudsman Details

1) Contact Information for Complaints & Grievance Redressal

a) Meet your Grievance Officer at Your nearest Digit Life Branch Office
b) Write to life@godigit.com from Your registered email address.
c) Call 9960126126 from your registered mobile number.

2) Grievance Escalation Matrix

a) Level 1: In case the complainant is not satisfied with the response, the complainant can escalate the grievance to Chief Grievance Redressal Officer within 8 weeks from date of complaint resolution at **lifegro@godigit.com.**

Address:
The Chief Grievance Redressal Officer
Go Digit Life Insurance Limited.
Atlantis,95,4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095

b) **Level 2:** In case the complainant is not satisfied with the response or does not receive any response from the Chief Grievance Redressal Officer within 15 days, complainant may approach the grievance cell of the Insurance Regulatory and Development Authority of India (IRDAI):

IRDAI Grievance Call Centre (IGCC) Address:
Consumer Affairs Department, Insurance Regulatory and Development Authority of India
Survey No. 115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad
Telangana State – 500032
Toll Free Number: 155255 (or) 1800 4254 732
Timings: 8 AM to 8 PM (Monday to Saturday)
Email: complaints@irdai.gov.in
Website: http://igms.irda.gov.in

c) **Level 3**

Manner of making complaints to Insurance Ombudsman: In case the complainant is not satisfied with the decision/resolution of the Company, or does not receive any response from the Company within 30 days of filing the complaint, the complainant may approach the nearest Insurance Ombudsman. Pls refer the list of Insurance Ombudsman at the end of this section.

As per the provisions of Rule 13(1) of Insurance Ombudsman Rules, 2017, the Ombudsman shall receive and consider complaints or disputes relating to:

i) delay in settlement of claims
ii) any partial or total repudiation of claims
iii) disputes over premium paid or payable in terms of the policy
iv) misrepresentation of policy terms and conditions
v) legal construction of insurance policies in so far as the dispute relates to claim.
vi) servicing related grievances against insurers, their agents and intermediaries
vii) issuance of policy not in conformity with Proposal form submitted.
viii) non-issuance of insurance policy after premium receipt; and
ix) any other matter resulting from regulatory violation, related to issues mentioned at clauses a. to h.

As per the provisions of Rule 14 of Insurance Ombudsman Rules, 2017:

Rule 14(1), any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located.

Rule 14(2), the complaint shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by

documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

Rule 14(3), no complaint to the Insurance Ombudsman shall lie unless:

i) the complainant makes a written representation to the insurer named in the complaint and
   (1) either the insurer had rejected the complaint; or
   (2) the complainant had not received any reply within a period of one month after the insurer received his representation; or
   (3) the complainant is not satisfied with the reply given to him by the insurer

ii) The complaint is made within one year—
   (1) after the order of the insurer rejecting the representation is received; or
   (2) after receipt of decision of the insurer which is not to the satisfaction of the complainant.
   (3) after expiry of a period of one month from the date of sending the written representation to the insurer if the insurer named fails to furnish reply to the complainant.

Rule 14(4), the Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

Rule 14(5), no complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

List of Insurance Ombudsman Centers

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	State of Karnataka
BHOPAL Office of the Insurance Ombudsman, 1st Floor, "Jeevan Shikha" 60-B, Hoshangabad Road, Opp Gayatri Mandir, Bhopal -462 011. Tel.:- 0755-2769201/2769202 Email: bimalokpal.bhopal@cioins.co.in	States of Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar-751009. Tel.:- 0674-2596461/2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	State of Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No.101-103,2nd Floor, Batra Building, Sector 17-D,	States of Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.

Chandigarh-160 017. Tel.:- 0172-4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	
CHENNAI Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai-600 018. Tel.:- 044-24333668 /24333678 Email: bimalokpal.chennai@cioins.co.in	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
NEW DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, New Delhi-110 002. Tel.:- 011-23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi and following districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, Guwahati-781 001 (ASSAM). Tel.:- 0361-2632204/2602205 Email: bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, Lane Oppo. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel : 040-23312122 Email: bimalokpal.hyderabad@cioins.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam and a part of the Union Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, Jaipur – 302005 Tel : 0141-2740363//2740798 Email: Bimalokpal.jaipur@cioins.co.in	State of Rajasthan
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 7th Floor, Kolkata - 700 072. Tel : 033-22124339/22124341 Email:- bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim, Union Territories of Andaman and Nicobar Islands.

LUCKNOW Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, Lucknow-226 001. Tel : 0522 - 4002082/ 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), Mumbai-400 054. Tel : 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	States of Goa and Mumbai Metropolitan Region excluding areas of Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Gautam Budh Nagar, U.P.-201301 Tel.: 0120-2514252 / 2514253 Email:- bimalokpal.noida@cioins.co.in	States of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA Office of the Insurance Ombudsman, 2nd Floor, North Wing, Lalit Bhawan, Bailey Road, Patna - 800 001. Tel.: 0612 – 2547068 Email:- bimalokpal.patna@cioins.co.in	States of Bihar and Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Maharashtra, Area of Navi Mumbai & Thane but excluding Mumbai Metropolitan Region

Note: For further information or latest updated list of Ombudsman Office addresses, kindly visit the following website. https://www.cioins.co.in/Ombudsman

IRDAI Notice - Beware of Spurious/Fraud Phone Calls: IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint**.**

Digit Glow Term Life Insurance Go Digit Life Insurance Limited (previously known as Go Digit Life Sciences Limited). IRDAI Registration number: 165, CIN: U66000PN2021PLC206995, Registered Office: Go Digit Life Insurance Limited, Ananta One (AR One), Pride Hotel Lane, Narveer Tanaji Wadi, City Survey No. 1579, Shivajinagar, Pune-411005; Corporate Office: Go Digit Life Insurance Limited, Atlantis,95,4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095; Customer Helpline Number: 9960126126; Website:www.godigit.com/life Email: life@godigit.com

ANNEXURE – I

Section 45 – Policy shall not be called in question on the ground of misstatement after three years.

Provisions regarding Policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1) No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 years from
   a) the date of issuance of Policy or
   b) the date of commencement of risk or
   c) the date of Revival of Policy or
   d) the date of rider to the Policy,
   whichever is later.
2) On the ground of fraud, a Policy of Life Insurance may be called in question within 3 years from
   a) the date of issuance of Policy or
   b) the date of commencement of risk or
   c) the date of Revival of Policy or
   d) the date of rider to the Policy
   whichever is later.

For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3) Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance Policy:
   a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b) The active concealment of a fact by the insured having knowledge or belief of the fact;
   c) Any other act fitted to deceive; and
   d) Any such act or omission as the law specifically declares to be fraudulent.
4) Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
5) No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / claimant can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Policyholder, if alive, or claimant.
6) Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which Policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the Policy of life insurance is based.
7) In case repudiation is on ground of misstatement and not on fraud, the Premium collected on Policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.
8) Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance Policy would have been issued to the insured.
9) The insurer can call for proof of age at any time if he is entitled to do so and no Policy shall be deemed to be called in question merely because the terms of the Policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 45 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

ANNEXURE – II

Section 38 – Assignment and Transfer of Insurance Policies:

Provisions regarding assignment or transfer of a Policy in terms of Section 38 of the Insurance Act, 1938, as amended from time to time are as follows:

1) This Policy may be transferred/assigned, wholly or in part, with or without consideration.
2) An Assignment may be effected in a Policy by an endorsement upon the Policy itself or by a separate instrument under notice to the Insurer.
3) The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
4) The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
5) The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly 68 authorized agents have been delivered to the insurer.
6) Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
7) On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
8) If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the Policy is being serviced.
9) The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
   a) not bonafide or
   b) not in the interest of the Policyholder or
   c) not in public interest or
   d) is for the purpose of trading of the Insurance Policy.
10) Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of Policyholder giving a notice of transfer or assignment.
11) In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.
12) The priority of claims of persons interested in an insurance Policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.
13) Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
   a) where assignment or transfer is subject to terms and conditions of transfer or assignment OR
   b) where the transfer or assignment is made upon condition that
   c) the proceeds under the Policy shall become payable to Policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
   d) the insured surviving the term of the Policy

Such conditional assignee will not be entitled to obtain a loan on Policy or surrender the Policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14) In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
   a) shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
   b) may institute any proceedings in relation to the Policy
   c) obtain loan under the Policy or surrender the Policy without obtaining the consent of the transfer or assignor or making him a party to the proceedings.
15) Any rights and remedies of an assignee or transferee of a life insurance Policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act 2015 shall not be affected by this section.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 38 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

ANNEXURE – III

Section 39 – Nomination by Policyholder

Provisions regarding nomination of a Policy in terms of Section 39 of the Insurance Act, 1938, as amended from time to time are as follows:

1) The Policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the Policy shall be paid in the event of his death.
2) Where the nominee is a minor, the Policyholder may appoint any person to receive the money secured by the Policy in the event of Policyholder's death during the minority of the nominee. The manner of appointment is to be laid down by the insurer.
3) Nomination can be made at any time before the vesting of the Policy.
4) Nomination may be incorporated in the text of the Policy itself or may be endorsed on the Policy communicated to the insurer and can be registered by the insurer in the records relating to the Policy.
5) Nomination can be cancelled or changed at any time before Policy matures, by an endorsement or a further endorsement or a will as the case may be.
6) A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bona fide payment is made to the person named in the text of the Policy or in the registered records of the insurer.
7) Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
8) On receipt of notice with fee, the insurer should grant a written acknowledgement to the Policyholder of having registered a nomination or cancellation or change thereof.
9) A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will get affected to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
10) The right of any creditor to be paid out of the proceeds of any Policy of life insurance shall not be affected by the nomination.
11) In case of nomination by Policyholder whose life is insured, if the nominees die before the Policyholder, the proceeds are payable to Policyholder or his heirs or legal representatives or holder of succession certificate.
12) In case nominee(s) survive the person whose life is insured, the amount secured by the Policy shall be paid to such survivor(s).
13) Where the Policyholder whose life is insured nominates his
    a) Parents, or
    b) Spouse, or
    c) Children, or
    d) Spouse, and children
    e) or any of them

The nominees are beneficially entitled to the amount payable by the insurer to the Policyholder unless it is proved that the Policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14) If nominee(s) die after the Policyholder but before his share of the amount secured under the Policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15) The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act 2015.
16) If Policyholder dies after maturity, but the proceeds and benefit of the Policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the Policy.
17) The provisions of Section 39 are not applicable to any life insurance Policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the Policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the Policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 39 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

Annexure IV

Exclusions to Additional Accidental Death Benefit

Additional Accidental Death Benefit shall not be payable if death occurs from, or is caused by, either directly or indirectly, voluntarily or involuntarily due to or caused, occasioned, accelerated or aggravated by, any one of the following:

1. Any injury before commencement of Additional Accidental Death Benefit's coverage.
2. Infection: Death caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
3. Death arising due to any condition other than death solely and directly as a result of an accident.
4. Intentional self-inflicted injury, attempted suicide / suicide while sane or insane.
5. Life Assured being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
6. War, invasion, act of foreign enemy, hostilities, war like operations (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
7. Taking part in any naval, military or air force operation during peace time or during service in any police, paramilitary or any similar organization;
8. Participation by the Life Assured in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
9. Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities
10. Participation by the Life Assured in a criminal or unlawful act with criminal intent.
11. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing, diving or riding or any kind of race.
12. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature. Biological, chemical or radioactive contamination.

Annexure V

Exclusions to Additional Accidental Total and Permanent Disability Benefit

Additional Accidental Total and Permanent Disability Benefit shall not be payable if total and permanent disability occurs from, or is caused by, either directly or indirectly, voluntarily or involuntarily due to or caused, occasioned, accelerated or aggravated by, any one of the following:

1. Any injury before commencement of Additional Accidental Total and Permanent Disability Benefit's coverage.
2. Infection: Total and permanent disability caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
3. Total and permanent disability arising due to any condition other than total and permanent disability solely and directly as a result of an accident.
4. Intentional self-inflicted injury, attempted suicide / suicide while sane or insane.
5. Life Assured being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
6. War, invasion, act of foreign enemy, hostilities, war like operations (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
7. Taking part in any naval, military or air force operation during peace time or during service in any police, paramilitary or any similar organization;
8. Participation by the Life Assured in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
9. Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities
10. Participation by the Life Assured in a criminal or unlawful act with criminal intent.
11. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing, diving or riding or any kind of race.
12. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature. Biological, chemical or radioactive contamination.

Annexure VI

Wellness Benefit Program

There are total 17 services applicable under Wellness Benefit Program, subject to availability of suitable service providers.

1. **Doctor on Call**
   Upon Your request, We will facilitate an appointment, through Our empanelled Service Provider, with a Medical Practitioner who can help You by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service or a video call service.
2. **Wellness Coach**
   In order to educate, empower and engage You to become more aware of Your health and proactively manage it, We will, through periodic communications like e-mailers, blogs, videos, webinar and online platform provide You information on wellness coaching including but not limited to the areas as provided below:
   a) Weight Management
   b) Activity and Fitness
   c) Nutrition
   d) Tobacco Cessation
   e) Alcohol Abuse de-addiction Program
   f) Information on various diseases
   g) Dietary Plans
3. **Lab Services and Imaging (For Diagnostic Services)**
   Upon Your request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc or imaging for further testing and analysis.
   The cost of these tests and reports will have to be borne by You.
4. **Pharmacy (Home Delivery)**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner and nutritional supplement from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy.
   The cost of the medication will have to be borne by You.
5. **Vital/Physical Activity Monitoring Services**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, the integration of Your Health Device(s), orDigital Wearables or trackers such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, heart rate monitors, pulse oximeters, non-invasive wearable blood-sugar sensors, Smart Watches etc. to an online database that will track and asses Your vitals as reported by the device.
   It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You.
6. **Reminder Notifications**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to You as a reminder to schedule Your medical appointments and/or take daily dosage of Your medicine as per the information shared by You.
7. **Medical Wallet**
   Upon Your request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow You to store all Your medical reports online. It will provide easy access of Medical history and reports to the treating Medical Practitioners and to any other person with whom You may share the login and access codes, easing Your need to physically carry documents with You.
8. **Report Aggregation**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of Your health status as per the medical records/reports/information or data shared by You. It will highlight your wellbeing or any areas of concern or deterioration in Your health, allowing You to take necessary calls about your health.
9. **Home Care Services**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, Home Care Services for You in case You are in need of services , including but not limited to the following:

a. Home Care Nursing
b. Patient Assistant
c. Physiotherapy
d. Yoga Trainer
e. Psychologist
f. Palliative Care
g. Renting Medical equipment. For Example - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.
h. Doctor Visit
i. Elderly care and senior living assistance related to their health condition

The cost of the Services/Equipment will have to be borne by You.

10. Ambulance Arrangement Services

Upon request, We will facilitate, through Our Empanelled Service Provider, ambulance services for Your transportation subject to availability of ambulance in the area where such service needs to be arranged.
The cost of the transportation will have to be borne by You.

11. Pick-up and Drop Services for Consultation

Upon Your request, We will facilitate, through Our Empanelled Service Provider, Pick-up and Drop Service, for Your transportation to the Health Care Facility for treatment/Diagnostics subject to availability of vehicle/taxi in the area where such service needs to be arranged.
The cost of the transportation will have to be borne by You.

12. Prioritizing Appointments

Upon Your request, We will facilitate, through Our Empanelled Service Provider, prioritization of Your appointment, based on the urgency, with the Network Providers offering the necessary consultation/treatment/diagnostics/packages/memberships/risk assessment/procedures subject to availability of the service(s).The cost of the Consultancy/Diagnostic will have to be borne by You. These may include the following but not limited to :-

- Doctors' services
- Nursing services
- Dietitian services

13. Mental wellbeing - Upon Your request, We will facilitate, through Our empanelled Service Provider, self-assessments, therapy sessions, activities and educational/awareness blogs, videos and webinars. The cost of these sessions will have to be borne by You.

14. Physiotherapy - Upon Your request, We will facilitate, through Our empanelled Service Provider, consultation and treatment sessions/packages, pain management sessions, ergonomics sessions The cost of these services will have to be borne by You.

15. Childcare/Children's activities - Upon Your request, We will facilitate, through Our empanelled Service Provider, recreational/developmental activities for children of different age groups. The cost of these services will have to be borne by You.

16. Out-Patient (OPD) Services - Upon Your request, We will facilitate, through Our empanelled Service Provider, outpatient care services like doctor consultation, pharmacy and diagnostics, both online and onsite. The cost of these services will have to be borne by You.

17. Fitness – Upon Your request, we will facilitate, through our empanelled service provider, access to membership or classes of fitness activities like but not limited to sports, yoga, Zumba, Pilates, dance, fitness coach services at gymnasiums, health studios, fitness centres, sports centres and playgrounds. The cost of these services will have to be borne by You.

Terms and Conditions applicable to Wellness Benefit Program

1. Any Information provided by You shall be kept confidential.
2. For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services. We will not charge any premium amount for the services. You need to pay directly to the Service Provider/Medical Experts/Centres for the services availed.
3. All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured Person may however consult their Personal/Family Doctor before

availing the medical services. The decisions to utilise the services will solely be at the discretion of the Insured Person.

4. We/Company/Us or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Person/You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
5. This shall not be deemed to substitute the Insured Person's visit or consultation to an Independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.
6. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

Subject otherwise to all the other terms, conditions, warranties, limitations and exceptions of the Policy to which this Benefit is attached.

Disclosures

1. The product is jointly offered by "Go Digit General Insurance Ltd" and "Go Digit Life Insurance Ltd."

2. The risks under the components of the Combi Product are distinct. Go Digit Life Insurance Ltd shall assume/accept the risk only in relation to the life insurance component of the Combi Product and Go Digit General Insurance Ltd shall assume/accept the risk only in relation to the health insurance component of the Combi Product.

3. The premium of the life insurance and health insurance components of the Combi Product are separate and have been separately identified and disclosed in the Combi Product policy document. The health insurance component of the Combi Product is entitled to be renewed at the option of the policyholder of Go Digit General Insurance Ltd.

4. You shall pay the integrated premium for the Combi Product to either of Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd. The insurer receiving the consolidated premium shall further transfer the relevant share of the premium to the other insurer. You shall be entitled to the underlying benefits of both life and health insurance components of the Combi Product from the date and time of acceptance of the integrated premium by Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd.

5. The Combi Product shall have a free look option, which shall be applied to the Combi Product as a whole. Provided where an existing policyholder of any health insurance product has migrated to the Combi Product, such policyholder is entitled to all the rights of migration as per the applicable portability norms.

6. At any time during the validity of the Combi Product policy, you shall be entitled to continue with either part of the Combi Product policy, discontinuing the other.

7. The liability to settle the claim vests with respective Insurers, i.e., for life insurance benefits, Go Digit Life Insurance Ltd and for health insurance benefits, Go Digit General Insurance Ltd.

8. All policy servicing requests pertaining to the Combi Product shall be received by either of the Insurers. However, Go Digit General Insurance Ltd, as the Lead Insurer of the Combi Product, shall play a facilitative role in policy servicing and shall be the nodal point for receiving the servicing requests, executing these requests and issuing acknowledgements as required.

9. All requests pertaining to the Combi Product impacting premium or policy terms of Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be serviced by Go Digit Life Insurance Ltd for life products and by Go Digit General Insurance Ltd for health products, as the case may be.

10. Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall fulfil servicing requests received by them in accordance with the IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024, as amended from time to time. Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be responsible for the pro-active and speedy settlement of claims and other obligations in accordance with the terms and conditions of their respective life insurance or health insurance components of the Combi Product. The claim process is available on the website of both Go Digit Life Insurance Ltd and Go Digit General Insurance Ltd.

11. You may lodge a grievance with respect to either or both of the life insurance and health insurance components of the Combi Product at branches of either Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd. Complaint belonging to any product shall be routed to the respective insurer viz. Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd, who shall then respond/address to the Customer directly. Complaints shall be forwarded by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd to each other for their respective Product. In the event you are not satisfied with the resolution offered, you

may also approach the Insurance Ombudsman in your region. Please refer to the relevant grievance redressal mechanism section mentioned under each component of the Combi Product.

12. The legal/quasi legal disputes, if any, are dealt by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd for their respective benefits. The legal disputes pertaining to life insurance benefits shall be dealt with by Go Digit Life Insurance Ltd and for health benefits all the legal disputes will be handled by Go Digit General Insurance Ltd.

13. You are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.

14. Withdrawal of tie up between the Insurers:
    Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up between them after obtaining the requisite approval from the IRDAI. Upon receipt of such approval from the IRDAI, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up with notice period of ninety (90) days, or such other period as may be prescribed by the IRDAI, from the date of such approval. The insurers may mutually decide to terminate the Agreement and intimate the same to the customer ninety (90) days prior to the termination of the relationship. However, the Policy will continue until the expiry or termination of the coverage in accordance with the policy wordings for respective coverage.
    In case of withdrawal of tie-up between insurers, the customer may choose to continue with either of the policies (health or life). However, the same will be subject to Migration guidelines with respect to health part of the combi product.
    In the event of termination of this tie up, Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall mutually cooperate for providing customer support and policy servicing post termination of the tie up between Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd. Further, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd, as the case may be, shall remain liable for its respective life insurance or health insurance components for all Combi Product policies in force at the time of termination of this tie up until their expiry.