DIGIT LIFE GROUP LONG TERM PLAN

A Non-Linked, Non-Participating, Group Pure Risk Premium Life Insurance Plan

UIN: 165N002V01

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No matter what your area of work is, the value that individual members bring to your group cannot be underestimated. While being an important part of the group or organization, your members or employees are also an essential part of their family. It hence becomes your responsibility to ensure financial security for them against death and range of other risks. Any untoward incident can derail the plans a group member has for his / her family and leave them exposed and vulnerable to life's hardships. Wouldn't it be good if an employee or a group member can be given peace of mind by financially securing him or her against such untoward incidents?

PRESENTING DIGIT LIFE GROUP LONG TERM PLAN

Digit Life Group Long Term Plan is a non-linked, non-participating, group pure risk premium life insurance plan that provides life insurance cover to insured members and in case of unfortunate event, financially protect their families with death benefit either by paying lumpsum benefit or in form of stream of income or provides combination of both as per the chosen option. This plan also offers a range of inbuilt optional benefits like financial protection against accidental death and disability, critical Illness, multi-stage cancer conditions, terminal illness, hospitalization to create a customized and comprehensive protection solution.

KEY FEATURES OF THE PLAN

- Can be offered to both Employer-Employee and Non-Employer-Employee or Affinity groups.
- Provides a high degree of customization and flexibility to create a tailormade solution.
  - Option to choose death benefit as lumpsum or regular income or combination of both basis members' financial needs.
  - Inbuilt optional benefits for financial protection against Terminal Illness, Critical Illnesses, Multi-Stage Cancer conditions, Hospitalization, death and disability due to accident
  - Flexibility to choose single life cover / joint life cover
  - Flexibility to choose coverage type – level cover, decreasing cover, flexi cover
  - Flexibility to choose premium payment options – Single Premium, Limited Premium and Regular Premium payment options
  - Option to pay the premium as per preferred premium payment frequency (Single, monthly, quarterly, half-yearly, or annually)
- Availability of Profit-sharing option to master policyholder
- Wellness benefits to insured members

An individual member will get the choice to opt from the various options made available by the master policyholder under the policy with respect to applicable benefit options, coverage term, coverage options, single or joint life cover, premium payment term, premium payment frequency, sum assured, other applicable options, if any, subject to terms and conditions of the master policy, scheme rules and prevailing underwriting policy of Company.

ELIGIBILITY CONDITIONS

Entry Age (as per last birthday)	Minimum - 14 years Maximum - 80 years		
Maturity Age (as per last birthday)	Minimum - 14 years Maximum - 80 years		
Group Size	Minimum - 5 members Maximum - No limit		
Minimum Sum Assured (SA)	Lumpsum Sum Assured per person - ₹10,000 Income Benefit per person (applicable in case of death benefit) - ₹100/ month (provided sum total of income payable is not less than ₹10,000)		
Maximum Sum Assured (SA)	Death Benefit	No Limit (subject to prevailing underwriting policy of the Company)	
	Inbuilt Optional Benefits	Terminal Illness Benefit Health Cover Benefit Hospitalization Cover Benefit Accidental Cover Benefit	No Limit (Subject to prevailing underwriting policy of the Company)
	Accelerated Benefits shall not exceed lumpsum sum assured chosen under death benefit		
Policy Term (Coverage Term)	Master policy will continue indefinitely until terminated. At member level, the policy term will be as per Premium Payment Option chosen		
	Premium Payment Option	Term Insurance under death benefit and inbuilt optional benefits	Term Insurance with Return of Premium (TROP) under death benefit
	Single Pay	1 month – 480 months	5 years – 40 years
	Limited Pay	3 months – 480 months	10 years – 40 years
	Regular Pay	2 months – 480 months	10 years – 40 years
	The coverage term at member level up to 3 years for Term insurance under death benefit and inbuilt optional benefits is applicable for lender-borrower schemes only.		
Premium Payment Term	Premium Payment Option	Term Insurance under death benefit and inbuilt optional benefits	Term Insurance with Return of Premium (TROP) under death benefit
	Single Pay	Single Premium Payment	Single Premium Payment
	Limited Pay	2 months – 479 months	5 years – 39 years
	Regular Pay	2 months – 480 months	10 years – 40 years
Premium Payment Frequency	Yearly, Half-Yearly, Quarterly, Monthly for Limited Pay and Regular Pay Single Pay for Single Premium option		

Coverage Term for inbuilt optional benefits can be less than or equal to coverage term for Death Benefit. In case of lender-borrower groups, maximum coverage term is same as outstanding loan term at inception.

WHAT ARE THE BENEFITS UNDER THIS PLAN?

A. DEATH BENEFIT

This is the base benefit and in case of unfortunate demise of the member during the coverage term, Death Benefit is payable to the nominee. Any one of the following death benefit options can be chosen by the member before coverage start date:

- Term Insurance – Death Benefit will be paid in the event of death of the insured member during the member coverage term, provided all premiums are paid as and when due. No survival benefit or maturity benefit shall be payable under this option.
- Term Insurance with Return of Premium (TROP) – Death Benefit will be paid in the event of death of the Insured Member during the member coverage term, provided all premiums are paid as and when due. In case of survival of the member (or survival of both individuals under joint life cover) till the end of member coverage term, total premiums paid will be returned in lumpsum at the end of such member coverage term.

Death Benefit Payout Options

Master policyholder can choose to offer the members any one or combination of the any of the following death benefit payout options subject to acceptance by the Company:

a. Lumpsum Sum Assured: Under this option (if chosen), a lumpsum amount will be paid following the death of insured member.

b. Income Benefit: Under this option (if chosen), regular income will be paid for chosen number of years (not exceeding 40 years minus coverage term) following date of member's death.

Income Benefit chosen can be level or increasing with income increasing at specified simple rate of up to 10% per annum. Any one of annual, half-yearly, quarterly or monthly mode can be chosen to receive the regular income payouts.

In case of income benefit option mentioned above, for presentation purpose, sum assured shall be defined as the total income payable in the next 12 months following the death of insured member.

Members of the same master policy can have different lumpsum sum assured amount and income benefit amount. The lumpsum sum assured or income benefit or combination of these two benefits, as chosen for each individual member will be specified on coverage inception date.

On payment of death benefit, insurance coverage for the insured member under this plan will immediately and automatically terminate.

Death Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Death Benefit	Death	In case of death of the member (on occurrence of first death in case of joint life cover) during the member coverage term, lumpsum sum assured and / or income benefit (if any), shall be payable.	**In case of Level Cover:** Lumpsum sum assured and / or income benefit under death benefit shall be payable. **Decreasing and Flexi Cover –** Prevailing lumpsum sum assured under death benefit, as per agreed schedule chosen before member's coverage start date shall be payable. Decreasing and Flexi Cover will not be applicable for income benefit.

B. INBUILT OPTIONAL BENEFITS

The master policyholder can choose one or more of the following in-built optional benefits before master policy commencement date subject to Company's acceptance and members can choose from such available options under the master policy, subject to prevailing underwriting policy of the Company and terms and conditions of this master policy. Premium will vary depending upon the inbuilt optional benefit/(s) chosen.

i. Terminal Illness (TI) Benefit

Terminal Illness means an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two independent Medical Practitioners, chosen by the Company and specializing in treatment of such illness, certify that the illness is expected to lead to death of the member within 6 months of the date of diagnosis of the Terminal Illness.

Accelerated Terminal Illness (TI) Benefit is offered under this benefit, which means payment of this benefit will not be in addition to lumpsum death benefit chosen and it only facilitates an earlier payment of lumpsum death benefit on prior occurrence of terminal illness. Accelerated TI benefit can be opted for when lumpsum death benefit is chosen (either as standalone or in combination with income benefit option). On diagnosis of a terminal illness, an amount equal to the TI Sum Assured will be paid. This benefit is payable only once during the lifetime of a member and shall not exceed lumpsum sum assured under death benefit.

Where the TI Sum Assured is equal to the applicable lumpsum sum assured under Death Benefit and income benefit option is not chosen under death benefit additionally, the insurance coverage for all the benefits, including inbuilt optional benefits (if any) in respect of the insured member will terminate immediately upon diagnosis of terminal illness and payment of accelerated TI benefit. However, if in such case, income benefit option is also chosen additionally, on payment of such accelerated TI benefit, the member's insurance coverage will continue with respect to only income benefit option under death benefit.

Where the TI Sum Assured is less than the applicable lumpsum sum assured under Death Benefit, on payment of the TI sum assured, the applicable lumpsum death benefit will be reduced to the extent of the TI sum assured paid and this change will be effective from the date of payment of accelerated TI benefit. On payment of the accelerated TI benefit, the member's insurance coverage in respect of inbuilt optional benefits (if any) under this master policy will immediately and automatically terminate.

Accelerated Terminal Illness (TI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Accelerated Terminal Illness Benefit	Terminal Illness (TI)	In case of diagnosis of Terminal illness, lumpsum Sum Assured is payable. In case of joint life cover, benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Terminal Illness condition.	**Level Cover:** TI Sum Assured, which will be acceleration of the lumpsum sum assured under death benefit shall be payable. **Decreasing & Flexi Cover:** TI Sum Assured, which will be acceleration of lumpsum sum assured under death benefit, prevailing as per agreed schedule chosen before member's coverage start date, shall be payable.

ii. Health Cover Benefit

There are three sub-options under Health Cover Benefit. A member can choose only one of these three following sub-options:

a) Accelerated Critical Illness (CI) Benefit

On occurrence of one of the covered Critical Illness Conditions with respect to the insured member, subject to survival period of 30 days and waiting period of 90 days, an amount equal to the Accelerated CI sum assured shall be payable in lumpsum.

This is an accelerated Benefit and it's payment will not be in addition to lumpsum sum assured chosen under Death Benefit and it only facilitates an earlier payment of such lumpsum sum assured under Death Benefit on prior occurrence of the Critical Illness. Accelerated CI Benefit can be opted for when lumpsum sum assured under Death Benefit is chosen (either standalone or in combination with income benefit option). Accelerated CI Benefit shall not exceed lumpsum sum assured under Death Benefit. On admission of claim under the accelerated CI Benefit:

Where the CI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and no Income Benefit is chosen in addition to lumpsum Sum Assured under Death Benefit, the insurance coverage for all the benefits, including Death Benefit and inbuilt optional benefits (if any) in respect of the insured member will cease immediately upon diagnosis of critical Illness and payment of Accelerated CI Benefit.

Where the CI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and Income Benefit is also chosen in addition to lumpsum Sum Assured under Death Benefit, on payment of CI Sum Assured, Accelerated CI Benefit along with the lumpsum sum assured under Death Benefit will terminate, however, member's insurance coverage shall continue with respect to income benefit under Death Benefit and other applicable inbuilt optional benefits, if any, for remaining of the respective member coverage terms.

Where the CI Sum Assured is less than the lumpsum Sum Assured under Death Benefit, on payment of the CI Sum Assured, the lumpsum sum assured under the Death Benefit will be reduced to the extent of the CI Sum Assured paid, and such change in the lumpsum sum assured under Death Benefit will be effective from the date of the payment of the Accelerated Critical Illness Benefit. Such member's insurance coverage under master policy in respect of other applicable inbuilt optional benefits (if any) will continue for the remaining of the respective member coverage terms.

Accelerated Critical Illness (CI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Accelerated Critical Illness (CI) Benefit	Critical Illness (CI)	In case of diagnosis of any one of the covered Critical Illnesses, basis the CI variant chosen, lumpsum Sum Assured is payable. In case of joint life cover, this Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Critical Illness condition.	**Level Cover:** CI Sum Assured, which will be acceleration of the lumpsum Sum Assured under Death Benefit, shall be payable. **Decreasing & Flexi Cover:** CI Sum Assured, which will be acceleration of lumpsum Sum Assured under Death Benefit, prevailing as per agreed schedule chosen before member's coverage start date, shall be payable.

b) Additional Critical Illness (CI) Benefit

On occurrence of one of the covered Critical Illness Conditions with respect to the insured member, subject to survival period of 30 days and waiting period of 90 days, an amount equal to the Additional CI sum assured shall be payable in lumpsum.

This is an additional Benefit and on admission of a claim under the Additional CI Benefit, the CI Sum Assured will be payable to the member. On payment of Additional CI Benefit, member's insurance coverage for this benefit under the master policy shall terminate, however member's insurance coverage shall continue in respect of applicable Death Benefit and other applicable inbuilt optional benefits (if any) for the remaining of the respective member coverage terms.

Additional Critical Illness (CI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Critical Illness (CI) Benefit	Critical Illness	In case of diagnosis of any one of the covered critical illnesses, basis the CI variant chosen, lumpsum Sum Assured is payable. In case of joint life cover, this Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Critical Illness condition.	**Level Cover:** CI Sum Assured shall be payable. **Decreasing Cover & Flexi Cover:** Prevailing CI Sum Assured as per agreed schedule chosen before member's coverage start date, shall be payable.

For both Accelerated CI Benefit and Additional CI Benefit: CI Sum Assured will not be paid on diagnosis of any of the covered critical illness condition when the master policy / insurance coverage to the member is in lapsed status. The claim for Critical Illness Benefit shall be accepted only if covered Critical Illness condition has happened to insured member for the first time in life and is not a consequence of or arising out of any pre- existing condition/disease. Once a claim has been accepted under Critical Illness Benefit, insurance coverage for the insured member under this policy with respect to CI Benefit shall cease and no further payment will be made for any consequent Critical Illness disease or any dependent critical illness/illnesses.

At the time of critical illness claim payment, the claimant will have an option to receive the additional / accelerated CI Benefit (as chosen) in the form of regular income over a period not exceeding 5 years. Such income payment can be chosen to be received in monthly, quarterly, half-yearly or annual mode. The first instalment pay-out shall be made immediately on acceptance of the CI claim by the Company. The lumpsum CI sum assured will be converted to the income amount as per chosen payment frequency and payment period using an effective interest rate of 5% p.a.

There are following three variants offered under Accelerated and Additional Critical Illness Benefit and any one of them can be chosen by member before inception of insurance coverage.

Variant 1 – 14 Critical Illnesses

Variant 2 – 20 Critical Illnesses

Variant 3 – 34 Critical Illnesses

The Critical Illnesses offered under three variants are as given in the table below:

S.No	Critical Illness Variant			List of Critical Illness Covered
1.	Variant 1	Variant 2	Variant 3	Cancer of Specified Severity
2.				Myocardial Infarction
3.				Open Heart Replacement or Repair of Heart Valves
4.				Surgery to Aorta
5.				Open Chest CABG
6.				End Stage Lung Failure
7.				End Stage Liver Failure
8.				Kidney Failure Requiring Regular Dialysis
9.				Major Organ/ Bone Marrow Transplant
10.				Benign Brain Tumour
11.				Coma of Specified Severity
12.				Major Head Trauma
13.				Permanent Paralysis of Limbs
14.				Multiple Sclerosis with Persisting Symptoms
15.				Primary (Idiopathic) Pulmonary Hypertension
16.				Apallic Syndrome
17.				Stroke Resulting in Permanent Symptoms
18.				Motor Neurone Disease with Permanent Symptoms
19.				Loss of Independent Existence
20.				Aplastic Anaemia
21.				Aneurysm of Abdominal Aorta
22.				Cardiomyopathy
23.				Pulmonary artery graft surgery
24.				Parkinson's Disease
25.				Muscular Dystrophy
26.				Progressive Supranuclear Palsy
27.				Creutzfeldt-Jakob disease (CJD)
28.				Bacterial Meningitis
29.				Alzheimer's disease
30.				Encephalitis
31.				Systemic lupus erythematosus
32.				Goodpasture's syndrome
33.				Fulminant Viral Hepatitis
34.				Pneumonectomy

Definitions and exclusions with respect to Critical Illness Benefit are provided in General Policy Provisions.

c) Additional Multi-Stage Cancer (MSC) Benefit

Multi-stage Cancer (MSC) Benefit is an additional benefit and shall be payable in lumpsum as mentioned in table below upon diagnosis of the listed conditions during Multi-Stage Cancer Benefit's Coverage Term.

Level and covered conditions	Additional MSC Benefit payable in lumpsum (as percentage of MSC Sum Assured)
Minor Condition a. Carcinoma in-situ of any organ except skin b. Early-Stage Cancers	25%
Major Condition a. Cancer of specific severity	100% less minor condition claim earlier paid, if any

On diagnosis of one of the listed illnesses under minor conditions, 25% of MSC Sum Assured shall be payable in lumpsum and on diagnosis of any of the conditions under major condition category, 100% of MSC Sum Assured in lumpsum, less minor condition claim already paid, if any, shall be payable.

Claim will be admissible only if the member is diagnosed for the first ever occurrence of any of the listed conditions (provided in General Policy Provisions along with definitions and exclusions). Multiple claims for minor conditions shall be admissible during Additional Multi-Stage Cancer Benefit's member coverage term as long as the total payout does not exceed 100% of the MSC Sum Assured. For multiple claims under minor conditions for a member to be admissible, there needs to be a period of at least 6 months between the date of diagnosis of one minor condition claim and date of diagnosis of subsequent minor condition claim. However, this requirement of 6 months is not applicable in the case of diagnosis of major condition claim following a minor condition claim.

Multiple claims under minor conditions from the same organ shall not be admissible. For the purpose of claim, each group of the following sites are treated as one organ:

- Basal cell and squamous skin cancer
- Breast, where the tumor is classified as Tis according to the TNM Staging method
- Corpus uteri, vagina, fallopian tubes, cervix uteri, ovary
- Colon and rectum
- Penis, testis
- Stomach and esophagus

The total claims payable under this Benefit, including claims under minor and major conditions put together, shall not exceed 100% of the MSC Sum Assured. Upon payment of the 100% of MSC sum assured, member's insurance coverage for this benefit under the master policy shall terminate, however, member's insurance coverage shall continue in respect of applicable Death Benefit and other applicable in-built optional benefits (if any) for the remaining of the respective member coverage terms.

Additional Multi-Stage Cancer Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Multi-Stage Cancer (MSC) Benefit	Minor or Major Conditions under Additional Multi-Stage Cancer Benefit	In case of diagnosis of minor or major conditions under Cancer, lump sum amount shall be payable. In case of joint life cover, lumpsum amount for minor conditions can be availed by both the lives separately. Minor condition Benefit already availed for any organ by one life shall be exhausted for both the lives. Lumpsum Benefit for major condition under cancer can be availed by any one of two lives, who is diagnosed first with such major condition.	**Level Cover:** 25% of MSC Benefit Sum Assured on diagnosis of minor condition. 100% of MSC Benefit Sum Assured, less claims earlier paid on account of minor condition(s), if any, shall be payable on diagnosis of a major condition. The Company's liability for payment of all the claims under additional MSC Benefit in aggregate during this Benefit's Coverage Term shall not exceed the 100% of MSC Sum Assured which includes multiple claims for minor conditions by the member (by both the lives put together in case of joint life cover) **Decreasing & Flexi Cover:** Not applicable

iii. Hospitalization Cover Benefit

Under this option, Additional Hospitalization Benefit (HB) shall be offered. A lumpsum amount equal to Additional Hospitalization Benefit (HB) Sum Assured shall be payable if a member, on recommendation of a Medical Practitioner, is hospitalized, provided such hospitalization happens for a continuous period of specified number of days between 1 to 15 days (number of days to be chosen by the member before his/her coverage start date) in a coverage year during Additional Hospitalization Benefit coverage term. For insurance coverage under Additional Hospitalization Benefit, completion of every 24 'in-patient care' hours in hospital from the time of admission is considered to be a day.

Additional Hospitalization Benefit can be claimed only once in a coverage year, subject to maximum 5 times during this benefit's member coverage term. Upon payment of maximum number of allowed claims, as applicable, under this benefit during the member coverage term, member's insurance coverage for this benefit under the master policy will terminate, however member's insurance coverage will continue in respect of applicable death benefit and other applicable in-built optional benefits (if any) for the remaining of the respective member coverage terms.

Hospitalization Cover Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Hospitalization Cover Benefit	Hospitalization	In case of Hospitalization of an Insured Member for a continuous period for specified number of days between 1 and 15 (as chosen by Member before member's coverage start date), a lumpsum benefit shall be payable in case of such hospitalization, only once in a coverage year, subject to maximum 5 times during member coverage term of this benefit. In case of joint life cover, the Hospitalization Cover Benefit can be availed once by only one of the two lives in each coverage year during the coverage term, provided in each coverage year, it is claimed on occurrence of first such hospitalization of only one of the two lives.	**Level Cover:** A lumpsum amount equal to 100% of Hospitalization Benefit Sum Assured shall be payable on each hospitalization. Hospitalization Cover Benefit can be claimed only once in a coverage year and not more than 5 times during the member coverage term (across two lives put together in case of joint life cover). **Decreasing & Flexi Cover:** Not applicable

Exclusions with respect to Hospitalization Cover Benefit are provided in General Policy Provisions.

iv. Accidental Cover Benefit: Following three sub-options shall be offered under this inbuilt optional benefit:

a). Additional Accidental Death Benefit (ADB)

In case of accidental death of insured member, in addition to Death Benefit, an amount equal to the ADB Sum Assured will be paid in lumpsum and on such payment, insurance coverage for the insured member under this plan will terminate.

A claim under this Benefit Option shall be admitted provided that the death:

a. is caused by injury resulting from an accident,
b. occurs solely and directly due to the Injury, and independent of any other causes,
c. occurs within 180 days of the occurrence of accident and
d. is not a result from any of the causes listed in the exclusions for additional Accidental Death Benefit specified in general policy provisions.

In case, the accident occurs while the insured member's additional ADB insurance coverage is in-force, but the accidental death occurs after the end of the member coverage term and within 180 days of the accident, additional ADB sum assured applicable at the time of such accident shall be payable.

This benefit will be paid in following conditions as well:

a. **Disappearance:** If the insured member'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 Member 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 member coverage term, where it is reasonable to believe that such insured Member has died as a result of an accidental injury.
b. **Drowning:** If the insured member's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the member coverage term, where it is reasonable to believe that such insured member has died as a result of drowning.

Additional Accidental Death Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Accidental Death Benefit (ADB)	Death due to Accident	In case of death of member due to accident, where such accident happens during the member coverage term, a lumpsum amount shall be payable. In case of joint life cover, lumpsum benefit shall be payable on happening of first death due to accident.	**Level Cover:** A lumpsum amount equal to 100% of Additional ADB Sum Assured shall be payable. **Decreasing & Flexi Cover:** A lumpsum amount equal to 100% of prevailing ADB Sum Assured as on the date of accident as per agreed schedule chosen before member's coverage start date, shall be payable.

Definitions and exclusions with respect to Additional ADB are provided in General Policy Provisions.

b). Additional Accidental Total And Permanent Disability (ATPD) Benefit

Accidental Total and Permanent Disability 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 Insured Member 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 date of inception of insurance coverage and before the termination/ expiry of the insured member's insurance coverage.

In case, the accident occurs while the insured member's additional ATPD benefit coverage is in force, but the ATPD occurs after the end of the member coverage term and within 180 days of the accident, additional ATPD sum assured applicable at the time of such accident will be payable.

This is an additional benefit and on occurrence of accidental total & permanent disability (ATPD), an amount equal to the ATPD sum assured will be payable in lump sum. On payment of the additional ATPD sum assured, additional ATPD benefit for the member will terminate (in case it was chosen by the member), however the member's insurance coverage will continue for death benefit and all the other inbuilt optional benefits, if chosen, for the remaining member coverage term.

Additional Accidental Total and Permanent Disability Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Accidental Total and Permanent Disability (ATPD) Benefit	Total and Permanent Disability (ATPD) due to Accident	In case of ATPD due to accident, while such accident happens during the member coverage term, a lumpsum amount shall be payable. In case of joint life cover, lumpsum Benefit shall be payable on first occurrence of Total and Permanent Disability due to accident to any one of the two lives.	**Level Cover:** A lumpsum amount equal to 100% of ATPD Sum Assured shall be payable. **Decreasing & Flexi Cover:** A lumpsum amount equal to 100% of prevailing ATPD Sum Assured as on the date of Accident as per agreed schedule chosen before member's coverage start date shall be payable.

Definitions and exclusions with respect to additional ATPD benefit are provided in General Policy Provisions.

c). Additional Personal Accident Benefit

Personal Accident Benefit is an additional Benefit. Following set of Benefits will be paid under this sub-option on occurrence of specified insured events due to an injury sustained by the member on account of an accident.

S.No.	Insured Event	Additional Personal Accident (PA) Benefit Payable
1	Accidental Death	100% of Additional PA Sum Assured shall be payable in lumpsum following death of member, due to an injury sustained in an accident during the member coverage term, provided that member's death due to such accident happens within 12 months from the date of such Accident. This benefit will be paid in following conditions as well: **a. Disappearance,** as defined under Additional Accidental Death Benefit. **b. Drowning** as defined under Additional Accidental Death Benefit.
2	Accidental Total and Permanent Disability (ATPD)	100% of Additional PA Sum Assured shall be payable in lumpsum if member suffers Total and Permanent Disability of the nature specified below, solely and directlydue to an accident during the member coverage term, provided that the Total and Permanent Disability occurs within 12 months from the date of the such Accident: a) Total and irrecoverable loss of sight of both eyes, or; b) Physical separation or loss of use of both hands or feet, or; c) Physical separation or loss of use of one hand and one foot, or; d) Loss of sight of one eye and Physical separation or loss of use of hand or foot; e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the insured person 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.

3	Accidental Permanent Partial Disablement (APPD)	Benefits are payable in lumpsum, if the member suffers permanent partial disablement of the nature specified in the Table A given below, solely and directly due to an accident during the member coverage term, provided that the Permanent Partial Disablement shall occur within 12 months of the date of such accident.
4	Accidental Temporary Total Disablement (ATTD)	If the insured member sustains an injury in an accident during the coverage term and which completely incapacitates the insured member from engaging in any employment or occupation of any description whatsoever which the insured member was capable of performing at the time of the accident (Temporary Total Disablement), compensation shall be payable, at the rate of 0.2% of the PA Sum Assured per week, till the time the insured member is able to return to work, provided that: a) Such period of ATTD exceeds 4 weeks, however benefit shall be payable for the entire duration of disablement. b) The compensation payable under this benefit mentioned under point (a) above, shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the PA Sum Assured. c) The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the accident. d) The compensation payable, shall be paid by the Company at quarterly intervals, after ascertaining the amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period. e) During the course of payment under this Benefit, the Company shall have right to call for a certification from an independent Medical Practitioner chosen by the Company, with regard to the continuity of temporary total disability specified under this ATTD.
5	Hospitalization due to Accident	A Daily Hospital Cash Benefit equal to a fixed percentage of PA Sum Assured, which is 1%/2%/3%/4%/5% (as chosen my member before his/her coverage start date) shall be payable on hospitalization due to an accident. Daily Hospital Cash Benefit can be availed on hospitalization of a minimum period of 24 hours and for a maximum period of up to 10 days per coverage year, subject to a maximum period of 30 days over the member coverage term, provided such hospitalization happens due to an accident. For insurance coverage under hospitalization due to accident, completion of every 24 'in-patient care' hours in hospital from the time of admission is considered to be a day.

TABLE A

Losses under Accidental Permanent Partial Disablement (APPD)	Benefit payable as percentage of PA Sum Assured
1. Loss of Use/Physical Separation:	
One entire hand	50
One entire foot	50
2. Loss of Use of one eye	50
3. Loss of toes - all	20
Great both phalanges	5
Great –one phalanx	2
Other than great if more than one toe lost each	1
4. Loss of Use of both ears	50
5. Loss of Use of one ear	20
6. Loss of four fingers and thumb of one hand	40
7. Loss of four fingers	35
8. Loss of thumb – both phalanges	25
One phalanx	10
9. Loss of Index finger-three phalanges	10
Two phalanges	8
One phalanx	4
10. Loss of middle finger – three phalanges	6
Two phalanges	4
One phalanx	2
11. Loss of ring finger – three phalanges	5
Two phalanges	4
One phalanx	2
12. Loss of little finger – three phalanges	4
Two phalanges	3
One phalanx	2
13. Loss of metacarpus	
First or second (additional)	3
Third, fourth or fifth (additional)	2

Where, Losses under APPD shall be irrecoverable losses and result in loss of use or physical separation which arises solely and directly from an injury, within 12 months from the date of Accident.

The Company's liability for payment of all claims under additional PA Benefit in aggregate during coverage term, in no case will exceed 100% of PA Sum Assured with respect to the member.

If the Accident occurs during the member coverage term, ADB, ATPD Benefit and APPD Benefit covered under Additional PA Benefit are payable, even if death or Total and Permanent Disability or Permanent Partial Disablement or any combination thereof occurs after the completion of coverage term, but within 12 months from the date of such accident.

On payment of Accidental Death Benefit under Additional PA Benefit, the member's insurance coverage under the master policy shall terminate and all other benefits including death benefit shall also cease to exist with immediate effect.

On payment of 100% of PA Sum Assured on account of insured events other than Accidental Death under Additional PA Benefit, Additional Personal Accident (PA) Benefit terminates. However, applicable Death Benefit, and all other applicable inbuilt optional benefits, if any, shall continue as applicable.

Definitions and Exclusions with respect to additional PA Benefit are provided in General Policy Provisions.

Additional Personal Accident Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Personal Accident (PA) Benefit	– Accidental Death	**Accidental Death** – Lumpsum amount on death of Member due to Accident (on occurrence of first death due to accident in case of joint life cover)	**Level Cover:** **Accidental Death:** 100% of PA sum assured shall be payable.
	– Accidental Total & Permanent Disability (ATPD)	**ATPD** – Lumpsum amount on occurrence of ATPD (on first occurrence to anyone of two lives in case of joint life cover)	**ATPD –** 100% of PA sum assured shall be payable.
	– Accidental Permanent Partial Disablement (APPD)	**APPD** – Lumpsum amount as a percentage of PA sum assured (on occurrence to any of the two lives separately under joint life cover)	**APPD** – a fixed percentage of PA Sum Assured for APPD losses as specified under Additional Personal Accident (PA) Benefit in Table A above shall be payable.
	– Accidental Temporary Total Disablement (ATTD)	**ATTD** – On occurrence of temporary total disablement due to an accident during the coverage term, a fixed amount shall be payable every week during the period of such disablement with respect to member (on occurrence to any of the two lives separately under joint life cover)	**ATTD** – Benefit shall be payable as 0.2% of PA Sum Assured every week provided such period of ATTD is more than 4 weeks. The benefit payable shall be for a period not exceeding 100 weeks from date of commencement of ATTD.
	– Hospitalization due to Accident	Hospitalization due to Accident– On hospitalization of the member for at least 24 hours due to an accident, a Daily Hospital Cash Benefit shall be payable (hospitalization of any of the two lives separately in case of joint life cover)	Hospitalization due to accident – A Daily Hospital Cash Benefit as a fixed percentage of PA sum assured (1%/2%/3%/4%/5%, as chosen by member before member's coverage start date) shall be payable. This benefit shall be payable on minimum 24 hours' hospitalization and maximum for 10 days' hospitalization in a coverage year (across two lives put together, in case of joint life cover), subject to maximum 30 days' hospitalization during coverage term (across two lives put together in case of joint life cover). Completion of every 24 'in-patient care' hours in hospital from the time of admission is considered to be a day. The claims payable on account all these insured events in aggregate under Additional PA Benefit shall not exceed 100% of PA sum assured in any case. (Including all the claims made by two lives put together in case of joint life cover) **Decreasing & Flexi Cover:** Not applicable

Additional PA Benefit cannot be chosen by the member, in case, either of Additional ADB, Additional ATPD Benefit or Additional Hospitalization Benefit under Hospitalization Cover Benefit is chosen.

On occurrence of 'Disappearance' and 'Drowning' as mentioned under Additional Accidental Death Benefit and Additional Personal Accident Benefit above, Company will only pay, when the claimant provides a legally binding indemnity bond or any other document as required by the Company which guarantees, that, if at any time, after the payment of the Accidental Death Benefit, it is discovered that the insured member is still alive, all payments shall be repaid in full to the Company by the claimant.

Exclusions with respect to Additional Personal Accident Benefit are provided in General Policy Provisions.

C. OTHER ADD-ON OPTIONS AVAILABLE UNDER THE PLAN

i. Profit sharing: This plan also offers a profit-sharing option wherein in case of favourable claims experience, the master policyholder would be refunded back a part of the premium depending on the formula mutually agreed between master policyholder and the Company for the same.

D. SURVIVAL / MATURITY BENEFIT

Benefit Options	Survival / Maturity Benefit
Death Benefit with Term Insurance or if any inbuilt optional benefit is chosen	No Survival / Maturity Benefit shall be payable
Death Benefit with Term with Return of Premium (TROP) option	On survival of member (survival of both lives in case of joint life cover) till the end of member coverage term, total premiums paid will be returned on completion of such member coverage term.

E. WELLNESS BENEFIT

We provide wellness benefits to the insured members which intends to incentivize the insured member 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 prevailing underwriting policy of Go Digit Life Insurance Limited. The list of benefits under this program and terms and conditions applicable to it are provided in Annexure I.

OTHER PLAN OPTIONS

Joint Life Cover Option

- This plan offers joint life cover option, under which two persons can be insured under a single lumpsum sum assured and / or income benefit under Death Benefit and under single sum assured for each of the applicable sub-options under inbuilt optional benefits, if chosen.
- Both the individuals to be covered shall have insurable interest to avail the insurance coverage on joint life basis.
- The premium, as applicable, shall be collected for both the insured persons under joint life cover during the premium payment term.
- For joint life cover, Death Benefit shall be payable as mentioned above under Death Benefit section. Inbuilt optional benefits, if chosen, shall be payable as mentioned above under inbuilt optional benefits section on occurrence of respective insured events.
- The surviving member shall receive the applicable benefit payable on first occurrence of death under joint life cover.
- On payment of Death Benefit or on payment of Accidental Death Benefit (under Additional Accidental Death Benefit or under Additional Personal Accidental Benefit) or on payment of accelerated benefits which leads to 100% exhaustion of applicable lumpsum sum assured under Death Benefit, provided income benefit option is not chosen, the insurance coverage for both the lives under master policy will terminate and no further benefits shall be payable under this master policy.
- On payment of 100% sum assured or 100% of applicable benefit amount, as the case may be, for Additional Critical Illness Benefit/ Additional Multi-Stage Cancer Benefit/Additional Hospitalization Benefit/Additional Total and Permanent Disability Benefit/Additional Personal Accident Benefit, insurance coverage for these respective benefits shall terminate for both the lives.
- In case of simultaneous death of both the lives under joint life cover, Death Benefit and Accidental Death Benefit (under Additional Accidental Death Benefit or under Additional Personal Accidental Benefit), if applicable, shall be payable for one life only.
- In case of simultaneous or subsequent occurrence of insured events with respect to two lives for inbuilt optional benefits, the total benefit amount payable put together under each of the applicable sub-options under inbuilt optional benefits (if chosen) shall be limited to 100% of the applicable respective sum assured or 100% of applicable respective benefit amount, subject to terms and conditions of this policy.
- In case of simultaneous or subsequent claims under joint life cover, where claim against one life is repudiable, the claim on the other life shall prevail, if it is valid and subject to terms and conditions of this policy.

Coverage Options under this Plan

Member can choose any one of the following Coverage Options before member's coverage start date, provided they are selected by the Master Policyholder under Master Policy.

a. Level Cover – Under this coverage option, sum assured shall remain constant throughout the member coverage term.
b. Decreasing Cover – Under this coverage option, sum assured as on member's coverage start date shall reduce over the member coverage term as per the agreed schedule chosen before member's coverage start date.
c. Flexi Cover – This option offers a combination of level cover and decreasing cover and shall be subject to agreed schedule chosen before member's coverage start date.

GENERAL POLICY PROVISIONS:

Digit Simplification: You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them. Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them

Grace Period

A grace period of 15 days in respect of monthly frequency and 30 days in other applicable frequencies from the instalment premium due date will be provided for limited and regular pay policies for paying overdue premium to the Company without any penalty/late fee during which time the benefits under the master policy/insurance coverage of insured member will be considered to be continuing without any interruption as per the terms of the master policy.

If the insured events, as applicable, occurs during the grace period, respective benefit will be paid subject to receipt of unpaid due premium for the master policy in cases, where premium is paid by master policyholder. However, in policies, where premium is paid by the member, the applicable benefit will be paid subject to deduction of unpaid due premium for such member. In case, the premium which was due with respect of any insured member, is collected by the master policyholder within grace period but is not remitted to the Company for some reason, then the insurance coverage for such member will continue even on expiry of grace period, provided such member has the receipt of payment of such premium to the master policyholder within grace period. The Company reserves the right to recover such premium from the master policyholder.

Free Look Period:

At Master policy Level

In case the master policyholder does not agree with the terms and conditions of the master policy, the master policyholder has the option to request for cancellation of the master policy by returning the original master policy document along with a written request stating the reasons for objection to the Company within 30 days from the date of receipt of master policy document. Upon the receipt of such a cancellation request, the Company will cancel the master policy and refund the premiums received after deducting proportionate risk premium for the period of insurance coverage and expenses incurred on medical examination, if any and applicable stamp duty. All insured members' coverage will cease post the request for free look cancellation by the master policyholder.

At Member Level

If the insured member does not agree with the terms and conditions specified in Certificate of Insurance, he/she has the option of returning the Certificate of Insurance to the company stating the reasons thereof, within 30 days from the date of receipt of the Certificate of Insurance. Upon receipt of the free look cancellation request and original Certificate of Insurance, we shall refund the premium received in respect of insured member, subject to deduction of the proportionate risk premium for the period of insurance coverage, expenses incurred on medical examination, if any and applicable stamp duty for that insured member. The coverage for the insured member will cease post the request for such free look cancellation.

For Administrative purposes, all free-look requests should be registered by the Master policyholder on behalf of the Insured.

Lapsation and Reduced Paid-Up Provisions

For regular pay death benefit with Term Insurance option and regular pay inbuilt optional benefits, if at any point of time during the coverage term, due premium is not paid within grace period, the master policy / member's insurance coverage shall lapse on expiry of grace period until it is revived. No benefits will be paid when the master policy / insurance coverage is in lapsed status for these options.

In case of limited pay death benefit with Term Insurance option, limited pay inbuilt optional benefits and limited or regular pay death benefit with TROP option, if the premiums are not paid for at least first two coverage years, the insurance coverage shall lapse on expiry of grace period until it is revived. For these options, no benefits except for unexpired risk premium value will be paid when insurance coverage is in lapsed status. However, for these benefits mentioned, if the premiums are paid for at least first two coverage years and if further due premium is not paid within the grace period, the policy / member's insurance coverage attains reduced paid-up status, wherein, benefits under all applicable insurance coverages (risk covers) become reduced paid-up. Reduced paid-up benefit shall be calculated as stated below:

Reduced Paid-up Sum Assured = Paid-up factor x Applicable Sum Assured

Reduced Paid-up Income Benefit = Paid-up factor x Income Benefit

Reduced Paid-up Survival / Maturity Benefit = 100% of Total Premiums Paid for TROP option under death benefit (if TROP option is chosen)

Where,

Paid-up Factor = Number of premiums paid/Total number of premiums payable over the premium payment term

Applicable Sum Assured = Sum Assured as per benefit and coverage option and as per agreed schedule (if any) chosen before effective date of coverage

Total Premiums Paid is the total of all the premiums received, excluding any extra premium, any rider premium and taxes.

Surrender Provisions and Benefit payable on Surrender

In case of surrender of the master policy by the master policyholder, the members shall have an option to continue the insurance coverage till the end of their respective member coverage term, such insurance coverage will continue with the same terms and conditions as the original insurance coverage and Company/ intermediary, if any, shall continue to be responsible to serve such members till their insurance coverage is terminated. Unexpired risk premium value (surrender value) for such members opting to continue the insurance coverage shall not be paid out.

Following Unexpired Risk Premium Value (surrender value) will be payable on surrender:

Following Unexpired Risk Premium Value (Surrender Value) shall be payable on Surrender:

a) For Death Benefit with Term Insurance and Inbuilt Optional Benefits chosen, if any:

Benefit	Option / Sub-option	Level Cover	Decreasing Cover	Flexi Cover
Death Benefit	Lumpsum	50% x ((Total Premiums paid) – (Total Premiums payable over the Premium Payment Term x Expired Coverage Term in months/ Coverage Term in months)))	50% x ((Total Premiums paid) – (Total Premiums payable over the Premium Payment Term x Expired Coverage Term in months/Coverage Term in months))) x Current Sum Assured / Initial Sum Assured	
	Income Benefit			
Terminal Illness Benefit	Accelerated Terminal Illness (TI) Benefit			
Health Cover Benefit	Accelerated Critical Illness Benefit			
	Additional Critical Illness Benefit			
	Additional Multi-Stage Cancer Benefit			
Hospitalization Cover Benefit	Additional Hospitalization Benefit (HB)			
Accidental Cover Benefit	Additional Accidental Death Benefit (ADB)			
	Additional Accidental Total and Permanent Disability (ATPD) Benefit			
	Additional Personal Accident (PA) Benefit			

b) For Death Benefit with Term Insurance with Return of Premium and Inbuilt Benefit Options chosen, if any In such cases, the total premium paid could be expressed as A + B + C, where,

- A = Total premium paid corresponding to Term Insurance component under TROP
- B = Additional premium payable over A, corresponding to Return of Premium component under TROP
- C = Total premium paid for the inbuilt optional benefits, if any

Unexpired risk premium value on surrender equals

- Cash value computed corresponding to A + C as per the formula provided above in (a), plus
- Discounted value of A+B, provided at least first two years' premium is paid in full.

where

- The discount rate shall be based on prevailing annualised yields on 30-year G-Sec +150 basis points, rounded up to the nearest 25 basis points.
- The discount rates will be reviewed semi-annually and shall be revised using the above-mentioned formula and the change in the discount rates shall be effective from 25th February and 25th August each year. The revised discount rates shall apply to all Policies/Member Insurance Coverages including those which are already In-Force.
- Currently, the discount factors have been derived using interest rate of 8.75% p.a.
- Any change on basis of determination of interest rate for discounting can be done only after prior approval of the Authority.

In case of surrender of entire master policy, the aggregate of unexpired risk premium value at member level with respect to discontinuing members shall be payable.

On surrender, the insurance coverage for the member terminates.

Revival: The Company will consider requests to revive lapsed / reduced paid-up policies or the member's insurance coverage, as applicable, within five years from the due date of first unpaid premium, provided such requests are received within policy or member coverage term, as applicable. Any agreement to revive the lapsed or reduced paid-up policy/ member's insurance coverage would be subject to Company's prevailing underwriting policy.

The Company shall collect all the premiums due and other charges or late fee if any, as per the terms and conditions of the Policy, to revive the lapsed / reduced paid-up policy or member's coverage term, as applicable.

The late fees shall be calculated at such interest rate as may be prevailing at the time of the payment. The revival interest rate compounding annually, will be set using prevailing interest rates. The prevailing interest rates will be derived from yields of the 30 years G-Sec security. Any change in the interest rate used will be in accordance with the formula below:.

Annualized Yield on reference government bond + 100 basis points, rounded up to the nearest 25 basis points.

The revival interest rate for the financial year 2023-24 is 8.25% p.a.

The revival interest rate will be reviewed semi-annually and shall be revised using the above-mentioned formula and the change in the rate shall be effective from 25th February and 25th August each year.

Any change on basis of determination of interest rate for revival can be done only after prior approval of the Authority.

Policy Loan This policy does not offer loan facility.

Premium payment

In case insurance coverage under any of the inbuilt optional benefits ceases before the completion of member coverage term, though member coverage continues for death benefit and other inbuilt optional benefits, if any, no further premium shall be payable for the remaining premium payment term (if any), for inbuilt optional benefit which has terminated.

Premium Payment Frequency

- The premium may be paid monthly, quarterly, half-yearly or annually in advance for one-year renewable term and regular pay policy.
- For non-annual premium payment frequency, instalment premiums are calculated by applying the loading factor as given below on annual premium:

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

Policy changes/alterations:

Addition of members

- New members can join the policy during the year at any well-defined date. Premiums shall be collected in advance for insurance coverage being provided to such members. Any applicable levies, taxes, duties or surcharges will also be charged.
- The master policyholder should inform or intimate the Company with the list of new joiners preferably within 45 days from the date of new joiners becoming eligible to be admitted under this master policy.
- The effective date of coverage for the new joiners shall be the date of joining of the member or the date of intimation whichever is earlier. The Company shall communicate its decision on addition of Member based on its then prevailing underwriting policy. In case of inadequate Premium, the insurance coverage will begin from the date of receipt of the full premium.
- Company will have right to discontinue addition of new members by giving a notice of 30 days to master policyholder of this effect.

Deletion of Members

- In case a member leaves the scheme during the member coverage term (due to reasons other than death), where master policyholder has paid the premium, the Company will refund applicable unexpired risk premium value (surrender value) with respect to such members to the master policyholder. Such members' insurance coverage will cease from the date of leaving.
- Member who has paid the premium for his/her insurance coverage leaves the scheme, shall continue his/her insurance coverage as per original terms and conditions of the master policy unless such member informs the Company about discontinuance of the insurance coverage.

In case of Lender-Borrower Schemes

Where the master policy is issued under Lender-Borrower category and master policyholder is one of the following entities:

i) RBI regulated Scheduled Commercial Banks (including Co-operative Banks);
ii) NBFCs having Certificate of Registration from RBI;
iii) National Housing Bank (NHB) regulated Housing Finance Companies
iv) National Minority Development Finance Corporation (NMDFC) and its State channelizing agencies
v) Small Finance Banks regulated by RBI
vi) Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies
vii) Microfinance companies registered under section 8 of the Companies Act, 2013
viii) Any other category as approved by the Authority., in accordance with IRDAI guidelines as amended from time to time,

the insured member may give Us a written authorization in the form specified by Us to make payment towards Insured member's outstanding loan balance amount to the master policyholder from lumpsum Death Benefit, Additional Accidental Death Benefit (ADB), Accident Death Benefit covered under Additional Personal Accident Benefit, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any payable on happening of respective insured events. Under no circumstance, we will pay any amount more than the outstanding loan to the master policyholder from these respective benefits. The remainder of the lumpsum Death Benefit, Additional Accidental Death Benefit (ADB), Accidental Death Benefit covered under Additional Personal Accident Benefit, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any shall be payable to the claimant other than the master policyholder.

Benefit on Foreclosure of loan

In case of lender-borrower schemes, in the event where the insured member(s) makes a prepayment for closure of the loan to the master policyholder or where the lender borrower relationship between an insured member and the master policyholder comes to an end prior to coverage end date (other than due to death of member), the insurance coverage provided to the insured member shall continue till the occurrence of covered insured event/s or end of the coverage term, whichever is earlier, as per applicable sum assured specified in the Certificate of Insurance, subject to the master policy being in-force. The insured member has the option to terminate his/her insurance coverage at the time of foreclosure of loan by applying for surrender and receive the unexpired risk premium value.

Actively at Work

Subject to prevailing underwriting policy, Company may require that the members covered under the Employer-Employee Scheme are not absent from work for more than 7 days immediately prior to commencement of insurance coverage.

Suicide Exclusion (in case of base death benefit)

- In case of schemes, where the insurance coverage is compulsory, suicide exclusion will not be applicable.
- In case of other schemes, under which members are covered on a voluntary basis and where the suicide exclusion clause is applicable, if the member commits suicide, whether sane or insane, within 12 (Twelve) months of continuous coverage from the date of inception of risk cover or from date of revival, as applicable, the nominee or beneficiary shall be entitled to get at least 80% of the total premiums paid till the date of death or unexpired risk premium value (surrender value) available as on the date of death, whichever is higher, provided such member's insurance coverage is in force.
- In case of joint life cover, on occurrence of first death due to suicide in the above -mentioned scenarios, the respective benefits as mentioned above in two scenarios will be paid to the surviving member and the insurance coverage will terminate for both the lives.

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 registered practitioner should not be the insured or close member of the family.

All medical professionals referred to in Digit Life Group Long Term Plan, that is, cardiologist, neurologist, consultant neurologist, rheumatologist, nephrologist, pathologist, specialist in respiratory medicine shall be registered Medical Practitioners.

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. Inpatient care means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for an insured event.

Waiting Period means a period of 90 days for Accelerated Critical Illness, Additional Critical Illness Benefit, Additional Multi-Stage Cancer Benefit (all sub-options under Health Cover Benefit) and 45 days for Additional Hospitalization Benefit (under Hospitalization Cover Benefit) starting from the effective date of insurance coverage for the member or from the date of revival of insurance coverage. No amount shall be payable in case of occurrence of covered critical illness Condition or in case of occurrence of covered condition under Additional Multi-Stage Cancer Benefit or on hospitalization under Additional Hospitalization Benefit within the Waiting Period. Waiting Period shall not be applicable in case critical illness condition/(s) or minor / major conditions under Additional Multi-Stage Cancer Benefit manifests due to an accident. Similarly waiting period shall not be applicable in case of Member's Hospitalization due an accident.

Definitions and Exclusions – Additional Accidental Death Benefit, Additional Accidental Total & Permanent Disability Benefit (ATPD Benefit) and Additional Personal Accident Benefit

"Accident" is defined as "A sudden, unforeseen and involuntary event, caused by external, visible and violent means.

Accidental Death The Accident shall result in bodily injury or injuries to the insured member independently of any other means. Such injury or injuries shall, within 180 days (in case of Additional Accidental Death Benefit) and within 12 months (in case of Accidental Death under Additional Personal Accident Benefit) of the occurrence of the Accident, directly and independently of any other means cause the death of the insured member. Such a death is defined as "Accidental Death". The date of the Accident should be after the start of insurance cover and before the termination/ expiry of the insured member's insurance cover.

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

Exclusions to additional Accidental Death Benefit (ADB) and additional Accidental Total and Permanent Disability (ATPD) Benefit

No ADB benefit will be payable on death of the insured member or no ATPD benefit will be payable on occurrence of total and permanent disability to the insured member which happens directly or indirectly as a result of any of the following:

1) Infection: Death or ATPD caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
2) Intentional self-inflicted injury, suicide / attempted suicide while sane or insane.
3) Insured member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
4) War, invasion, act of foreign enemy, hostilities (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.
5) Participation by the Insured member 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.
6) Participation by the insured member in a criminal or unlawful act with criminal intent.
7) 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 or any kind of race.
8) 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.
9) Biological, chemical or radioactive contamination.

Exclusions to additional Personal Accident (PA) Benefit

No benefit under Additional Personal Accident Benefit shall be payable, if insured events under this benefit occur directly or indirectly as a result of any of the following:

1) Infection: Insured events under Additional Personal Accident Benefit caused or contributed to by any infection except, infection caused by an external visible wound accidentally sustained.
2) Intentional self-inflicted injury, suicide / attempted suicide while sane or insane.
3) Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
4) War, invasion, act of foreign enemy, hostilities (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.

5) Participation by the Insured Member 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.
6) Participation by the insured member in a criminal or unlawful act with criminal intent.
7) 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 or any kind of race.
8) 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.
9) Biological, chemical and radioactive contamination.
10) Hospitalization for treatment of accidental injuries which does not warrant Hospitalization, Domiciliary Hospitalization and OPD treatment are excluded.
11) Hospitalization / Treatment taken outside the geographical limits of India shall be excluded.
12) Hospitalization primarily for diagnostics and evaluation purpose.

Critical Illness Benefit and Multi-Stage Cancer Benefit – Definitions and Exclusions

Survival Period means the period of 30 days from the date of the first diagnosis of covered Critical Illness condition that the insured member has to survive to be eligible for receiving Critical Illness sum assured (if opted) under the master policy. Survival period is not applicable for Additional Multi-Stage Cancer Benefit.

Critical Illness (CI) Condition means the first diagnosis of any of the covered Critical Illnesses or undergoing any surgery explained and defined below:

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 leukemia, lymphoma and sarcoma.

II. The following are excluded –

- All tumors which are histologically described as carcinoma in situ, benign, pre- malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- 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
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- 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:

- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

- Other acute Coronary Syndromes
- Any type of angina pectoris
- 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.

II. 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:

- Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- 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:

- 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:

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
- 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:

- Permanent jaundice; and
- Ascites; and
- 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:

- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- 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:

- Other stem-cell transplants
- 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.

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- 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:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- 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:

- 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;
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- Mobility: the ability to move indoors from room to room on level surfaces;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

- 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:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- 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:
- investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- 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. Other causes of neurological damage such as SLE are excluded.

Specific Definitions:

17. SURGERY TO AORTA

I. 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. ABDOMINAL AORTA ANEURYSM

I. An abdominal aortic aneurysm (AAA) is a swelling/dilatation (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body.
- The diagnosis must be supported by a CT scans or CTA (Angiography) and requiring Endovascular aneurysm repair and the realization of surgery has to be confirmed by a cardiovascular surgeon.
- Congenital conditions are excluded

19. CARDIOMYOPATHY

I. A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist). There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association classifications of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.

II. The following conditions are excluded:
- Cardiomyopathy secondary to alcohol or drug abuse.
- All other forms of heart disease, heart enlargement and myocarditis.

20. PULMONARY ARTERY GRAFT SURGERY:

I. The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

21. APALLIC SYNDROME

I. 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.

22. PARKINSON'S DISEASE

I. The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to Us.

II. The diagnosis must be supported by all of the following conditions:
- the disease cannot be controlled with medication;
- signs of progressive impairment; and
- inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.

III. Parkinson's Disease secondary to drug and/or alcohol abuse is excluded.

23. MUSCULAR DYSTROPHY

I. A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following four conditions:

- Family history of muscular dystrophy;
- Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
- Characteristic electromyogram; or
- Clinical suspicion confirmed by muscle biopsy.

II. The condition must result in the inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months. Activities of daily living means:

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

24. PROGRESSIVE SUPRANUCLEAR PALSY:

I. A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.

25. CREUTZFELDT-JAKOB DISEASE (CJD)

I. A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

II. Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.

III. Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

26. BACTERIAL MENINGITIS

I. Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living.

II. This diagnosis must be confirmed by:

- The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- A consultant neurologist certifying the diagnosis of bacterial meningitis.

27. ALZHEIMER'S DISEASE

I. Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

II. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our Appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

III. The following conditions are however not covered:

- non-organic diseases such as neurosis and psychiatric Illnesses;
- alcohol related brain damage; and
- any other type of irreversible organic disorder/dementia.

28. ENCEPHALITIS

I. Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist)

II. The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.

29. LOSS OF INDEPENDENT EXISTENCE

I. 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 Activities of Daily Living.

30. SYSTEMIC LUPUS ERYTHEMATOUS

I. A multi-system, multifactorial, autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. Systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specializing in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only hematological and joint involvement are however not covered:

II. The WHO lupus classification is as follows:

- Class I: Minimal change – Negative, normal urine.
- Class II: Mesangial – Moderate proteinuria, active sediment.
- Class III: Focal Segmental – Proteinuria, active sediment.
- Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
- Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. GOODPASTURE`S SYNDROME

I. Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of atleast 30 Days. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist or Nephrologist).

32. FULMINANT HEPATITIS

I. A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

II. This diagnosis must be supported by all of the following:

- Rapid decreasing of liver size;
- Necrosis involving entire lobules, leaving only a collapsed reticular framework;
- Rapid deterioration of liver function tests;
- Deepening jaundice; and
- Hepatic encephalopathy.

III. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

33. PNEUMONECTOMY

I. The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

II. The following conditions are excluded:

- Removal of a lobe of the lungs (lobectomy)
- Lung resection or incision

34. APLASTIC ANAEMIA

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

- Blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

II. 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.

Additional Multi-Stage Cancer Conditions - Definitions and Exclusions

Multi-Stage Cancer Conditions means first diagnosis of any of the covered minor or major conditions under Additional Multi-Stage Cancer Benefit. Following are the definitions of such minor and major conditions covered under Additional Multi-Stage Cancer Benefit:

1. **Carcinoma-in-Situ (CIS) of any organ (except skin)**
   - It means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. Invasion means an infiltration and/or active destruction of normal tissue beyond the basement membrane.
   - The diagnosis of Carcinoma-in-Situ must always be supported by a histopathological report.
   - Furthermore, the diagnosis of Carcinoma-in-Situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.
   - In the case of cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy and colposcopy with the cervical biopsy report clearly indicating presence of CIS.
   - Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I and CIN II (where there is severe dysplasia without Carcinoma-in-Situ) does not meet the required definition and are specifically excluded.
   - All CIS of skin are specifically excluded.
   - This coverage is available to the first occurrence of CIS of same organ. Multiple claims from the same organ shall not be admissible.

2. **Early-Stage Cancers**
   - Early-Stage Cancer shall mean first ever diagnosis with presence of one of the following malignant conditions:
     i) Any malignant tumor of the thyroid, positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of the tissue, which is histologically classified as T1N0M0 according to the TNM classification system, or another equivalent classification.
     ii) Prostate tumor should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent classification.
     iii) Chronic lymphocytic leukaemia classified as RAI Stage I or II.
     iv) Basal Cell and Squamous skin cancer that has spread to distant organs beyond the skin
     v) Hodgkin's lymphoma Stage I by the Cotswold's classification staging system
     vi) All tumors of urinary bladder histologically classified as T1N0M0 (TNM Classification)

The diagnosis must be based on histopathological features and confirmed by a pathologist. Pre-malignant lesions and conditions, unless listed above are excluded.

3. **Cancer of Specified Severity As defined in Definition (1) under Critical Illness conditions**
   Accelerated / Additional Critical Illness Benefit and Additional Multi-Stage Cancer Benefit – General Exclusions Claim for Critical Illness Benefit will be accepted subject to survival period of 30 days and waiting period of 90 days. Claim for Additional Multi-Stage Cancer Benefit will be accepted subject to waiting period of 90 days. Waiting period shall not be applicable if critical illness or multistage cancer condition manifests due to an accident.
   Notwithstanding anything to the contrary stated herein and in addition to the foregoing exclusions, no Critical Illness Benefit / Multi-Stage Cancer Benefit will be payable if any of the covered conditions under Critical Illness / Multi-Stage Cancer occurs from, or is caused or aggravated, either directly or indirectly by, voluntarily or involuntarily, due to one of the following:

   1) Congenital Condition: Any external congenital condition or related illness is not covered. In case any internal congenital condition or related illness is known and was/is being treated, is disclosed at proposal stage and accepted, claims will be processed as per Policy terms and conditions.
   2) Any covered condition or its signs or symptoms having occurred within the Waiting Period.
   3) Drug Abuse: Insured Member 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.

4) Pre-existing Disease: means any condition, ailment, Injury or disease:
   - that is/are Diagnosed by a physician within 48 months prior to the effective date of the Insurance Coverage issued by Company or
   - for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival.
5) Self-inflicted Injury: Intentional self-inflicted injury by the Insured Member.
6) Suicide: If the condition covered under Critical Illness Benefit / Multi-Stage Cancer Benefit was contracted due to attempted suicide.
7) Criminal Acts: Insured Member involvement in criminal activities with criminal intent.
8) War, invasion, act of foreign enemy, hostilities (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.
9) Nuclear Contamination: Exposure to radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
10) Biological, chemical or radioactive contamination.
11) Aviation: Participation by the Insured Member 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.
12) Hazardous sports and pastimes: 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 or any kind of race.
13) Any treatment of the donor for the replacement of an organ.
14) Unreasonable failure to seek or follow medical advice or treatment by a Medical Practitioner leading to occurrence of the insured event or Member delaying medical treatment in order to circumvent the Waiting Period or other conditions and restrictions applying to this Policy.

Additional Hospitalization Benefit – General Exclusions

No Benefits shall be payable with respect to any of the hospitalization unless the entire period of confinement to hospital and all the Hospital services rendered and performed there have been recommended by a registered medical practitioner and are in accordance with the diagnosis and treatment of the condition for which hospitalization was required.

The Company shall not be liable to make any payment if hospitalization or claims are attributable to, or based on, or arise out of, or are directly or indirectly connected to any of the following:

1) Pre-existing Disease: means any condition, ailment, Injury or disease:
   - that is/are Diagnosed by a physician within 48 months prior to the effective date of the Insurance Coverage issued by Company or
   - for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival.
2) Hospitalization / treatment within the waiting period and hospitalization / treatment following the diagnosis within the waiting period. However, waiting period shall not be applicable for hospitalization due to accidental injuries.
3) Hazardous sports and pastimes: 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 or any kind of race.
4) Aviation: Participation by the insured member 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.
5) War, invasion, act of foreign enemy, hostilities (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.
6) Criminal Acts: Insured member involvement in criminal activities with criminal intent.
7) Nuclear Contamination: Exposure to radioactive, 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.
8) Any treatment due to any external congenital conditions.
9) Any dental surgery, extraction of impacted tooth/teeth, orthodontics or orthognathic surgery, or tempero-mandibular joint disorder except as necessitated by an accidental injury;

10) Treatment arising from or traceable to pregnancy which shall include childbirth, infertility, miscarriage, abortion, sterilization and contraception including complications related thereto / treatment to assist reproduction including IVF treatment.
11) Hospitalization primarily for investigatory purpose, diagnosis, X-ray examinations, general physical or routine medical examinations; preventive treatment or medicines, treatments/ examinations specifically for weight management regardless of whether the same is caused by a medical condition; or any treatment or study related to sleep disorder or sleep apnoea syndrome.
12) Convalescence, general debility, custodial, sanitaria, rehabilitation centre, nature care clinics, or respite care or long-term nursing care.
13) Stem cell implantation or surgery, harvesting/storage/any other treatment using stem cells, or any type of hormone replacement therapy.
14) Any form of plastic surgery except to the extent that such surgery is necessary for the treatment of cancer, burns or Accidental Injuries happened during the contract period;
15) Cosmetic or aesthetic treatments, treatment or surgery for change of life / gender
16) Treatment of xanthelasma, syringoma, acne and alopecia;
17) Circumcision unless necessary for treatment of a disease or necessitated due to an Accident;
18) Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health and/ or who has been declared brain dead, as demonstrated by:
    - Deep coma and unresponsiveness to all forms of stimulation; or
    - Absent pupillary light reaction; or
    - Absent oculovestibular and corneal reflexes; or
    - Complete apnea
19) Treatment for accidental physical injury or illness caused by violation or attempted beach of the law, or resistance to arrest;
20) Hospitalization and treatment of any kind not actually performed, not necessary or reasonable, or any kind of elective surgery or treatment which is not medically necessary.
21) Any treatment for any sexually transmitted disease (STD), and its related complications (except for HIV / AIDS); treatment of any sexual problem including impotence (irrespective of the cause) and sex changes / gender reassignments or erectile dysfunction.
22) Treatment for or arising from an Injury that is intentionally self-inflicted, including attempted suicide.
23) Hospitalization due to use and abuse of any substance, drug (not prescribed by registered independent medical practitioner) or alcohol or treatment for de-addiction / smoking cessation programs or taking of poison.
24) 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.
25) Treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
26) Routine eye examinations and ear examinations, cochlear implants, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, hair fall treatment & products, and all other similar external appliances and / or devices whether for diagnosis or treatment.
27) Unreasonable failure to seek or follow medical advice or treatment by a Medical Practitioner leading to occurrence of the insured event or Member delaying medical treatment in order to circumvent the Waiting Period or other conditions and restrictions applying to this Policy.
28) Any treatment related to donor screening or treatment including surgery to remove organs of a donor for the replacement of an organ (where Member is donor)
29) Ayurvedic, Homeopathy, Unani, Yoga and naturopathy, Siddha, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, Rolfing, massage therapy, aroma therapy or any other treatments other than Allopathy/ western medicines.
30) Hospitalization / any treatment received outside India
31) Treatment for developmental problems including learning difficulties e.g. Dyslexia, behavioral problems

32) The following diseases/surgeries and any complications arising out of them will not be covered during the first two years from the Risk Commencement Date or date of Revival:
- Deviated Nasal Septum / Nasal and Paranasal Sinus Disorders
- Diseases of Tonsils / Adenoids
- Surgery of Thyroid Gland excluding Malignancy
- All types of Hernia
- Hydrocele / Varicocele / Spermatocele
- Piles / Fissure / Fistula-in-Ano / Rectal Prolapse
- Benign Prostatic Hypertrophy
- Menstrual Irregularities, Dysfunctional Uterine Bleeding
- Hysterectomy with or without Bilateral Salpingo-oophorectomy excluding Malignancy
- Uterine Fibroid
- Calculus Diseases
- Prolapsed Intervertebral disc
- Retinopathy / Retinal detachment
- Peripheral Vascular Diseases due to diabetes / diabetic foot
- Renal failure due to diabetes
- Osteoporosis / Pathologiocal Fracture
- Cataract
- Joint replacements except due to an accident (one knee or one hip replacement in a Coverage Year)
- Congenital Internal Disease or Anomalies or Disorder

Nomination Provisions: The nomination shall be subject to Section 39 of the Insurance Act, 1938, as amended from time to time.

Assignment Provisions: Assignment shall be as per the provisions of Section 38 of the Insurance Act, 1938 as amended from time to time.

Section 41: Prohibition of Rebate: Under the provisions of Section 41 of the Insurance Act, 1938 as amended from time to time.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

2. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

Section 45 of the Insurance Act, 1938 as amended from time to time

Fraud, misstatement and forfeiture would be dealt with in accordance with provisions of Sec 45 of the Insurance Act 1938 as amended from time to time. For provisions of this Section, please contact the Insurance Company or refer to the policy contract of this product.

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.

Please Note: *In the event of any inconsistency or contradiction between the sales brochure and policy terms & conditions, the terms and conditions contained in the policy will prevail.*

ANNEXURE I – WELLNESS BENEFIT PROGRAM

Below listed benefits will be made available under Wellness Benefit Program

1. **Doctor on Call**

   Upon Insured member's request, we will facilitate an appointment, through our empanelled Service Provider, with a Medical Practitioner who can help Insured member 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 Insured member to become more aware of his/her health and proactively manage it, We will, through periodic communications like e-mailers, blogs, videos, webinar and online platform provide him/her 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 Insured member's 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 the Insured member.

4. **Pharmacy (Home Delivery)**

   Upon Insured member's 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 the Insured member.

5. **Vital/Physical Activity Monitoring Services**

   Upon member's request, We will facilitate, through Our Empanelled Service Provider, the integration of his/her Health Device(s), or Digital 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 his/her vitals as reported by the device. It can provide periodic updates and reports of Insured member's health status. The cost of the device will have to be borne by the Insured member.

6. **Reminder Notifications**

   Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to the Insured member as a reminder to schedule his/her medical appointments and/or take daily dosage of his/her medicine as per the information shared by the him/her.

7. **Medical Wallet**

   Upon Insured member's request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow the Insured member to store all his/her 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 he/she may share the login and access codes, easing his/her need to physically carry documents with himself/herself.

8. **Report Aggregation**

   Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of his/her health status as per the medical records/reports/information or data shared by him/her. It will highlight his/her wellbeing or any areas of concern or deterioration in his/her health, allowing him/her to take necessary calls about his/her health.

9. Home Care Services

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, Home Care Services for him/her in case he/she 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 the Insured member.

10. Ambulance Arrangement Services

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, ambulance services for his/her 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 the insured member.

11. Pick up and drop services for consultation

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, Pick-up and Drop Service, for his/her 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 Insured member.

12. Prioritizing Appointments

Upon Insured member's request, We will facilitate, through Our Empanelled Service Provider, prioritization of his/her 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 the Insured member. These may include the following but not limited to :-

- Doctors' services
- Nursing services
- Dietitian services

13. Mental wellbeing

Upon Insured member's 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 the Insured member.

14. Physiotherapy

Upon Insured member's 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 the Insured member.

15. Childcare/Children's activities

Upon Insured member's 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 the Insured member.

16. Out-Patient (OPD) Services

Upon Insured member's 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 the Insured member.

17. Fitness

Upon Insured member's 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 the Insured member.

Terms and Conditions applicable to Wellness Benefit Program

1. Any Information provided by the Insured member 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. Insured member needs 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 member 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 member.
4. We 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 member 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 member's visit or consultation to an Independent Medical Practitioner. The Insured member 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.

Annexure II – Grievance Redressal Mechanism

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: I**n 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. For latest updated list of Ombudsman Office addresses, kindly visit this website **https://www.cioins.co.in/Ombudsman**

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 i). to viii).

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.