# DIGIT LIFE GROUP TERM LIFE INSURANCE

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

UIN: 165N004V01

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

The most important asset for any organization is its people, who give their heart and soul to the growth of the organization and make it successful. It is therefore important for an organization to provide their people a complete peace of mind and sense of reassurance of financial security against a range of risks, especially when they have members in their families financially dependent on them.

## PRESENTING DIGIT LIFE GROUP TERM LIFE INSURANCE

Digit Life Group Term Life Insurance 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 protection against accidental death, critical Illness, accidental total & permanent disability and terminal illness, 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 protection against **Accidental Death, Critical Illness, Total & Permanent Disability and Terminal Illness,** based on the option chosen.
  - Option to extend insurance coverage to member's spouse.
  - Option to change the members' Sum assured during the coverage term.
  - Single Pay, One Year Renewable Term, Regular Premium pay options.
  - Option to pay the premium as per preferred premium payment frequency (Single, monthly, quarterly, half-yearly, or annually).
- Super Simple services with our **Corporate Portal** where any changes like addition or deletion of members at any time during the policy year can be done easily.
- **Hassle Free Implementation - No medical check-up** is required for the cover up to the free cover limit.
- Up to 3 year premium rate guarantee with regular pay option.
- Availability of Profit-sharing option to master policyholder.
- **Wellness benefits** to insured members.
- Offers Cover for policies issued in lieu of Employees' Deposit Linked Insurance Scheme.

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, 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.

## HOW THIS POLICY BENEFITS MASTER POLICYHOLDER AND MEMBERS?

| BENEFITS TO MASTER POLICYHOLDER | BENEFITS TO MEMBER |
|---|---|
| • Financial Protection to family of all members under one policy<br>• Provides high coverage amount at low costs<br>• Highly customizable solution providing additional comprehensive benefit options to suit member needs<br>• Hassle free implementation<br>• Can serve as employee retention tool<br>• Tax Benefit on Premium paid by Employer as per prevailing tax laws<br>• Group Term Insurance coverage for future service gratuity liability | • Peace of Mind with family being financially protected in case of unfortunate event with member<br>• Protection against Death, Disease and Disability<br>• Convenience of no medical tests till free cover limits<br>• Premium paid by individual member (if any) qualifies for tax deduction as per prevailing tax laws<br>• Death Benefits received by the beneficiary is exempt from tax as per prevailing tax laws |

## ELIGIBILITY CONDITIONS

| | | | |
|---|---|---|---|
| Entry Age (as per last birthday) | Minimum - 14 years<br>Maximum - 80 years | | |
| Maturity Age (as per last birthday) | Minimum - 14 years<br>Maximum - 80 years | | |
| Group Size | Minimum - 5 members<br>Maximum - No limit | | |
| Minimum Sum Assured (SA) | Lumpsum Sum Assured per person - ₹10,000<br>Income Benefit per person - ₹100/month<br>(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) | |
| | Optional Benefits | Additional Accidental Death Benefit, Additional Accidental Total & Permanent Disability Benefit, Additional or Accelerated Critical Illness Benefit, Accelerated Terminal Illness 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 | Master policy will continue indefinitely until terminated.<br>At member level, the coverage term will be as per Premium Payment Option chosen<br>• For Single Premium Option – One Month to Three Years (in multiples of months)<br>• For Regular Premium Option – Two or Three Years<br>• One Year Renewable Term – One Year | | |
| Premium Payment Term | • For Single Premium Option – Single Pay<br>• For Regular Premium Option – Two or Three Years<br>• One Year Renewable Term – One Year | | |
| Premium Payment Frequency | Yearly, Half-Yearly, Quarterly, Monthly for One Year Renewable Term and Regular Pay<br>Single Pay for Single Premium Option | | |

***Please Note:*** *For Group Term Life policies in lieu of EDLI, the eligibility conditions will be as per Employees' Deposit Linked Insurance (Amendment) Scheme, 2018, as amended from time to time.*

## WHAT ARE THE BENEFITS UNDER THIS PLAN?

### A. Death Benefit

This is the compulsory benefit and in case of unfortunate demise of the member during the coverage term, Death Benefit is payable to the nominee.

**Death Benefit Payout Options**

Master policyholder can choose to offer the members any one or combination of the any of the following four 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. Regular Income till the retirement age of insured member: Under this option (if chosen), regular income will be paid following date of member's death till his / her retirement age.

c. Regular Income linked to the age of members' child/children: Under this option (if chosen), regular income will be paid following date of member's death till his or her child / children attain a certain age, as chosen (not exceeding 25 years as on last birthday)
d. Regular Income for a specified period: Under this option (if chosen), regular income will be paid for chosen number of years (not exceeding 40 years) following date of member's death.

Regular Income 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 any of the regular income options 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 regular income amount. The lumpsum sum assured or regular annual income or combination of these two benefits, as chosen for each individual member will be specified on coverage inception date or the coverage renewal date, if applicable. Any changes in the lumpsum sum assured or regular income during the coverage term will be as per the master policyholder's request and Company's acceptance.

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

## B. Inbuilt Optional Benefits

The master policyholder can choose one or more of the following in-built optional benefits before master policy commencement date or policy renewal date (if applicable) 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. Only lumpsum sum assured shall be available for inbuilt optional benefits. Option to choose income benefit is available in case of death benefit only.

**i. 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.

For both (a) and (b) above, benefit will be paid, 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 additional Accidental Death Benefit, it is discovered that the insured member is still alive, all payments shall be repaid in full to the Company.

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

**ii. 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.

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

**iii. Critical Illness Benefit (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 CI sum assured shall be payable in lumpsum.

There are following three variants offered under this 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:

| Sr. No. | Category | Critical Illness | Plan A | Plan B | Plan C |
|---|---|---|---|---|---|
| 1 | **Cancer** | Cancer of Specified Severity | Covered | Covered | Covered |
| 2 | **Cardiovascular system** | Myocardial Infarction | Covered | Covered | Covered |
| 3 | | Open Heart Replacement or Repair of Heart Valves | Covered | Covered | Covered |
| 4 | | Surgery to Aorta | Covered | Covered | Covered |
| 5 | | Primary (Idiopathic) Pulmonary Hypertension | Not Covered | Covered | Covered |
| 6 | | Aneurysm of Abdominal Aorta | Not Covered | Not Covered | Covered |
| 7 | | Cardiomyopathy | Not Covered | Not Covered | Covered |
| 8 | | Pulmonary artery graft surgery | Not Covered | Not Covered | Covered |
| 9 | | Open Chest CABG | Covered | Covered | Covered |
| 10 | **Major Organ Transplant** | End Stage Lung Failure | Covered | Covered | Covered |
| 11 | | End Stage Liver Failure | Covered | Covered | Covered |
| 12 | | Kidney Failure Requiring Regular Dialysis | Covered | Covered | Covered |
| 13 | | Major Organ/Bone Marrow Transplant | Covered | Covered | Covered |
| 14 | **Nervous System** | Apallic Syndrome | Not Covered | Covered | Covered |
| 15 | | Benign Brain Tumour | Covered | Covered | Covered |
| 16 | | Coma of Specified Severity | Covered | Covered | Covered |
| 17 | | Major Head Trauma | Covered | Covered | Covered |
| 18 | | Permanent Paralysis of Limbs | Covered | Covered | Covered |
| 19 | | Stroke Resulting in Permanent Symptoms | Not Covered | Covered | Covered |
| 20 | | Motor Neurone Disease with Permanent Symptoms | Not Covered | Covered | Covered |
| 21 | | Parkinson's Disease | Not Covered | Not Covered | Covered |
| 22 | | Muscular Dystrophy | Not Covered | Not Covered | Covered |
| 23 | | Progressive Supranuclear Palsy | Not Covered | Not Covered | Covered |
| 24 | | Creutzfeldt-Jakob disease (CJD) | Not Covered | Not Covered | Covered |
| 25 | | Bacterial Meningitis | Not Covered | Not Covered | Covered |
| 26 | | Alzheimer's disease | Not Covered | Not Covered | Covered |
| 27 | | Encephalitis | Not Covered | Not Covered | Covered |
| 28 | | Multiple Sclerosis with Persisting Symptoms | Covered | Covered | Covered |
| 29 | **Others** | Loss of Independent Existence | Not Covered | Covered | Covered |
| 30 | | Systemic lupus erythematosus | Not Covered | Not Covered | Covered |
| 31 | | Goodpasture's syndrome | Not Covered | Not Covered | Covered |
| 32 | | Fulminant Viral Hepatitis | Not Covered | Not Covered | Covered |
| 33 | | Pneumonectomy | Not Covered | Not Covered | Covered |
| 34 | | Aplastic Anaemia | Not Covered | Covered | Covered |

The CI benefit can be either chosen as additional benefit to the death benefit or as an accelerated benefit.

**If CI Benefit is chosen as Additional CI Benefit –** On admission of a claim under the additional CI benefit, the member's Insurance Coverage under the master policy will continue in respect of death benefit and all other in-built optional benefits (if any) except additional CI benefit for the remaining of the member coverage term.

**If CI Benefit is chosen as Accelerated CI Benefit –** Accelerated Benefit means payment of this benefit shall not be in addition to lumpsum death benefit chosen and it only facilitates an earlier payment of lumpsum death benefit on prior occurrence of critical illness. Accelerated CI Benefit can be opted for when lumpsum sum assured under death benefit is chosen (either standalone or in combination with any of the regular income benefit options) and 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 applicable lumpsum sum assured under Death Benefit and income benefit option is not chosen under death benefit additionally,** the member's insurance coverage for all the benefits will terminate immediately upon diagnosis of Critical Illness and payment of CI Benefit. However, if in such case, income benefit option is also chosen additionally, on payment of such accelerated CI benefit, insurance coverage for accelerated CI benefit and lumpsum sum assured under death benefit will terminate, whereas the member's insurance coverage will continue with respect to the income benefit option under death benefit and other inbuilt optional benefits, if any.
- **Where the CI Sum Assured is less than the applicable lumpsum sum assured under Death Benefit,** on payment of the CI Sum Assured, the applicable lumpsum sum assured under the Death Benefit will be reduced to the extent of the CI sum assured paid, and such change will be effective from the date of the payment of the accelerated CI benefit. Such member's insurance coverage for other applicable inbuilt optional benefits (if any) shall continue for rest of member coverage term.

The claim for Critical illness Benefit shall be accepted only if 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 CI 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 condition or any dependent Critical Illness/Illnesses.

Definitions and exclusions with respect to critical illness benefit are provided in General Policy Provisions.

**iv. Accelerated 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.

The Terminal Illness must be diagnosed and confirmed by Medical Practitioners. The Company reserve the right for an independent assessment by two different medical practitioners other than the medical practitioner whose diagnosis has been provided by the insured member.

Terminal Illness is an accelerated 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 any of the regular income benefit options). 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 shall 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.

## C. Other Add-On Benefits available under the plan

**i. Spouse Cover**

- This option is provided to extend insurance coverage to the spouse of members in the group.
- Insurance cover to members' spouse will be provided subject to the submission of the evidence of insurability and evidence of health as per prevailing underwriting policy and terms and conditions of this plan and upon payment of an additional premium.

**ii. Voluntary Insurance Coverage**

The member has an option to choose for voluntary Insurance Coverage, subject to following conditions:

- Maximum sum assured allowed will be as per Company's prevailing underwriting policy.
- A written request is submitted along with the evidence of insurability and health to the Company as per our prevailing underwriting policy and on payment of an additional Premium.
- The premium rate applicable for sum assured under this Voluntary Insurance Coverage shall be independently derived based on the expected risk profile and take-up rates.

Some of the coverages where this option could be utilized, including but not limited to cover the following:

- Coverage towards Credit card outstanding
- Coverage for Funeral expenses
- Coverage for Child education

**iii. 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.

**iv. Renewal Rate Guarantee:** The master policyholder by choosing a regular pay option can ensure that the premium paid by them remains the same during the chosen policy term.

**v. Risk Sharing and Risk Capping:** To address the ever-evolving needs of the group customers who have partial risk appetite at their own or through suitable insurance arrangement and requires insurance for the risks beyond their appetite and up to a maximum limit subject to board approved underwriting policy, this product offers the following options at master policy and member level as well.

**Options at Member Level:**

**Proportional sharing:** The Master Policyholder can choose the option to insure a certain percentage (lesser than 100%) of applicable Benefits for each Member where the Insurance Coverage / claim liability for Us will be limited to the opted percentage of Benefits / claims for each member.

**Excess level sharing:** The Master Policyholder can choose the option to insure the Benefits above certain threshold level for each applicable Member where the Insurance Coverage / claim liability for Us will be the amount of Benefits / claims in excess of the opted threshold limit for each applicable Member.

**Options at Master Policy Level:**

**Proportional sharing:** The Master Policyholder can choose the option to insure a certain percentage (lesser than 100%) of applicable Benefits capped to maximum limit at master policy level, applicable for the entire group where the Insurance Coverage / claim liability for Us towards the group will be limited to the opted percentage of Benefits / claims at the concerned group level.

**Excess level sharing:** The Master Policyholder can choose the option to insure the Benefits above certain threshold level capped to maximum limit at master policy level, where the Insurance Coverage / claim liability for Us will be the amount in excess of the opted threshold limit at the concerned group level.

If any of the options at Master Policy level is chosen, any Benefit payable will further be subject to the arrangement agreed at Master Policy level.

***Please Note -*** *The option to choose spouse cover and voluntary insurance coverage will not be available for policies issued in lieu of EDLI.*

## D. SURVIVAL / MATURITY BENEFIT

There is no survival / maturity benefit under this plan.

## 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.

## F. BENEFIT IN CASE OF 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 will be payable on Surrender:

| | |
|---|---|
| Single Pay | In case of surrender of the master policy or member's insurance coverage where premiums are paid by member, an amount equal to 60% of the single premium adjusted for the unexpired duration of the policy term or member coverage term of the discontinuing members, as applicable, would be payable.<br>In case of surrender by members for schemes where premiums are paid by the master policyholder, an amount equal to the single premium adjusted for the unexpired duration of the coverage term of the discontinuing member would be payable to the master policyholder. |
| One Year Renewable Term | In case of surrender of the master policy, an amount equal to the instalment premium for the unexpired coverage term of the discontinuing members, less appropriate deduction for expenses, stamp duty paid, commission and taxes and levies as applicable shall be payable.<br>In case of surrender by members for schemes where premiums are paid by the master policyholder, an amount equal to the instalment premium for the unexpired duration of the member coverage term for which the instalment premium was applicable, in respect of the discontinuing members, shall be payable to the master policyholder, who typically adjusts it against any premiums payable. |
| Regular Pay | In case of surrender of the master policy or member's insurance coverage where premiums are paid by member, an amount equal to 60% of the instalment premium adjusted for the unexpired duration of the policy term or member coverage term, as the case may be, for which the instalment premium was applicable in respect to discontinuing members shall be payable.<br>In case of surrender by members, for schemes where premiums are paid by the master policyholder, an amount equal to the instalment premium adjusted for the unexpired duration of member coverage term for which the instalment premium was applicable in respect of the discontinuing members, shall be payable to the master policyholder, who typically adjusts it against any premiums payable. |

## GENERAL POLICY PROVISIONS / DEFINITIONS / EXCLUSIONS:

**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

In the event where the master policyholder or insured Member (as applicable) fails to pay the due Premium on the instalment premium due date, a grace period will be allowed to pay the due Premium while continuing the applicable insurance coverage and other benefits under it. After the expiry of the grace period without receipt of the due premium in full, the insurance coverage and benefits under the master policy or for the respective insured member(s) will lapse. 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 one year renewable term 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 any of the insured event occurs during the grace period, applicable benefit shall be payable subject to receipt of unpaid due premium for the master policy, where premium is paid by master policyholder. However, in policies, where premium is paid by the member, the applicable benefit shall be payable 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

If the due premium is not paid within grace period, the insurance coverage and other applicable benefits will be lapsed till the policy or member's coverage, as applicable, is revived/reinstated. No benefit shall be paid during lapsed status.

**Paid-up Benefit** No paid-up benefits are available under this policy.

**Revival:** The Company will consider requests to revive lapsed policies or the member's insurance coverage, as applicable from the date of first unpaid premium, provided such requests are received within the original policy or member coverage term, Any agreement to revive the lapsed 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 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.

**Reinstatement:** If the due premium is not received by the end of the grace period, the policy will lapse. The lapsed policy could be reinstated and the insurance coverage will recommence from the date of reinstatement and the premium will be collected accordingly. The Company shall not collect any unpaid premiums on reinstatement, nor shall be liable to pay the claims occurring during the period for which the policy is in lapsed status. In certain circumstances, the Company may also change certain terms of the policy including the pricing. Such reinstatement shall be as per the prevailing underwriting policy of the Company.

**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 or other applicable inbuilt optional benefits, no further premium shall be payable for the remaining premium payment term, if any, for the inbuilt optional benefit(s) which are 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.
- 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.
- Members joining the scheme during policy year or policy term will be charged the premium proportionate to the duration the member is covered during the policy year or policy term, as applicable. Any applicable levies, taxes, duties or surcharges will also be charged.
- 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.
- Where appropriate, Company may permit at scheme level for individual scheme members to be covered for chosen coverage term from their scheme joining date.
- 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 the pro-rata premium to the master policyholder. The master policyholder should inform the Company of deletions for members leaving the scheme. The risk will cease from the date of leaving.

- The insurance coverage of the member paying premium for his/her coverage, if he/she leaves the scheme, will continue as per original terms and conditions of the master policy, unless such member informs the Company about discontinuance of the insurance coverage.

**Sum Assured Reset**

- The lumpsum Sum Assured or income benefit amount under Death Benefit for each insured member can be increased or decreased during the policy term, subject to prevailing underwriting policy. The pro-rated excess premium will be payable by or payable to the master policyholder, as the case may be.

**Change of Policy Renewal date**

- The master policyholder has the option to modify the policy renewal date at any time during the policy term. Premium applicable from the modified policy renewal date will be calculated based on the latest data provided, adjusting for the Premium for the unexpired period up to the original policy renewal date on a pro-rata basis.

## 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 and certain inbuilt optional Benefits (if any) payable on happening of respective insured events during member coverage term under this master policy. This written authorization may be given to Us at the stage of member's addition to the master policy or at a later date. On receipt of such written authorization from the member we will pay an amount to the extent of outstanding loan to the master policyholder from the lumpsum Death Benefit and from Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit (if any of these inbuilt optional benefits are chosen by the member) on occurrence of respective insured events, while member's insurance coverage is in-force and on providing documents as mentioned in scheme rules. The remainder of the lumpsum Death Benefit, Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any shall be payable to the claimant other than the master policyholder. We shall, under no circumstance, pay any amount more than the outstanding loan to the master policyholder. In case, benefits other than those mentioned above in this para, are chosen by the member, 100% of such benefits shall be paid directly to the claimant other than the master policyholder. Where no such authorization is received by us from the insured member or the master policyholder does not fall under the above-mentioned regulated entities, we will pay the entire lumpsum death benefit and Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any, directly 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 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.

**Free Cover Limit** represents the amount of sum assured granted on life of the member without any need for individual underwriting for assessment of risk on account of various benefits offered under Digit Life Group Term Life Insurance. Sum Assured in excess of free cover limit may be accepted subject to evidence of insurability satisfactory to the Company. Such free cover limit shall be determined by the prevailing underwriting policy of the Company and subject to amendment from time to time.

**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 or date of reinstatement, 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 the surrender value available as on the date of death whichever is higher, provided such member's insurance coverage is in force.

**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 Term Life Insurance, that is, cardiologist, neurologist, consultant neurologist, rheumatologist, nephrologist, specialist in respiratory medicine shall be registered Medical Practitioners.

**Definitions and Exclusions - Additional Accidental Death Benefit and Additional Accidental Total & Permanent Disability Benefit (ATPD 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 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 insurance cover start date and before the termination/ expiry of the Insured member's insurance coverage.

**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.

The date of the Accident should be after the effective date of Coverage and before the termination/ expiry of the insured member's insurance coverage.

**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. Biological, chemical or radioactive contamination.

**Critical Illness Benefit – Definitions and Exclusions**

**Waiting Period means** a period of 90 days beginning from the date of start of insured member's coverage or from the date of its revival or date of its reinstatement. No amount shall be payable in case of occurrence of covered Critical Illness Condition within the Waiting Period. Waiting Period shall not be applicable for the Insured Member(s) whose insurance coverage is renewed with the Company before due date or Grace Period, if any, provided who have already completed their Waiting Period fully. In cases where the Waiting Period is only partially exhausted at the time of renewal, the balance Waiting Period shall be applicable on the renewed coverage.

Waiting period shall not be applicable in case critical illness condition manifests due to an accident.

**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.

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

# STANDARD DEFINITIONS

### 1. CANCER OF SPECIFIED SEVERITY

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

## CRITICAL ILLNESS – GENERAL EXCLUSIONS

The Critical illness condition should have been diagnosed for the first time in life.

Claim for Critical Illness Benefit will be accepted subject to Survival Period of 30 days and Waiting Period of 90 days. Waiting period shall not be applicable if critical illness condition manifests due to an accident.

Notwithstanding anything to the contrary stated herein and in addition to the foregoing exclusions, no Critical Illness Benefit will be payable if any of the above listed Critical Illness Conditions occurs from, or is caused by, either directly or indirectly, 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 or its Reinstatement.
5. Self-inflicted Injury: Intentional self-inflicted injury by the Insured member.
6. Suicide: If the Critical Illness 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 / violent acts.
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.

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

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

**c) Level 3:**

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