GROUP LOAN INSURANCE POLICY

POLICY WORDING

1. PREAMBLE

In consideration of payment of Premium by You and realized by Us, We will provide insurance cover to the Insured Person(s) under this Policy up to Sum Insured and/or limits as specified in the Policy Schedule subject to all terms, condition and exclusion as mentioned under the Policy and declaration, medical reports as provided by You. This Policy is subject to Your statements in respect of all the Insured Persons in Proposal form, declaration and/or medical reports, payment of premium and the terms and conditions of this Policy.

2. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

2.1 Standard Definitions

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Condition Precedent** means a Policy term or condition upon which the Insurer 's liability under the Policy is conditional upon.
3. **Congenital Anomaly** refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a) **Internal Congenital Anomaly** means a congenital anomaly which is not in the visible and accessible parts of the body.
   b) **External Congenital Anomaly** means a congenital anomaly which is in the visible and accessible parts of the body.
4. **Break in policy** means the period of gap that occurs at the end of the existing policy term/ installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
5. **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.
6. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:
   a) has qualified nursing staff under its employment;
   b) has qualified medical practitioner/s in charge;
   c) has fully equipped operation theatre of its own where surgical procedures are carried out;
   d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
7. **Day Care Treatment** means medical treatment, and/or Surgical Procedure which is:
   a) undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement, and
   b) which would have otherwise required hospitalization of more than 24 hours Treatment normally undertaken on an out-patient basis is not included in the scope of this definition.
8. **Disclosure to information norm** means the Policy shall be void and all premium paid thereon shall be forfeited to The Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
9. **Domiciliary Hospitalisation** means medical treatment for a period exceeding 3 days, for an illness/disease/Injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
   - the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
   - the patient takes treatment at home on account of non-availability of room in a hospital.
10. **Emergency Care** means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
11. **Grace period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The Grace Period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
12. **Hospital** means any institution established for in-patient care and day care treatment of Illness and / or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration & Regulation) Act 2010 or under enactments specified under the Schedule of Section 56 (1) and the said act Or compliance with all minimum criteria as under-
    a) has qualified nursing staff under its employment round the clock;
    b) has at least 10 inpatient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    c) has qualified medical practitioner(s) in charge round the clock;
    d) has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
    e) maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

13. **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.

14. **Illness** means a sickness, or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

    a) Acute Condition - is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/Injury which leads to full recovery.

    b) Chronic Condition - is defined as a disease, illness, or Injury that has one or more of the following characteristics:

        i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests.

        ii. it needs ongoing or long-term control or relief of symptoms.

        iii. it requires your rehabilitation for the patient or for the patient to be specially trained to cope with it

        iv. it continues indefinitely.

        v. it recurs or is likely to recur.

15. **Injury** means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

16. **In-patient Care** means treatment for which the Insured person has to stay in a Hospital for more than 24 hours for a covered event.

17. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

18. **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 the scope and jurisdiction of the licence.

19. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

    a) is required for the medical management of the Illness or Injury suffered by the insured;

    b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

    c) must have been prescribed by a medical practitioner;

    d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

20. **Notification of claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

21. **Pre-existing disease (PED)** means any condition, ailment, injury or disease:

    a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

    b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

22. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

23. **Senior citizen** shall have the same meaning assigned to it under Maintenance and Welfare of Parents and Senior Citizens Act, 2007.

24. **Senior citizen** means any person, who has attained the Age of sixty years or above.

25. **Solicitation** means the act of approaching a prospect or a Policyholder by an Insurer or by a distribution channel with a view to persuading the prospect or a Policyholder to purchase or to renew an insurance Policy.

26. **Sum Insured** means the pre-defined limit specified in the Policy Schedule/ Certificate of Insurance. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person.

27. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.

28. **Surgery/Surgical Procedure** means manual and/or operative procedures required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

2.2 Specific Definitions

1. **Age** means completed years on last birthday as on Commencement Date.

2. **AIDS** means Acquired immunodeficiency syndrome (AIDS), a condition characterized by a combination of signs and symptoms, caused by Human Immunodeficiency Virus(HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions ,as may be specified from time to time.

3. **Bank** means a banking company which transacts the business of banking in India or abroad.

4. **Bank Rate** means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.

5. **Base Sum Insured** means the pre-defined limit specified in the Policy Schedule /Certificate of Insurance.

6. **Beneficiary** in case of death of the Insured Person, the Beneficiary means, unless stipulated otherwise by the Insured Person, the surviving Spouse of the Insured Person, mentally capable and not divorced, followed by the children recognized or adopted, followed by the Insured Person's legal heirs. For all other benefits, the Beneficiary means the Insured Person himself unless stipulated otherwise.

7. **Commencement Date** means the Commencement Date of this Policy as specified in the Policy Schedule /Certificate of Insurance.

8. **Compensation** means Sum Insured, Total Sum Insured or percentage of the Sum Insured, as appropriate and mentioned in Policy Schedule /Certificate of Insurance.
9. **EMI or EMI Amount** means and includes the amount of monthly payment required to repay the principal amount of Loan and/or interest by the Insured person as set forth in the amortization chart referred to in the Loan agreement (or any amendments thereto) between the Bank/Financial Institution and the Insured person prior to the date of occurrence of the Insured Event under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments including additional interest thereon that are overdue and unpaid by the Insured person prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.
10. **Financial Institution shall have the same** meaning assigned to the term as per the Reserve Bank of India Act, 1934 and shall include a Non-Banking Financial Company as defined under section 45 I of the Reserve Bank of India Act, 1934.
11. **HIV** means Human Immunodeficiency Virus
12. **Insured Event** means any event specifically mentioned as covered under this Policy.
13. **Loan /Credit** means the sum of money lent at interest or otherwise to the Insured person by any Bank/Financial Institution as identified by the Loan Account Number(s) or any such identification number
14. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.
15. **Nominee** means the person(s) named in the Policy Schedule/ Certificate of Insurance who is nominated to receive the benefits in respect of an Insured person under the Policy in accordance with the terms and conditions of Policy, if the Insured person is deceased.
16. **Policy** means the Policy wordings, the Policy Schedule / Certificate of Insurance and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.
17. **Policy holder** means the entity or person named as such in the Policy Schedule/ Certificate of Insurance.
18. **Policy Period** means the period between the Commencement Date and either the Expiry Date specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.
19. **Policy Schedule / Certificate of Insurance** means the document issued by us to You as per the terms and conditions detailing the commencement date and expiry date of the cover, Insured Person(s) name, address, age, coverage, sums insured, Deductible, condition(s), exclusions and or endorsement(s) as fully mentioned in the respective Policy Period.
20. **Principal Outstanding** means the principal amount of the Loan outstanding as on the date of occurrence of the Insured Event less the portion of principal component included in the EMIs payable but not paid from the date of the loan agreement till the date of the Insured Event/s. For the purpose of avoidance of doubt, it is clarified that any EMIs including additional interest thereon that are overdue and unpaid to the Bank/Financial Institution prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured Person.
21. **Proposal form** means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

    Explanation:

    (i) "Material Information" for the purpose of these regulations shall mean all important, essential and relevant information and documents explicitly sought by insurer in the proposal form.

    (ii) The requirements of "disclosure of material information" regarding a proposal or policy, apply both to the insurer and the prospect, under these regulations.

21. **Proposer** means the person furnishing complete details and information in the Proposal form for availing the benefits either for himself or towards the person to be covered under the Policy and consents to the terms of the contract of insurance by way of signing the same.
22. **Survival Period** means the benefits under the Policy shall be payable only if the Insured is first diagnosed as suffering from a defined Critical Illness during the Policy Period, and the Insured survives for at least 28 days following such diagnosis.
23. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Schedule/ Certificate of Insurance which shall be served before a claim related to such condition becomes admissible. The Waiting Period will be computed from the date of commencement of Policy period.
24. **We, Our, Ours, The Company, Insurer** means SBI General Insurance Company Limited
25. **You, Your, Yourself/ Your Family, Insured, Insured Person**, named in the Policy Schedule that We insure as set out in the Schedule.

3. SCOPE OF COVER

BASE COVERS

SECTION 3.1: PERSONAL ACCIDENT

Section 3.1.1 - Accidental Death

Insured event: For the purposes of this Section and the determination of Our liability under it, Insured Event in relation to any Insured Person, shall mean Injury sustained during the Policy Period which shall within twelve months of its occurrence be the sole and direct cause of

a) Death

Section 3.1.2 - Permanent Total Disablement

Insured event: For the purposes of this Section and the determination of Our liability under it, Insured Event in relation to any Insured Person, shall mean Injury sustained during the Policy Period which shall within twelve months of its occurrence be the sole and direct cause of

a) Permanent Total Disablement as described in Table of Benefits be

Table of Benefits	
Permanent Total Disability	**% of Sum Insured**
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
Either Hand or Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

Specific Condition

1. If an Insured person dies as a result of bodily Injury any amount claimed and paid to an Insured person under this section will be deducted from any payment under Accidental Death (3.1.1)

Section 3.1.3 - Funeral Expenses

If we have accepted a claim under Accidental Death (3.1.1) benefit of this Policy, then we will in addition pay benefit amount towards funeral expenses including transporting the mortal remains of the Insured person from the place of the Accident or the Hospital to his residence.

The benefit amount payable is the admissible claim amount under Accidental Death (3.1.1) or Rs. 20,000, whichever is lower.

This benefit is over and above the base Sum Insured.

Specific Exclusions Applicable to SECTION 3.1- PERSONAL ACCIDENT:

1. Payment of Compensation in respect of death arising from or resulting directly or indirectly from any Illness to any Insured.

Special conditions applicable to SECTION 3.1- PERSONAL ACCIDENT:

The cover under this section in case of Accidental death for the specific Insured Person, shall terminate in the event of claim in respect of that Insured person becoming admissible and accepted by Us, under this Section.

Except If claim is paid under Section 3.1.2- Permanent Total Disablement, the amount payable for the subsequent claims/s under such benefits shall be reduced by the amount/s already paid.

However, Section 3.2. Critical Illness and Section 3.3: Admission Benefit-Accident Hospitalization shall remain in force during the remaining Policy Period.

OPTIONAL COVERS

SECTION 3.2: CRITICAL ILLNESS COVERS

Section 3.2.1 – Critical Illness

Insured event: For the purposes of this Section and the determination of Our liability under it, the Insured Event in relation to the Insured person, shall mean any illness, medical event or surgical procedure as specifically defined below whose signs or symptoms first commence more than 90 days after the commencement of Policy Period and provided that the Insured Person survives for a minimum of 28 days from the date of diagnosis.

1. Cancer of specific 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 –

i. 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.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of Specific Severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagn-osis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Chest CABG

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.

The following are excluded:

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

4. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace

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

5. Coma of Specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

6. Kidney Failure Requiring Regular Dialysis

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.

7. Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation 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.

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

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

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

9. Permanent Paralysis of Limbs

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 recoveryand must be present for more than 3 months.

10. Multiple Sclerosis with Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Neurological damage due to SLE is excluded.

11. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;

ii. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

12. Primary (Idiopathic) Pulmonary Hypertension

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 (NYHA) Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

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

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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.

13. Aorta Graft Surgery

The actual undergoing of surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

The following are excluded:

i. Surgery following traumatic injury to the aorta.

ii. Surgery to treat peripheral vascular disease of the aortic branches is excluded even if a portion of the aorta is removed during the operative procedures.

iii. Surgery performed using only minimally invasive or intra-arterial techniques such as percutaneous endovascular aneurysm with insertion of a stent graft.

14. Benign Brain Tumor

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

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

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

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.

15. Motor Neurone Disease with Permanent Symptoms

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.

Benefit payable under section II: We hereby agree, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, General Exclusions stated in this Policy, to pay the Sum Insured in relation to the Insured person as stated against Section II under the Policy Schedule on the occurrence of an Insured Event as stated above under this Section.

Section 3.2.2 - Incidental Benefit

If we have accepted a claim under Critical Illness (II) benefit of this policy, then we will in addition pay benefit amount towards incidental expenses as lumpsum payment.

The benefit amount payable is the admissible claim amount under Critical Illness (II) or Rs. 100,000, whichever is lower.

This benefit is over and above the base Sum Insured.

Specific Exclusions Applicable to SECTION 3.2:

1. Any Critical Illness or covered Disease/Illness/Sickness of which, the signs or symptoms first occurred within ninety (90) days following the first risk inception date. This 90 days period shall not be applicable on renewals to the extent of sum insured under the previous policy.
2. Any Critical Illness resulting from a physical condition which existed prior to first risk inception date which was not disclosed,
3. Any claim under for any Insured if the Insured does not survive a period of at least 28 days after the date of occurrence Insured Event.

Specific conditions applicable to SECTION 3.2:

The cover(s) under this Section, for the specific Insured Person, shall terminate in the event of claim in respect of that Insured person becoming admissible and accepted by Us under this Section. However, Section 3.1. Personal Accident and Section 3.3. Admission Benefit-Accident Hospitalization shall remain in force during the remaining Policy Period.

SECTION 3.3

ADMISSION BENEFIT - ACCIDENTAL HOSPITALIZATION

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment due to Injury resulting from an Accident that occurred during the Policy Period for a minimum period of continuous 48 Hours then We will pay admission benefit of the 3 EMI Amount(s) falling due in respect of the Loan as a fixed benefit.

Specific Exclusion applicable to SECTION 3.3:

1. Any stay in Hospital for an Illness or Injury due to Accident without undertaking any treatment.
2. Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to Accident or as a part of any Injury.
3. Any admission for any dental treatment except any dental Surgery or facial reconstruction being performed under Emergency Care due to an Accident.
4. Hospitalization for the sole purpose of traction, physiotherapy or any ailment for which Hospitalization is not warranted due to advancement in medical technology.
5. Any treatment taken for Domiciliary Hospitalization.

Specific conditions applicable to section 3.3:

Notwithstanding anything contrary stated in the Policy, the Sum Insured under the Policy on the date of the Insured Event covered under this section for the purpose of calculation of claim shall be the least of the following:

- If the Sum Inured as appearing in Personal Accident (Section 3.1) is equal to the Loan Amount disbursed, then actual 3 EMIs as on date of Insured Event will be paid.
- In the event the Sum Insured as appearing against Personal Accident (Section 3.1) of the Schedule of the Policy is less than the total of the actual Loan disbursed up to the date of the occurrence of the Insured Event, then the Amortization Schedule shall be calculated as if the actual Loan disbursed was equivalent to the Sum Insured;

SECTION 3.4 WAIVER OF SURVIVAL PERIOD

- Under this option, we shall waive off the 28 days Survival Period condition as mentioned in 2.2 Specific Definition, sub point (22). Such waiver, if allowed, shall be expressly mentioned in the Policy Schedule / Certificate of Insurance.

4. EXCLUSIONS

4.1 STANDARD EXCLUSIONS

4.1.1 Hazardous or Adventure sports (Code: Excl 09):

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

4.1.2 Breach of law (Code: Excl 10):

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

4.1.3 Substance Abuse and Alcohol (Code: Excl12):

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

4.1.4 Sterility and Infertility (Code: Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

4.1.5 Maternity Expenses (Code - Excl 18)

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

4.2 SPECIFIC EXCLUSIONS

We shall not be liable for any loss under this Policy if:

1. Any Pre-existing condition, or its related conditions arising from it.
2. Arising out of or as a result of any act of self-destruction or self-inflicted injury, attempted suicide or suicide.
3. Directly or indirectly caused by or contributed to by or arising from ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission.
4. Directly or indirectly caused by or contributed to by or arising from nuclear weapon materials.
5. Due to, or arising out of, or directly or indirectly connected with or traceable to, war, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of all Heads of State and citizens of whatever nation.
6. External congenital anomalies/defects (known or unknown) or any complications or conditions arising there from
7. Loss due to Terrorism arising in connection with Nuclear and /or chemical and /or biological events.
8. Participation in an actual or attempted felony, riot, crime, misdemeanour, or civil commotion

5. GENERAL TERMS AND CLAUSES

5.1 STANDARD GENERAL TERMS AND CLAUSES

5.1.1 Disclosure of Information

The Policy shall be void and all premiums paid thereon shall be forfeited to The Company in the event of misrepresentation, mis-description, or non-disclosure of any Material Fact by the Insured Person.

5.1.2 Condition Precedent to Admission of Liability

The Due observance and fulfillment of the terms and conditions of the Policy, by the Insured Person, shall be a condition precedent to any liability of The Company to make any payment for claim(s) arising under the Policy.

5.1.3 Complete Discharge

Any payment to the Policy holder, Insured person or his/ her Nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by The Company to the extent of that amount for the particular claim.

5.1.4 Multiple policies

In case of multiple policies which provide fixed benefits, on the occurrence of the Insured Event in accordance with the terms and conditions, and limit of the policies, the insurer shall make the claim payments independent of payments received under other similar policies.

5.1.5 Fraud

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

Any amount already paid against claims which are found fraudulent later under this Policy shall be repaid by all person(s) named in the Policy Schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured person or by his agent, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy: —

(a) the suggestion, as a fact of that which is not true and which the Insured person does not believe to be true;

(b) the active concealment of a fact by the Insured person having knowledge or belief of the fact;

(c) any other act fitted to deceive; and

(d) any such act or omission as the law specially declares to be fraudulent.

The Company shall not repudiate the Policy on the ground of fraud, if the Insured person beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Policy holder, if alive, or beneficiaries.

5.1.6 Cancellation and Termination Terms of Policy

A. Cancellation by you

i) You can choose to cancel the Policy, giving us a 15-day notice period by recorded delivery. This, provided there is no claim under the Policy. The insured shall be entitled for premium refund at the company's Short Period Scale provided in table below.

For policies upto one year :

Length of time Policy in force	Refund of Premium (% of Annual Premium)
Up to 1 month	75%
Up to 3 months	50%
Up to 6 months	25%
Exceeding 6 Months	0%

Refund grid for policies with term longer than 1 year – Fixed Sum Insured:

Loan Period	2	3	4	5+
Policy Period	2	3	4	5
Return Premium Factors				
Year of Cancellation	% return premium			
1	25%	45%	57%	65%
2	Nil	11%	26%	37%
3	-	Nil	6%	17%
4	-	-	Nil	4%
5	-	-	-	Nil

Refund grid for policies with term longer than 1 year – Reducing Sum Insured:

Policy Period	2	3	4	5	5	5	5	5	5	5	5	5	5	5
Loan Period	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Year 1	25%	45%	57%	65%	70%	73%	74%	75%	76%	77%	77%	78%	78%	78%
Year 2		11%	26%	37%	45%	49%	51%	53%	54%	55%	56%	56%	57%	57%
Year 3			6%	17%	24%	28%	31%	33%	34%	35%	36%	36%	37%	37%
Year 4				4%	9%	12%	14%	15%	16%	16%	17%	17%	18%	18%
5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
78%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	80%	80%	80%
57%	58%	58%	58%	58%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%
37%	38%	38%	38%	38%	39%	39%	39%	39%	39%	39%	39%	39%	39%	39%
18%	18%	19%	19%	19%	19%	19%	19%	19%	19%	19%	19%	19%	20%	20%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

B. Cancellation by Us

Policy may be cancelled by us on the grounds of misrepresentation, fraud or non-disclosure of material facts by sending to you 15 days' notice by recorded delivery at last known address/e-mail ID without refund of premium.

5.1.7 Free Look Period

The Free Look Period shall be applicable on new Group Loan Insurance policies and not on renewals or at the time of porting/migrating the Policy.

(1) Every Policyholder of new individual health insurance policies except those with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such Policy.

(2) In the event a Policyholder disagrees to any of the Policy terms or conditions, or otherwise and has not made any claim, he shall have the option to return the Policy to the insurer for cancellation, stating the reasons for the same.

(3) Irrespective of the reasons mentioned, the Policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

(4) A request received by insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request, as stated at sub regulation (3) above.

5.1.8 Withdrawal of the Policy

i. In the likelihood of this product being withdrawn in future, The Company will intimate the Insured person about the same 90 days prior to expiry of the Policy.

ii. Insured Person will have the option to migrate to similar product available with The Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of Waiting Period as per IRDAI guidelines, provided the Policy has been maintained without a break.

5.1.9 Possibility of Revision of terms of the Policy including the Premium Rates

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

5.1.10 Nomination

The Policy holder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of Your death. Any change of nomination shall be communicated to The Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Insured Person, The Company will pay the Nominee (as named in the Policy Schedule) and in case there is no subsisting Nominee, to the legal heirs or legal representatives of the Insured person whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.2 SPECIFIC TERMS AND CLAUSES

5.2.1 Age Limit

To be eligible to be covered under the Policy or get any benefits under the Policy, the Insured person should have attained the age of at least 18 years on the date of commencement of the Policy.

5.2.2 Alterations in the Policy

The Proposal Form, Certificate, and Policy Schedule /Certificate of Insurance constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policy holder and Us. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Us. All endorsement requests will be made by the Policy holder and/or the Insured person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us.

5.2.3 Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two Arbitrators who shall act as the presiding arbitrator and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 (as amended).

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if The Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by

such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

5.2.4 Assignment clause

It is hereby declared and agreed that:

- from the Policy Start Date, the monies payable by Us to the Insured Person and all rights, title, benefits and interest of the Insured Person under this Policy stand assigned in favour of the "Bank / Financial Institution as named in the Schedule of this Policy";
- upon any monies becoming payable under this Policy the same shall be paid by Us to the "Bank/Financial Institution as named in Schedule of this Policy" without any reference / notice to the Insured, but not exceeding the Principal Outstanding as defined under the Policy. In the event of any monies payable under this Policy exceeding the Principal Outstanding, We shall pay such monies as exceeding the Principal Outstanding to the Insured;
- the receipt of such monies in the manner aforesaid by the Bank/Financial Institution as named in the Schedule of this Policy and the Insured Person shall completely discharge Us from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured Person, as the case may be.

That any adjustment, settlement, compromise or reference to arbitration in connection with any dispute between Us and the Insured Person or any of them arising under or in connection with this Policy if made by the Bank/Financier shall be valid and binding on all parties insured hereunder but not so as to impair rights of the Bank/Financier to recover the full amount of any claim it may have on other parties insured hereunder.

5.2.5 Automatic Termination of Insurance

This Policy shall automatically terminate upon the Insured Person's death or payment of 100% Sum Insured. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the Policy.

In case, the other Insured person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to The Company along with the application.

5.2.6 Currency

The monetary limits applicable to this Policy will be in INR.

5.2.7 Change of Sum Insured

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the Waiting Period shall start afresh only for the enhanced portion of the Sum Insured.

5.2.8 Geography

Policy Applies to events or occurrences taking place anywhere in the world.

However, all admitted or payable claims under this Policy shall be settled in India in Indian rupees.

5.2.9 Material Change

The Insured person shall immediately notify The Company in writing of any change in his business or occupation or physical defect or infirmity with which he has become affected since the payment of last preceding premium.

5.2.10 No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/Insured Person which is in Our possession or in the possession of any of Our official shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve the Policyholder /Insured Person from their duty of disclosure, notwithstanding subsequent acceptance of any premium.

5.2.11 Notice and Communication

i. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of The Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

5.2.12 Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of the Policy (including the realisation of premium by their respective due dates by Us and compliance with the specified procedure on all claims) in so far as they relate to anything to be done or complied with by the Policyholder or any of the Insured Persons or Claimants, shall be the condition precedent to Our liability to make payment under this Policy.

5.2.13 Portability and Continuity Benefits

We will grant continuity of benefits which were available to the insured members under a health insurance policy which provides similar indemnity/benefits in the immediately preceding cover year provided that:

- We shall be liable to provide continuity of only those benefits (for e.g.: initial wait period, wait period of specific diseases pre-existing disease etc) which are applicable under this policy.
- Any other wait period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.
- Insured members covered under this policy shall have the right to migrate from this policy to an individual health insurance policy or a family floater policy offered by our company. The credit for wait periods would be given in the opted individual health insurance policy or a family floater policy offered by our company. Application for this policy is made within 45 days before, but not earlier than 60 days from the expiry of that group insurance policy.

5.2.14 Premium

The premium payable under this Policy shall be paid in accordance with the schedule of payments in the Policy Schedule agreed between the Policy holder and Us in writing. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment

of premium and realization thereof by Us and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured person in so far as they relate to anything to be done or complied with by the Insured person shall be a condition precedent to Our liability to make any payment under this Policy.

5.2.15 Renewal conditions:

i. The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person.

ii. The Company shall endeavor to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

iii. Renewal shall not be denied on the ground that the Insured Person had made a Claim or Claims in the preceding Policy years.

iv. Request for Renewal along with the requisite premium shall be received by the Company before the end of the Policy Period

v. At the end of the Policy Period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

vi. No loading shall apply on Renewals based on individual Claims experience.

5.2.16 Records to be Maintained

The Insured person shall keep an accurate record containing all relevant medical records and shall allow The Company or its representatives to inspect such records. The Insured person shall furnish such information as The Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

5.2.17 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

6. OTHER TERMS AND CONDITIONS

6.1 Claims Procedure

- **Claim Intimation**

  • Upon the discovery or occurrence of an event or Hospitalisation that may give rise to a claim under this Policy, Insured person or the Nominee as the case may shall undertake the following:

  • In case of Hospitalisation, notify Us either at Our call centre or in writing within 48 hours of the Hospitalization but not later than discharge from the Hospital.

  • In case of diagnosis or actual undergoing of procedure, notify Us either at the call centre or in writing, within 10 days from the date of occurrence of such event. The following details are to be provided to Us at the time of intimation of Claim:

    - o Policy Number
    - o Name of the Policy holder
    - o Date and Time of Loss Location of Accident
    - o Name of the Insured person in whose relation the claim is being lodged
    - o Nature of claims, Accidental death, Accidental Hospitalisation, Critical Illness
    - o Name and address of the attending Medical Practitioner and Hospital (if admission has taken place)
    - o Date of admission if applicable
    - o Any other information, documentation as requested by Us

  Intimation about an event or occurrence that may give rise to a claim under this Policy must be given within 30 days of its happening. We will examine and relax this time limit mentioned herein depending upon the merits of the case.

- **Claim Notification**

  It is a condition precedent to Our liability hereunder that written notice of claim must be given by the Insured person to us within seven (7) days after an actual or potential loss begins or as soon as reasonably possible and, in any event, no later than (30) Days after an actual or potential loss begins. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if you can satisfy us that it was not reasonably possible for you to give proof within such time.

  We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

- **Claim Documents –**

  1. Section 3.1: Personal Accident

  a) Accidental Death & Funeral Expenses

  The following documents are required to be submitted to Us within 15 days from the date of loss

  - Duly completed and signed claim form with annexure of Bank certificate duly certified
  - Loan account statement and amortization schedule
  - Death Certificate issued by municipal/equivalent authority
  - Certified copies of MLC Report, FIR report, Spot Panchnama, Inquest Panchnama, Postmortem Report, Final Police Report
  - NEFT details of Nominee (required in case of pay out to be made in favour of)
  - Duly filled KYC form & KYC Documents (if payment to be made to Nominee)
  - Any other documents as may be required by Us

  The above list is indicative and We may call for any additional documents/ information/ subject the Insured person to additional medical examinations as required to ascertain the admissibility of any Benefit including Optional Covers under the relevant Section of the Policy, based on the circumstances of the claim on a case to case basis.

  b) Permanent Total Disablement:

  - Duly completed claim form with duly certified bank annexure.

- Certificate issued by Competent medical authority confirming nature & extent of disability with period and prognosis for (Permanent Total Disability, Permanent Partial Disability
- Photograph of the injured with reflecting disablement.
- Certified copy of hospital admission/ discharge card with complete medical records including relevant Investigation/ Lab reports (X-Ray, MRI etc.)
- Certified copies of MLC Report, FIR report, Spot Panchnama, Inquest Panchnama, Final Police Report
- NEFT details of insured / Nominee (required in case of payout applicable to be made in favour of)
- Duly filled KYC form & KYC Documents (if payment to be made to insured/Nominee)
- Loan account statement, & Certificate from bank confirming Loan account details including Loan outstanding as on date of loss (Principal amount & Interest) excluding overdues/penalties
- Any other documents as may be required by Us

2. Section 3.2: Critical Illness

The Insured person may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense within ninety (90) days of date of first diagnosis of the Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be

- Duly completed and signed claim form in original as prescribed by Us.
- First diagnostic report confirming diagnosis of critical Illness claimed
- Medical Certificate confirming details of first consultation, medical history, symptoms and date of 1st diagnosis of critical illness
- All consultation papers including first consultation and subsequent follow up, medical records and prescriptions related to illness.
- Certified copy of Hospital Discharge Certificate/ Card from the hospital, if any
- Indoor case papers
- Duly filled KYC form & KYC Documents of insured/ Nominee, if payout applicable to be made in favour of insured/ Nominee
- Loan account statement, & Certificate from bank confirming Loan account details including Loan outstanding as on date of loss (Principal amount & Interest) excluding overdues/penalties
- In the cases where Critical Illness claimed arises due to an Accident, certified copy FIR, medico legal certificate and other relevant police documents will be required wherever applicable.
- Copy of cancelled cheque with Insured printed name or passbook first page or bank statement for NEFT payment.

The above list is indicative and We may call for any additional documents/ information/ subject the Insured person to additional medical examinations as required to ascertain the admissibility of any Benefit including Optional Covers under the relevant Section of the Policy, based on the circumstances of the claim on a case to case basis.

3. Section 3.3: Admission Benefit - Accidental Hospitalization

Following documents need to be submitted

- Duly filled claim form by the Insured Person/claimant.
- Certified copy of Hospital discharge summary
- Certified copy of In-patient detailed bill
- Certified copies of all investigation/diagnostic test reports – Blood, Pathology, Radiology etc.
- Certified copies of all consultation papers related to diagnosis
- Duly filled KYC form & KYC Documents of insured (if payout to be made in favour of insured).
- NEFT details of insured (Copy of Bank passbook/ cancelled cheque/letter from bank confirming account details, IFSC & MICR codes) for household expense benefit payout to be made to insured

In case there is a delay in the submission of claim documents, then in addition to the documents mentioned above, the claimant is also required to provide Us the reasons for such delay in writing. We shall condone delay on merit for delayed claims where delay is proved to be for reasons beyond the control of the Policy holder or Insured person or the claimant, as the case may be.

Scrutiny of Claim Documents

We shall scrutinize the claim and accompanying documents. Any deficiency of documents shall be intimated to Insured Person, within 15 days of their receipt. If the deficiency in the necessary claim documents is not met or are partially met in 15 working days of the first intimation, We shall remind the Insured person of the same and every 15 days thereafter. We will send a maximum of 3 (three) reminders following which We will send a closure letter.

Claim Assessment

We will pay fixed amounts as specified in the applicable Sections for Basic or Optional Benefits in accordance with the terms of this Policy.

We are not liable to make any payments that are not specified in the Policy.

Re-opening of Claim

We may allow a closed claim to be reopened depending on the validity and the circumstances of the claim post receipt of documents sufficient to decide the claim.

Settlement & Repudiation of a Claim

We shall settle a claim including its rejection within 15 days of the receipt of the last "necessary" documents.

In case of suspected frauds, the last "necessary" document shall mean the receipt of verification/ investigation report to determine the validity of the claim.

In the cases of delay in the payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

(Explaination: Bank Rate means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due)

- **Representation against Rejection**

  Where a rejection is communicated by Us, the claimant may if so desired within 15 days of the communication of the rejection, represent to Us for reconsideration of the decision.

- **Payment Terms**

  All claims will be payable in India and in Indian rupees.

- **Limitation of Liability**

  If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within thirty six months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

  Any claim for which the notification of claim is received 12 calendar months after the event or occurrence giving rise to the claim shall not be admissible, unless it is proved to Our satisfaction that the delay in reporting of the claim was for reasons beyond Your or the Insured Persons control.

6.2 Grievances Redressal Procedure

Stage 1:

If you are dissatisfied with the resolution provided above or for lack of response, you may write to **head.customercare@sbigeneral.in** We will look into the matter and decide the same expeditiously within 14 days from the date of receipt of your complaint.

For Senior Citizens: Senior Citizens can reach us at **seniorcitizengrievances@sbigeneral.in;** Toll Free - 1800 22 1111 / 1800 102 1111 Monday to Saturday (8 am - 8 pm)

Stage 2:

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may send your Appeal addressed to the Grievance Redressal Officer at : **gro@sbigeneral.in** or contact at 022-45138021.

Address: Grievance Redressal Officer, 9th Floor, A & B Wing, Fulcrum Building, Sahar Road, Andheri (East), Mumbai 400 099. List of Grievance Redressal Officers at Branch:

https://content.sbigeneral.in/uploads/0449cac1bcd144bbb160d3f6b714fbbd.pdf/

Stage 3:

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may Register your complaint with IRDAI on the below given link

https://bimabharosa.irdai.gov.in/Home/Home

Stage 4:

If your grievance remains unresolved from the date of filing your first complaint or is partially resolved, you may approach the Insurance Ombudsman falling in your jurisdiction for Redressal of your Grievance. The details of the Insurance Ombudsman can be accessed at **(https://www.cioins.co.in/Ombudsman)**

You may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices attached as Annexure A

Endorsement Wordings:

Reducing Sum Insured:

Notwithstanding anything contrary stated in the Policy, the Sum Insured under the Policy on the date of the Insured Event covered under Sections 3.1, 3.2 and 3.3 for the purpose of calculation of claim shall be the least of the following:

- The Principal Outstanding in the books of the Bank/Financial Institution as on the date of occurrence of the Insured Event; or
- The Principal Outstanding as per the amortization Schedule prepared by Bank/Financial Institution. In the event the Sum Insured as appearing against Section 3.1, 3.2 and 3.3 of the Schedule of the Policy is less than the total of the actual Loan disbursed upto the date of the occurrence of the Insured Event, then the Amortization Schedule shall be calculated as if the actual Loan disbursed was equivalent to the Sum Insured; or
- The Sum Insured as appearing against Section 3.1, 3.2 and 3.3 of the Schedule

Annexure-I Coverage Summary – Group Loan Insurance Policy

Policy type	Group
Policy Period	6 months to 5 years
Waiting Period (For Critical Illness and Incidental Expenses)	90 Days
Survival Period (For Critical Illness and Incidental Expenses)	28 Days (Survival period can be waived off)

Base Cover	**Sum Insured**	**Policy Tenure**	**Claim Payout**
Accidental Death (AD)	Maximum Sum Insured of Rs. 1,00,00,000	6 months to maximum 5 years	Within base sum insured
Permanent Total Disablement (PTD)	Maximum Sum Insured of Rs. 1,00,00,000		
Funeral Expenses	Rs. 20,000 or Outstanding Loan Amount, whichever is less in case of accidental death		Over and above Sum Insured
Optional Covers			
Critical Illness (15 Cis)	Maximum Sum Insured of Rs. 15,00,000 (whichever is less)	12 months to maximum 5 years	Over and above Sum Insured
Incidental Expenses	Rs. 1,00,000 or Outstanding Loan Amount, whichever is less	12 months to maximum 5 years	Over and above Sum Insured
Admission Benefit - Accidental Hospitalization	Actual EMI * 3	6 months to maximum 5 years	Over and above Sum Insured
Waiver of Survival Period	Not Applicable	Not Applicable	Not Applicable

Annexure A

Names of Ombudsman and Addresses of Ombudsmen centers

	Office of the Insurance Ombudsman
Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu	Shri Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th Foor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh, Chattisgarh	Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 1st Foor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in
Odhisa	Shri Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	Mr Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).	Shri Segar Sampathkumar Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	Ms Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	Shri N. Sankaran Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st Floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan	Shri Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	Shri G. Radhakrishnan Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	Ms Kiran Sahdev Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Shri. Atul Sahai Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in

Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).	Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Shri Bimbadhar Pradhan Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand.	Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).	Shri Sunil Jain Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in
The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.in, our website www.SBI Generaleneral.in	

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