SURAKSHA AUR BHAROSA DONO

Arogya Sanjeevani Policy, SBI General Insurance Company Limited, Group

PROSPECTUS

Serious Illness or accident along with routine health problem may disturb the financial planning of an individual and Family. Arogya Sanjeevani Policy, SBI General Insurance Company Limited- Group provides financial protection against medical costs due to hospitalisation.

Who Can Buy This Policy?

Arogya Sanjeevani Policy, SBI General Insurance Company Limited- Group can be bought by any individual between the age of 18 Years to 65 Years on Individual and Family floater basis.

(Family means self, spouse, dependent children ,parents, parents in law)

Age Criteria

Minimum Entry Age: Adult - 18 Years, Dependent Children: 3 months

Maximum Entry Age: 65 Years, Dependent Children:25 Years

There is no exit age applicable to the policy. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals under family floater.

Scope of Cover

Section I - Hospitalization Cover

I.A. Base Cover

I.a.1 – Hospitalization Medical Expenses

a) Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the Sum insured subject to maximum of Rs.5000/- per day.

b) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.

c) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.

(Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital/and the Insured is discharged on the same day.)

d) Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.

Other Expenses

a) Expenses incurred on treatment of Cataract subject to sub limit of 25% of Sum insured or Rs.40,000/- whichever is lower, per eye.

b) Dental treatment necessitated due to disease or injury.

c) Plastic surgery necessitated due to disease or injury.

d) All the day care treatments.

e) Expenses incurred on Road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

I.a.2 – Pre-Hospitalization Medical Expenses

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

I.a.3 – Post-Hospitalization Medical Expenses

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

I.a.4 – Ayush Treatments

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

I.a.5 – Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured orRs.40,000/-, whichever is lower, per each eye in one policy year.

I.A.6

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period but not limited to the following

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

Period of Insurance:

The policy can be issued for Annual Period Only

Co Pay:

5 % on all admissible claim amount.

Renewal Benefits:

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported). provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the insured Persons.
iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. If the insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for Such insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
v. In case of floater policies where insured Persons Renew their expiring policy by splitting the Sum insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years. the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

Waiting Period

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

1. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum insured increase.

c) If the insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage

d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. First Thirty Days Waiting Period Code Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

3. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, Surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then wating period for the same would be reduced to the extent of prior coverage.

i. 24 Months waiting period

1. Benign ENT disorder
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benig breast lumps.
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non-Infective Arthritis
15. Piles, Fissures, and Fistula in Anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

Exclusions

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of;

1. Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily tor diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the Current diagnosis and treatment

2. Rest Cure, rehabilitation and respite care (Code- Excl05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. Obesity/ Weight Control (Code- Excl06)

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

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

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: (Code- Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. However, such exclusion shall not be applicable to respective Insured Person to comply with Transgender Persons (Protection of Rights) Act, 2019.

5. Cosmetic or plastic Surgery: (Code- Excl08)

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

6. Hazardous or Adventure sports: (Code- Excl09)

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.

7. Breach of law: (Code- Excl10)

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

8. Excluded Providers: (Code-Excl 11)

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

9. Treatment for, Alcoholism. drug or substance abuse or any addictive condition and consequences thereof **(Code- Excl 12)**
10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Exel13)**
11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**

12. Refractive Error:(Code- Excl15)

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

13. Unproven Treatments:(Code- Exel16)

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

14. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility this includes:

(i) Any type of 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

15. 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.

16. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

17. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

18. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

19. Treatment taken outside the geographical limits of India

20. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

Premium Rates

As per Rating Chart attached

Pre Policy Medical Examination And Loadings

1) Medical Examinations:
Medical Tests as indicated in the grid below are applied to those proposed insured person/s whose age is >45 years of age and/or where the proposed insured person/s is/are suffering from an existing medical condition (as mentioned in the proposal form or is identified so in the reports from the medical tests applied), additional medical test/s (depending upon the type of medical condition) may be applied for understanding the complete health condition.

Medical Testing Grid*	**Medical Tests**
ME	Medical Examination
ECG	Electrocardiogram
CBC	Complete Blood Count
ESR	Erythrocyte Sedimentation Rate
HbA1c	Glycated Hemoglobin
SGPT	Serum Glutamate Pyruvate Transaminase
Sr. Creatinine	Serum Creatinine
Urine Routine	Urine Routine
Total Lipids	Total Lipids

If the proposal is accepted, the Insurer will reimburse 50% of the cost incurred towards the medical tests so undertaken at the advice of the insurer.

2) Loadings:

a. We may apply Medical Underwriting loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.

b. For Medical Age Band cases or cases with medical history will be subject to medical UW and will attract medical Loading on the premium, the maximum loading % will not exceed 100% of Base Premium under any policy

c. Medical Underwriting loadings will be applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on increased Sum Insured. We will not apply any additional loading on Your policy premium at Renewal based on claim experience in Your Policy.

d. We will inform You about the applicable Medical underwriting loading with time bound exclusion (if any) through a counteroffer letter and will issue the Policy only on Your acceptance within 15 days of the receipt of such counteroffer letter. In case, you neither accept the counteroffer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

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.

Portability Benefits

The Insured Person will have the option to port the Policy to other Insurers by applying to such Insurer to port the entire Policy along with all the members of the Family, if any, at least 30 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/Health Insurer, the proposed Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period, etc. from the existing Insurer to the acquiring Insurer in the previous Policy.

For Detailed Guidelines on Portability, kindly refer the link-
https://content.sbigeneral.in//uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

Alterations In The Policy

This Policy constitutes the complete contract of insurance between the Policyholder 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.

Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the Policy at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period etc. in the previous Policy to the Migrated Policy. For Detailed Guidelines on Migration, kindly refer the link https://content.sbigeneral.in//uploads/c6a2844dd6544601 9b130ffbae1fa20f.pdf

Cancellation And Free Look

1) Cancellation

The Policyholder may cancel his/her Policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall:

i. refund proportionate premium for unexpired Policy Period, if the term of Policy upto one year and there is no Claim (s) made during the Policy Period.

ii. refund premium for the unexpired Policy Period, in respect of policies with term more than 1 year and risk coverage for such Policy years has not commenced

2) Free Look:

(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.

Redressal of Grievances

Stage 1: Bima Bharosa

You can register your grievances with the regulator using the following link:
https://bimabharosa.irdai.gov.in/Home/Home

Stage 2: Head – Customer Care

Alternatively, if you wish to register your grievances directly with us, you may write to the Head – Customer Care. We aim to respond to all Grievances within 7 days. In our initial acknowledgement of receipt letter, we will provide the name and title of the person that is handling your Grievance. This individual will have the authority necessary to investigate and resolve the Grievance.

Email:head.customercare@sbigeneral.in
Phone: 1800 102 1111
For Senior Citizens:
Senior citizens can reach us through the following dedicated channels:
Email:Seniorcitizengrivences@sbigeneral.in
Toll-Free Number: 1800 102 1111 (Available 24/7)

Stage 3: Grievance Redressal Officer (GRO)

In case, you are still not satisfied with the decision/resolution communicated by the above officer or have not received any response within 5 days, you may escalate the matter to the Grievance Redressal Officer (GRO) which will undergo a detailed case investigation, and we aim to resolve the issue within 7 days from the date of receipt of your Grievance at GRO Desk

Email: gro@sbigeneral.in
Phone: 022-45138021
Note:- The Company shall endeavour to maintain the regulatory TAT of 14 days in resolving your grievances.

Stage 4: Escalation to Insurance Ombudsman

If you feel that the response to your Grievance was unsatisfactory, or if you believe your concerns have not been adequately addressed by the company, you may escalate the matter to the Insurance Ombudsman.

Submit your Grievance online: https://www.cioins.co.in/Ombudsman

Automatic Change In Coverage

Not Applicable

Change In Sum Insured

Sum Insured can be changes (Increase and Decrease) only at the time of renewal for more detail please refer policy wordings.

Claim Procedure

1. **Procedure for Cashless claims:**

i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA,
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
v. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details,
vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

2. **Procedure for reimbursement of claims:**

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

S. No	Type of Claim	Prescribed Time limit
1	Reimbursement of hospitalization, day care and prehospitalization expenses	Within thirty days of date of discharge from hospital
2	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

3. **Notification of Claim**

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

Claim Documents

1. Claims Intimation

If You meet with any Accidental bodily Injury or suffer an Illness that may result in a claim, then as a Condition Precedent to Our liability, you must comply with the following claim procedures

S. No	Type of Hospitalization	Notify Us or Our TPA (either at Our call centre or in writing)
1	Planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier.
2	Emergency Hospitalization	within twenty-four (24) hours of Your admission to hospital or before discharge whichever is earlier
3	Diagnosis or actual undergoing of procedure	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:

- Health Card ID number
- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Hospitalisation/ Critical Illness
- Name and address of the attending Medical Practitioner and Hospital (if admission has taken place)
- Date of Admission if applicable
- Any other information, documentation as requested by Us

1.A Claim Cashless Process

Cashless facility is available for Hospitalization only at our Network Provider. The Insured Person can avail Cashless facility at Network Provider, by presenting the health card as provided by Us with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / Aadhar Card, any other identity proof as approved by Us).

1.A.1 For Planned Hospitalization

a. The Insured Person should at least forty-eight (48) hours prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.

b. The Network Provider will issue the request for authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDAI.

c. The Network Provider shall electronically send the filled pre-authorization form along with all the relevant details to the twenty-four (24) hour authorization/cashless department of TPA along with contact details of the treating Medical Practitioner and the Insured Person.

d. Upon receiving the pre-authorization form and all related medical information from the Network Provider, the eligibility of cover under the Policy will be verified.

e. Wherever the information provided in the request is sufficient to ascertain the authorisation, the authorisation letter will be issued to the Network Provider. Wherever additional information or documents are required, the same will be called for from the Network Provider and upon satisfactory receipt of last necessary documents the authorisation will be issued. All authorisations will be issued within a period of six (6) hours from the receipt of last complete documents.

f. The authorisation letter will include details of sanctioned amount, any specific limitation on the claim, any Co-Payment or Deductible and non- payable items if applicable.

g. The authorisation letter shall be valid only for a period of fifteen (15) days from the date of issuance of authorization

In the event that the cost of Hospitalization exceeds the authorized limit as mentioned in the authorization letter:

a. The Network Provider shall request for an enhancement of authorisation limit.

b. Eligibility will be verified, and the enhancement will be evaluated on the availability of further limits.

c. In the event of a change in the treatment during Hospitalization of the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us.

At the time of discharge:

a. The Network Provider may forward a final request for authorization for any residual amount along with the discharge summary and the billing format in accordance with the process.

b. Upon receipt of the final authorisation letter, the Insured Person may be discharged by the Network Provider.

c. Ensure that the final authorization letter is signed by the Insured Person.

d. Ensure to take photocopies of relevant medical records for future reference.

1.A.2 For Emergency Hospitalization

a. The Insured Person may approach the Network Provider for Hospitalization

b. Insured Person will need to provide health card / health insurance Policy at hospital admission counter

c. The Network Provider shall forward the request for authorization to TPA within twenty-four (24) hours of admission to the Hospital or before discharge whichever is earlier.

d. In the interim, the Network Provider may either consider treating the Insured Person by taking a token deposit or treating as per their norms.

e. The Network Provider shall refund the deposit amount to you barring a token amount to take care of non-covered expenses once the authorization is issued

The Network Provider will send the claim documents to TPA within fifteen (15) days from the date of discharge from Hospital.

List of necessary claim documents to be submitted for Cashless are as following:

- Claim Form duly filled and signed
- Original signed pre-authorisation request
- Copy of authorisation approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Original Discharge/Death Summary
- Operation Theatre Notes (if any)
- Original Hospital Main Bill along with break up Bill and original receipts
- Original Investigation Reports, X Ray, MRI, CT Films, HPE etc.
- Details of the implants including the sticker indicating the type as well as invoice towards the cost of implant
- Doctors Reference Slips for Investigations/Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted)

Any additional documents may be called as required based on the circumstances of the claim

There can be instances where Cashless Facility may be denied for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case You/Insured Person may be required to pay for the treatment and submit the claim for reimbursement to TPA which will be considered by Us subject to the Policy Terms &Conditions.

We in Our sole discretion, reserves the right to modify, add or restrict any Network Provider for Cashless services under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable/latest list of Network Provider on TPA's website or by calling call centre.

1.B Claim Reimbursement Process

Wherever You have opted for a reimbursement of expenses, You may submit the documents for reimbursement of the claim to Our / TPA office not later than thirty (30) days from the date of discharge from the Hospital. You can obtain a Claim Form from any of Our / TPA Offices or download a copy from Our website https://www.sbigeneral.in

List of necessary claim documents/information to be submitted for reimbursement are as following:

Sr No	List of Documents / Information	
1	Duly Filled and Signed Claim Form	Y
2	Discharge Summary	Y
3	Medical Records (Indoor Case Papers, OT notes, PAC Notes etc.)	Y
4	Original Hospital Main Bill	Y
5	Original Hospital Bill Break-up	Y
6	Original Pharmacy Bills	Y
7	Prescriptions for the medicines purchased (except hospital supply) and investigations done outside the hospital	Y
8	Consultation Papers	Y
9	Investigation Reports	Y
10	Digital Images/CDs of the Investigation Procedures (if required)	Y
11	MLC/FIR Report (If applicable)	Y
12	Original Invoice/Sticker (If applicable)	Y
13	Post Mortem Report (If applicable	Y
14	Disability Certificate (If applicable)	Y
15	Attending Physician Certificate (If applicable)	Y

16	Ante-natal Record (If applicable)	Y
17	Birth Discharge Summary (If applicable	Y
18	Death Certificate (If applicable)	Y
19	KYC (Photo ID card, If applicable)	Y
20	Bank Details with Cancelled Cheque (If applicable)	Y

a. 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. Our branch offices shall give due acknowledgement of collected documents. 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 anyone claiming from their behalf, as the case may be.

Revision And Modification Of The Policy Product

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.

Withdrawal Of The Product

In case the Policy is found to be financially unviable or is deficient in any manner, We shall, in terms of Insurance Regulatory & Development Authority Health Insurance Regulations (2016), have the option to withdraw this Policy from the market subject to prior approval of such withdrawal from the Regulatory Authority.

Any withdrawal of the Policy would be duly intimated to the Policy Holder/Insured Person at least ninety (90) days prior to date of such revision or modification, who on expiry of the existing Policy will have an option to obtain Renewal under similar product/s available with Us. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us

Section 41 of Insurance Act 1938 (Prohibition of Rebates)

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out 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 prospectus 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.

Contact Us

For any product or service related information or assistance, here's how you can reach Us.

Contact details for Policy Servicing	Contact details for Claim Servicing
SBI General Insurance Company Limited, **Address**:9th Floor, Wing A & B, Fulcrum, Sahar Road, Andheri (East), Mumbai – 400 099. **Email:** customer.care@sbigeneral.in ; seniorcitizengrievances@sbigeneral.in (for Senior Citizens) **Toll Free number:** 1800221111, 18001021111 (Monday to Saturday (8 am - 8 pm). **Website:** www.sbigeneral.in	**Accident & Health claims team,** **SBI General Insurance Company Limited,** **Address:** 9th Floor, Westport, Pan Card Club Road, Baner, Pune, Maharashtra – 411 045. **Email:** sbig.health@sbigeneral.in **Toll Free number:** 1800 210 3366, 1800 210 6366 **Website:** www.sbigeneral.in

Rate Chart

Final Office premium: Office Premium * (1 – Additional Family Member (Non-Floater Basis)) * (1 + Premium Payment Mode Loading) *(1 – Online Discount – Employee Discount) + GST 18%

Appendix 1

Final Rates (Excluding GST)

Individual Plan

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	1,185	1,499	1,812	2,010	2,209	2,482	2,639	2,759	2,879
19Y-35Y	1,775	2,280	2,786	3,107	3,427	3,860	4,113	4,307	4,501
36Y-45Y	2,025	2,622	3,218	3,597	3,975	4,483	4,781	5,010	5,238
46Y-55Y	3,178	4,060	4,941	5,500	6,059	6,803	7,244	7,582	7,920
56Y-60Y	4,634	5,990	7,346	8,206	9,066	10,206	10,884	11,404	11,924
61Y-65Y	5,994	7,794	9,594	10,736	11,877	13,386	14,286	14,976	15,667
66Y-70Y	7,650	9,990	12,330	13,814	15,298	17,257	18,427	19,324	20,221
71Y-75Y	9,085	11,893	14,701	16,481	18,262	20,611	22,016	23,092	24,169
75Y +	10,807	14,176	17,546	19,683	21,819	24,637	26,322	27,614	28,906

Floater Plan 1A +1C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	2,910	3,712	4,515	5,024	5,533	6,225	6,626	6,934	7,242
36Y-45Y	3,155	4,046	4,938	5,503	6,069	6,834	7,280	7,622	7,964
46Y-55Y	4,290	5,461	6,632	7,375	8,117	9,114	9,699	10,148	10,597
56Y-60Y	5,717	7,353	8,989	10,026	11,064	12,448	13,267	13,894	14,521
61Y-65Y	7,050	9,121	11,192	12,505	13,818	15,565	16,601	17,395	18,189
66Y-70Y	8,673	11,273	13,873	15,522	17,171	19,358	20,659	21,656	22,652
71Y-75Y	10,079	13,137	16,196	18,136	20,076	22,646	24,175	25,348	26,521
75Y +	11,766	15,375	18,984	21,273	23,562	26,591	28,396	29,779	31,163

Floater Plan 1A + 2C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	4,041	5,139	6,237	6,934	7,630	8,581	9,130	9,551	9,972
36Y-45Y	4,283	5,470	6,656	7,408	8,161	9,183	9,777	10,232	10,686
46Y-55Y	5,410	6,873	8,336	9,263	10,191	11,443	12,174	12,735	13,296
56Y-60Y	6,822	8,745	10,668	11,888	13,108	14,743	15,705	16,442	17,180
61Y-65Y	8,142	10,495	12,849	14,341	15,834	17,828	19,005	19,908	20,810
66Y-70Y	9,748	12,625	15,502	17,327	19,152	21,583	23,022	24,125	25,228
71Y-75Y	11,140	14,471	17,802	19,915	22,028	24,837	26,503	27,780	29,057
75Y +	12,810	16,686	20,562	23,020	25,478	28,741	30,680	32,166	33,652

Floater Plan 1A + 3C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	5,154	6,541	7,928	8,808	9,688	10,892	11,586	12,118	12,650
36Y-45Y	5,393	6,867	8,342	9,278	10,213	11,488	12,226	12,791	13,356
46Y-55Y	6,511	8,259	10,007	11,116	12,225	13,727	14,601	15,271	15,942
56Y-60Y	7,908	10,112	12,316	13,714	15,112	16,993	18,096	18,941	19,786
61Y-65Y	9,214	11,844	14,474	16,142	17,810	20,047	21,362	22,370	23,379
66Y-70Y	10,804	13,952	17,100	19,097	21,094	23,762	25,337	26,544	27,751
71Y-75Y	12,181	15,779	19,376	21,658	23,940	26,983	28,782	30,161	31,541
75Y +	13,834	17,971	22,108	24,731	27,355	30,847	32,916	34,502	36,088

Floater Plan 2A

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	2,930	3,739	4,548	5,061	5,574	6,271	6,676	6,986	7,296
36Y-45Y	3,319	4,273	5,228	5,833	6,438	7,255	7,732	8,098	8,464
46Y-55Y	5,275	6,686	8,096	8,991	9,885	11,078	11,784	12,325	12,865
56Y-60Y	7,604	9,774	11,944	13,320	14,696	16,523	17,608	18,440	19,272
61Y-65Y	9,781	12,661	15,541	17,367	19,193	21,611	23,052	24,156	25,260
66Y-70Y	12,430	16,174	19,918	22,292	24,666	27,804	29,677	31,112	32,548
71Y-75Y	14,726	19,218	23,711	26,560	29,410	33,172	35,418	37,141	38,863
75Y +	17,481	22,872	28,263	31,682	35,101	39,612	42,309	44,376	46,443

Floater Plan 2A + 1C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	3,882	4,929	5,975	6,638	7,302	8,209	8,733	9,134	9,535
36Y-45Y	4,266	5,456	6,646	7,400	8,155	9,180	9,775	10,231	10,687
46Y-55Y	6,205	7,845	9,485	10,526	11,566	12,962	13,783	14,412	15,041
56Y-60Y	8,505	10,895	13,285	14,801	16,317	18,339	19,534	20,451	21,367
61Y-65Y	10,654	13,745	16,837	18,797	20,758	23,364	24,910	26,095	27,280
66Y-70Y	13,270	17,215	21,159	23,661	26,162	29,479	31,452	32,964	34,477
71Y-75Y	15,537	20,221	24,905	27,876	30,846	34,780	37,122	38,918	40,714
75Y +	18,258	23,829	29,400	32,933	36,467	41,140	43,926	46,062	48,198

Floater Plan 2A + 2C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	4,816	6,093	7,370	8,180	8,991	10,102	10,741	11,231	11,721
36Y-45Y	5,194	6,613	8,032	8,932	9,832	11,060	11,769	12,314	12,858
46Y-55Y	7,115	8,979	10,843	12,025	13,207	14,802	15,734	16,448	17,163
56Y-60Y	9,386	11,990	14,594	16,246	17,898	20,110	21,412	22,411	23,409
61Y-65Y	11,508	14,805	18,101	20,192	22,282	25,071	26,720	27,984	29,248
66Y-70Y	14,091	18,230	22,369	24,994	27,619	31,110	33,179	34,766	36,353
71Y-75Y	16,330	21,198	26,067	29,155	32,243	36,343	38,778	40,644	42,511
75Y +	19,016	24,761	30,505	34,149	37,793	42,622	45,495	47,698	49,901

Floater Plan 2A + 3C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	5,790	7,311	8,833	9,798	10,763	12,091	12,851	13,435	14,018
36Y-45Y	6,168	7,831	9,495	10,550	11,605	13,048	13,880	14,517	15,155
46Y-55Y	8,089	10,197	12,305	13,642	14,979	16,790	17,844	18,652	19,461
56Y-60Y	10,360	13,208	16,057	17,864	19,670	22,098	23,523	24,615	25,707
61Y-65Y	12,482	16,023	19,564	21,809	24,055	27,059	28,830	30,188	31,545
66Y-70Y	15,065	19,448	23,831	26,611	29,391	33,098	35,290	36,970	38,651
71Y-75Y	17,304	22,417	27,530	30,773	34,016	38,331	40,888	42,848	44,809
75Y +	19,990	25,979	31,968	35,767	39,565	44,610	47,606	49,902	52,198

Floater Plan 3A

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	4,348	5,546	6,745	7,504	8,264	9,298	9,898	10,357	10,816
36Y-45Y	4,540	5,810	7,080	7,885	8,691	9,784	10,419	10,906	11,393
46Y-55Y	5,510	7,005	8,500	9,448	10,396	11,675	12,423	12,996	13,569
56Y-60Y	6,659	8,530	10,400	11,586	12,772	14,363	15,298	16,015	16,733
61Y-65Y	8,175	10,539	12,904	14,404	15,903	17,906	19,089	19,995	20,902
66Y-70Y	9,368	12,159	14,950	16,720	18,490	20,843	22,239	23,309	24,379
71Y-75Y	12,498	16,109	19,720	22,010	24,300	27,337	29,142	30,527	31,911
75Y +	13,858	17,913	21,968	24,539	27,111	30,517	32,544	34,099	35,654

Floater Plan 3A + 1C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	5,276	6,703	8,130	9,036	9,941	11,178	11,892	12,439	12,986
36Y-45Y	5,465	6,963	8,461	9,411	10,362	11,656	12,406	12,980	13,554
46Y-55Y	6,425	8,146	9,867	10,958	12,049	13,527	14,388	15,047	15,707
56Y-60Y	7,561	9,652	11,742	13,068	14,394	16,181	17,227	18,029	18,830
61Y-65Y	9,057	11,636	14,215	15,850	17,486	19,680	20,970	21,958	22,947
66Y-70Y	10,234	13,234	16,234	18,136	20,039	22,578	24,078	25,228	26,379
71Y-75Y	13,332	17,142	20,951	23,367	25,783	28,997	30,902	32,363	33,823
75Y +	14,675	18,923	23,170	25,864	28,558	32,137	34,261	35,890	37,518

Floater Plan 3A + 2C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	6,250	7,921	9,593	10,653	11,713	13,166	14,002	14,643	15,284
36Y-45Y	6,439	8,181	9,924	11,029	12,134	13,644	14,516	15,184	15,852
46Y-55Y	7,399	9,364	11,329	12,575	13,821	15,515	16,498	17,251	18,005
56Y-60Y	8,535	10,870	13,205	14,686	16,167	18,169	19,337	20,233	21,128
61Y-65Y	10,031	12,854	15,678	17,468	19,259	21,668	23,080	24,162	25,245
66Y-70Y	11,208	14,452	17,696	19,754	21,811	24,566	26,188	27,432	28,676
71Y-75Y	14,306	18,360	22,414	24,985	27,556	30,985	33,012	34,567	36,121
75Y +	15,649	20,141	24,633	27,482	30,331	34,125	36,371	38,094	39,816

Floater Plan 3A + 3C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	7,224	9,140	11,056	12,271	13,486	15,154	16,112	16,847	17,581
36Y-45Y	7,413	9,400	11,386	12,647	13,907	15,632	16,626	17,388	18,150
46Y-55Y	8,373	10,583	12,792	14,193	15,594	17,503	18,608	19,455	20,302
56Y-60Y	9,509	12,088	14,668	16,304	17,939	20,157	21,447	22,436	23,425
61Y-65Y	11,005	14,073	17,140	19,086	21,031	23,656	25,190	26,366	27,542
66Y-70Y	12,182	15,670	19,159	21,371	23,584	26,554	28,298	29,636	30,974
71Y-75Y	15,280	19,578	23,876	26,602	29,328	32,973	35,123	36,771	38,419
75Y +	16,623	21,359	26,095	29,099	32,103	36,113	38,481	40,297	42,113

Floater Plan 4A

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	5,736	7,313	8,890	9,891	10,891	12,253	13,042	13,647	14,251
36Y-45Y	6,171	7,890	9,610	10,700	11,790	13,271	14,130	14,790	15,449
46Y-55Y	8,035	10,199	12,363	13,735	15,107	16,952	18,034	18,864	19,694
56Y-60Y	10,306	13,210	16,114	17,956	19,798	22,260	23,713	24,826	25,940
61Y-65Y	12,863	16,602	20,340	22,711	25,082	28,240	30,109	31,543	32,976
66Y-70Y	15,331	19,912	24,493	27,398	30,303	34,157	36,447	38,204	39,960
71Y-75Y	19,549	25,304	31,059	34,710	38,360	43,192	46,071	48,277	50,484
75Y +	22,235	28,866	35,498	39,704	43,909	49,472	52,788	55,331	57,874

Floater Plan 4A + 1C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	6,710	8,531	10,353	11,508	12,663	14,241	15,152	15,850	16,549
36Y-45Y	7,145	9,109	11,072	12,317	13,563	15,259	16,241	16,993	17,746
46Y-55Y	9,009	11,417	13,825	15,353	16,880	18,940	20,144	21,068	21,991
56Y-60Y	11,280	14,428	17,577	19,574	21,571	24,248	25,823	27,030	28,238
61Y-65Y	13,837	17,820	21,803	24,329	26,855	30,228	32,219	33,746	35,273
66Y-70Y	16,305	21,130	25,955	29,016	32,076	36,145	38,558	40,408	42,258
71Y-75Y	20,523	26,522	32,522	36,327	40,132	45,180	48,181	50,481	52,782
75Y +	23,209	30,085	36,960	41,321	45,682	51,460	54,899	57,535	60,171

Floater Plan 4A + 2C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	7,684	9,750	11,816	13,126	14,436	16,229	17,262	18,054	18,846
36Y-45Y	8,119	10,327	12,535	13,935	15,335	17,247	18,351	19,197	20,044
46Y-55Y	9,983	12,635	15,288	16,970	18,652	20,928	22,255	23,272	24,289
56Y-60Y	12,254	15,647	19,040	21,191	23,343	26,236	27,933	29,234	30,535
61Y-65Y	14,811	19,038	23,265	25,946	28,627	32,216	34,330	35,950	37,571
66Y-70Y	17,279	22,349	27,418	30,633	33,848	38,133	40,668	42,612	44,555
71Y-75Y	21,497	27,741	33,985	37,945	41,905	47,168	50,291	52,685	55,079
75Y +	24,183	31,303	38,423	42,939	47,454	53,448	57,009	59,739	62,469

Floater Plan 4A + 3C

Age Band	Sum Insured								
	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
3m-18Y	-	-	-	-	-	-	-	-	-
19Y-35Y	8,658	10,968	13,278	14,743	16,209	18,217	19,372	20,258	21,144
36Y-45Y	9,093	11,545	13,997	15,553	17,108	19,235	20,461	21,401	22,341
46Y-55Y	10,957	13,854	16,751	18,588	20,425	22,916	24,365	25,475	26,586
56Y-60Y	13,228	16,865	20,502	22,809	25,116	28,224	30,043	31,438	32,833
61Y-65Y	15,785	20,257	24,728	27,564	30,400	34,204	36,440	38,154	39,869
66Y-70Y	18,253	23,567	28,881	32,251	35,621	40,121	42,778	44,815	46,853
71Y-75Y	22,471	28,959	35,447	39,562	43,677	49,156	52,401	54,889	57,377
75Y +	25,157	32,521	39,886	44,556	49,227	55,436	59,119	61,943	64,766

Please Note above rates are inclusive of commission & margin charges & exclusive of GST.
Please note that the rates can be rounded to the closest hundred after the application of tax for the ease of the customer and marketing purposes

SURAKSHA AUR BHAROSA DONO

Disclaimer

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