

CRITICARE PROSPECTUS

A. SALIENT FEATURES

- This policy covers persons in the age group 6 years onwards. The maximum entry age is 65 years.
- The policy can be renewed lifelong.
- The policy will be issued for a 1 year period.
- This policy can be issued to an individual and/ or family.
- The family includes You, Your Spouse, Your first two dependent children and your two dependent parents.
- Maximum sum insured available as follows

Entry Age	Max Sum insured option (INR)
6 yrs to 45 yrs	5,000,000
46 yrs to 65 yrs	2,000,000

- The maximum sum insured under family floater plan can be provided up to sum insured eligibility of the eldest member.
- Premium for the primary insured remain as per the individual table.
- For remaining dependent members discounts applicable as per the table below on their respective premium

Age Group	Premium Discounts
6 yrs to 25 yrs	50%
26 to 30 yrs	30%
31 to 35 yrs	30%
36 to 40 yrs	30%
41 to 45 yrs	20%
46 to 50 yrs	10%
Above 51 yrs	5%

- The entire sum insured would be paid out upon the first diagnosis/ occurrence/ actual undergoing of the surgical procedures that are mentioned below.
- Upon the occurrence of an event of Critical Illness and (subject to the terms, conditions and exclusions of this Policy) without prejudice to the Company's obligation to make payment, this Policy shall immediately cease to exist with reference to that Insured.
- Applicable for family floater policy:
 - i. Upon the occurrence of an event of Critical Illness and (subject to the terms, conditions and exclusions of this Policy) for any insured under the family floater policy, without prejudice to the Company's obligation to make payment, this Policy shall immediately cease to exist.
 - ii. The rest of the family members can opt for a separate critical illness policy and they will be given continuity for the period they have been insured under the Criticare Policy.
 - iii. In the event of the death of any of the insured members subject to no critical illness claim being paid on the policy, the cover ceases to exist for that insured and the remaining members would continue to have the coverage until the end of the policy period.
- Premium payable by any mode other than cash is eligible for Tax relief as provided under section 80 D of the Income Tax Act.
- Renewal: The maximum sum insured eligibility for renewals –

Age	Max Sum insured option (INR)
66 years to 70 years	1,000,000
71 years to 75 years	5,00,000
Above 75 years	2,00,000

- 1) Renewals will be invited for the above age bands as per respective Sum Insured mentioned in the table.

2) Premium would be charged as per the restricted Sum Insured

Renewal premium: Following loadings in premiums will be applicable for policies above 65 years of age for lifelong renewal:

1. Above 65 years up to 70 years – 10% (loading on 61-65 yrs age band)
2. 71 years to 75 years – 20% (loading on 61-65 yrs age band)
3. Above 75 years – 25% (loading on 61-65 yrs age band)

B. COVERAGE AND BENEFITS:

The entire sum insured under the policy is payable upon survival of 28 days from the first diagnosis/ actual undergoing of the surgical procedures that are mentioned below provided whose signs or symptoms first commence more than 90 days after the commencement of Period of Insurance and shall only include:

a) First Diagnosis of the below-mentioned **Illnesses** more specifically described below:

1. Cancer (cancer of specified severity)
2. Kidney failure requiring regular dialysis
3. Primary (Idiopathic) pulmonary hypertension
4. End Stage Liver failure
5. Multiple sclerosis with persisting symptoms

Or

b) Undergoing for the first time of the following **Surgical Procedures**, more specifically described below:

1. Major organ/bone marrow transplant
2. Open chest CABG (coronary artery bypass graft)
3. Aorta graft Surgery

Or

c) Occurrence for the first time of the following medical events more specifically described below:

1. Stroke resulting in permanent symptoms
2. First heart attack (myocardial infarction)- of specified severity
3. Coma of specified severity
4. Total blindness

The **Insured** Event under this Section and the conditions applicable to the same are more particularly defined below:

1. **CANCER** (Cancer of specified severity)

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

II. The following are excluded –

- 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. 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 (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a **Specialist** medical practitioner.

3. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

- I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
- II. The NYHA Classification of Cardiac Impairment are as follows:
 - i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
 - ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
- III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

4. END STAGE LIVER FAILURE

- I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
 - i. Permanent jaundice; and
 - ii. Ascites; and
 - iii. Hepatic encephalopathy.
- II. Liver failure secondary to drug or alcohol abuse is excluded.

5. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS:

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

6. MAJOR ORGAN/BONE MARROW TRANSPLANT:

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

J. The following are excluded:

- i. Other stem-cell transplants
- ii. Where only islets of langerhans are transplanted.

7. OPEN CHEST CABG (Coronary Artery Bypass Graft):

- I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
 - II. The following are excluded:
 - i. Angioplasty and/or any other intra-arterial procedures
8. **Aorta Graft Surgery:** Aorta Graft **Surgery** is defined as 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.

Exclusions:

- a) **Surgery** following traumatic **Injury** to the aorta.
- b) **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.
- c) **Surgery** performed using only minimally invasive or intra-arterial techniques such as percutaneous endovascular aneurysm with insertion of a stent graft.

9. **STROKE RESULTING IN PERMANENT SYMPTOMS:**

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

10. **MYOCARDIAL INFARCTION** (First Heart Attack of specific severity)

- I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
 - i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
 - ii. New characteristic electrocardiogram changes
 - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- II. The following are excluded:
 - i. Other acute Coronary Syndromes
 - ii. Any type of angina pectoris
 - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

11. **COMA OF SPECIFIED SEVERITY:**

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

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

12. **TOTAL BLINDNESS:**

- I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
- II. 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.
- III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

C. DEFINITIONS:

The following words or terms shall have the meaning ascribed to them wherever they appear in the Policy, and references to the singular or the masculine shall include references to the plural or to the female wherever the context so permits:

I. Standard Definitions

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Condition Precedent** shall mean a **Policy** term or condition upon which the Insurer's liability under the **Policy** is conditional upon.
3. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
 - a) **Internal Congenital Anomaly** -Congenital Anomaly which is not in the visible and accessible parts of the body.
 - b) **External Congenital Anomaly** – Congenital Anomaly which is in the visible and accessible parts of the body.
4. **Disclosure to information norm:** The **Policy** shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
5. **Hospital** means any institution established for in-patient care and day care treatment of **Illness** and/ or injuries and which has been registered as a **Hospital** with the local authorities under Clinical Establishments (Registration and Regulation) Act,2010 or under enactments specified under the **Schedule** of Section 56(1) of the said Act OR complies with all minimum criteria as under:
 - i. has qualified nursing staff under its employment round the clock;
 - ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places
 - iii. has qualified medical practitioner(s) in charge round the clock;
 - iv. has a fully equipped operation theatre of its own where **Surgical Procedures** are carried out
 - v. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
6. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
 - (a)**Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health

- immediately before suffering the disease/ illness/ injury which leads to full recovery
- (b) **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 2. it needs ongoing or long-term control or relief of symptoms
 3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 4. it continues indefinitely
 5. it recurs or is likely to recur
7. **Injury** means accidental physical bodily harm excluding **Illness** or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
8. **Insured** means the person specified in the **Schedule** who is **Insured** by the Company under this **Policy**.
9. **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 his licence. The registered practitioner should not be the **Insured** or close **Family** members.
10. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
11. **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
12. **Pre-Existing Disease** means any condition, ailment, injury or disease:
- a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or
 - b) For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy or its reinstatement.
13. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner
14. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods

II. Specific Definitions

15. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
16. **Consultant/ Specialist** means a qualified **Medical Practitioner** holding a valid and subsisting license, granted by the appropriate licensing authority, and acting within the scope of his license, expert in the field of medicine for which he carries the status of a **Consultant**. The **Consultant** should not be related to the **Insured** or the Named **Insured**

by blood or marriage.

17. **Critical Illness** means an **Illness**, sickness or a disease or a corrective measure as specified in Section B of this **Policy**.
18. **Critical Illness Benefit** means the amount specified in the **Schedule**, which is the maximum amount for which the Company may be liable to make payment for any or all Critical Illnesses covered under this **Policy**
19. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary **Insured** or **Proposer** and does not have his/ her independent sources of income.
20. **Family** means and includes You, Your Spouse, Your first two dependent children and your two dependent parents. At any point of time the family floater cannot exceed for more than 6 members. The sum insured, as mentioned in the **Schedule**, would be shared among all the members of the Family Floater.
21. **Proposer** means the person specified in the Schedule who is the owner of the Policy at any point of time.
22. **Policy** means the complete documents consisting of the Proposal, Policy wording, Schedule and Endorsements and attachments if any.
23. **Policy Period** means the date between the commencement date specified in the Schedule and, in respect of any Insured, the earlier of (a) the expiry date specified in the Schedule and (b) the occurrence of an event of Critical Illness
24. **Prospect** means any person who is a potential customer of an insurer and likely to enter into an insurance contract either directly with the insurer or through a distribution channel.
25. **Prospectus** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.
26. **Schedule** means the Schedule, and any annexure to it, attached to and forming part of this Policy.
27. **Survival Period:** At any point of time during the term of the Policy, any benefit shall be payable only if the Insured is alive for a period of more than or equal to 28 days from the date of the first diagnosis of the Critical illness/ Undergoing for the first time of the Surgical Procedures/ for the first time of occurrence of medical events.
28. **Waiting Period:** At no point of time during the term of the Policy, any benefit shall be payable for the claim which occurs or where the signs and/ or the symptoms of Illness/ condition for the claim has occurred within 90 days of first Policy issue Date. Waiting Period is not applicable for the subsequent continuous renewals.

Please note

a) Insect and mosquito bites is not included in the scope of definition of **Accident**.

D. EXCLUSIONS:

Without prejudice to the exclusions mentioned elsewhere in this document, the following exclusions shall apply to the benefits admissible under this **Policy**; No benefit shall be paid for the following circumstances and for the following conditions/ tests/ treatments:

1. Benefits will not be available for Any Pre- Existing conditions or related condition(s) for which You have been diagnosed, received medical treatment, had signs and/ or symptoms, prior

to inception of Your first **Policy**, unless such a condition is stated in the proposal form and specifically accepted by the Company and endorsed thereon.

2. The Company shall not be liable to make any payment under this **Policy** in connection with or in respect of any **Insured** Event, as stated in this Section, occurred or suffered before the commencement of Period of Insurance or arising within the first 90 days of the commencement of the Period of Insurance.

i. Standard Exclusions:

3. 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.

4. 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 medically necessity, it must be certified by the attending Medical Practitioner.

5. Unproven Treatments: Code- Excl16

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.

6. Birth control, Sterility and Infertility: Code- Excl17

Expenses related to Birth Control, 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

7. Code- Excl12

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

8. 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.

ii. Specific Exclusions:

9. Any medical procedure or treatment, which is not medically necessary or not performed by a Doctor.
10. Any treatment relating to birth defects and external.
11. Hormone replacement therapy.
12. Treatment by a **Family** member and self-medication
13. Ayurvedic, Homeopathy, Unani, naturopathy, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, rolfing, massage therapy, aroma therapy or any other treatments including **Alternative treatments** other than Allopathy / western medicines.

14. Attempted suicide (whether sane or insane) or intentionally self inflicted **Injury** or **Illness**, nervous disorder or sexually transmitted conditions, other than Acquired Immune Deficiency Syndrome (AIDS), Human Immune deficiency Virus (HIV) infection.
15. War, civil War, invasion, insurrection, revolution, act of foreign enemy, hostilities (whether War be declared or not), rebellion, mutiny, use of military power or usurpation of government or military power.
16. Participation in winter sports, skydiving/parachuting, hang gliding, bungee jumping, riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), participation in any Professional Sports, any bodily contact sport or any other hazardous or potentially dangerous sport for which You are untrained.
17. Loss caused directly or indirectly, wholly or partly by infections (except pyogenic infections which shall occur through an Accidental cut or wound) or any other kind of Disease.
18. Diagnosis outside India; unless reaffirmed by **Physician** in India and subject to presentation of all Claim documents in English.

E. General Terms And Clauses

i. Standard Terms and Clauses

1. Disclosure to information norm:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability

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

3. Free Look Period

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

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

4. 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 will get all the accrued continuity benefits in waiting periods as per the IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
<https://generalicentralinsurance.com/portability-and-migration>

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 and the premium paid shall be forfeited.

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

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

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

The Company shall not repudiate the claim and / or forfeit the policy benefits on the 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.

6. **Moratorium Period**

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

7. **Nomination:**

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

8. **Possibility of Revision of Terms of the Policy Including the Premium Rates**

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

changes are effected.

9. Redressal of Grievance

In case of any grievance the insured person may contact the company through Website: <https://generalicentralinsurance.com>

Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800

Email: GCicare@generalicentral.com

Courier: Grievance Redressal Cell, Generali Central Insurance Company Ltd.
Lodha I –Think Techno Campus, B Wing –2nd Floor, Pokhran Road –2, Off Eastern Express Highway Behind TCS, Thane West – 400607

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at GCIGRO@generalicentral.com or call at: 7900197777

For updated details of grievance officer, kindly refer the link <https://generalicentralinsurance.com/customer-service/grievance-redressal>

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

Grievance may also be lodged at IRDAI Bima Bharosa (an Integrated Grievance Management System) - <https://bimabharosa.irdai.gov.in/>

ii. Specific Terms and Clauses

10. Due Observance

The due observance of and compliance with the terms, provisions, warranties and conditions of this **Policy** in so far as they relate to anything to be done or complied with by the **Insured** and/or the **Proposer** shall be a **Condition Precedent** to the Company's liability under this **Policy**.

11. Duties and Obligations of the Insured and/or Named Insured Upon the Diagnosis of an Event of Critical Illness

It is a **Condition Precedent** to the company's liability to make any payment under this **Policy** that, upon the diagnosis of an event of critical Illness:

- a. The **Insured** and /or the Named **Insured** shall immediately and in any event within 60 days provide the Company with written notification of a claim, and
- b. The **Insured** and/or the Named **Insured** shall expeditiously provide the Company with any and all information and documentation in respect of the critical Illness. The claim and/or the Company's liability hereunder that may be requested, and the **Insured** shall submit himself for examination by the Company's medical advisors as often as may be considered necessary by the company. The cost of such medical examination will be borne by the company.
- c. The company shall be under no obligation to make any payment under this **Policy** until such time as the **Insured** has taken all necessary steps to satisfy the company that here has been an event of **Critical Illness** within the terms of this **Policy** and this diagnosis has been confirmed by the Company's medical advisors.

- d. In case of premium paid under the mode other than the annual mode, the Company reserves the right to deduct the premium cost equivalent to the unpaid premium amount for the **Policy** year from the eligible claim amount.

12. Pre acceptance Medical Tests

Pre-Insurance medical tests are not required for all proposers upto the age of 45 yrs upto 5 lacs sum insured, if the proposal form is clean. (No health declaration). For age 46 years and above medical tests are required.

13. Cost of Pre-insurance Health Check up

We will reimburse 50% of the cost of any pre-insurance medical examination once the proposal is accepted and **Policy** issued for that **Insured**. We shall maintain a list of and the fees chargeable by, institutions where such Pre-insurance medical examination may be conducted, the reports from which will be accepted by Us. Such list shall be furnished to the prospective policyholder at the time of pre-insurance medical examination.

14. Payment of claims

If You are diagnosed / underwent a surgical procedure/ a medical condition occurs as per the definition of the **Critical Illness** mentioned that may result in a claim, then as a **Condition Precedent** to Our liability, you must comply with the following:

- a. You or someone claiming on Your behalf must give **Notification of Claim** to us in writing immediately, and in any event within 60 days of the aforesaid **Illness**/ condition/ surgical event but after the **Survival Period** of 28 days.
- b. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary.
- c. You or someone claiming on Your behalf must give Us the documentation and other information We ask for to investigate the claim or Our obligation to make payment for it.
- d. List of necessary documents required for processing of the Claims are: (You need to submit all documents in original and photocopy. The original documents would be returned to you post verification if requested by You)
 - i. Claim form
 - ii. Discharge certificate/card from the **Hospital**
 - iii. Attending Doctor's/ **Consultant's**/ **Specialist's**/ Anaesthetist's certificate regarding diagnosis
 - iv. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt
 - v. Indoor case papers from the **Hospital**
- e. In the event of the death of the **Insured** person post the **Survival Period**, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 14 days.
- f. The Company shall make payment under this **Policy** in the name of or the benefit of the **Insured** by delivering the same to the **Insured/Proposer** in case of minors/ Nominee in case of the death of the **Insured**.
- g. Any payment made in good faith by the company as aforesaid shall operate as a complete and final discharge of the company's liability to make payment under this **Policy**, and the named **Insured** agrees to and shall hold the company harmless against any and all claims, costs and expenses that may result because of any failure to make payment of all or part of the sum due under this **Policy** to the **Insured**.
- h. Lack of documents or medical certificates confirming the diagnosis of **Illness** or undergoing of medical/**Surgical Procedure** will result in forfeiture of the claim.
- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- j. Pending claims will be asked for submission of incomplete documents.
- k. Rejected claims will be informed to the **Insured** Person in writing with reason for rejection.
- l. Upon acceptance of an offer of settlement as stated in sub-regulation (5) of the (Protection of Policyholders' Interest) Regulations, 2000 by You, We will make payment of the amount due within 7 days from the date of acceptance of the offer by the **Insured**. In the case of

delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

- m. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- n. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)
- o. We will make all claim payments in Indian rupees within India only.

15. Notifications & Declarations

- a. All notices and declarations for the attention of the Company shall be submitted in writing and shall be delivered to the address specified in the **Schedule**.
- b. All notices and declaration for the attention of the **Insured** or the Named **Insured** shall be posted and addressed to the **Insured's** address as stated in the **Schedule** or last known address as per our records.
- c. The **Insured** and **Proposer** agree that the **Proposer** shall also act on behalf of the **Insured** as to
 - i. The giving and receiving of any notice or declaration under or in respect of this **Policy** (including notice of cancellation),
 - ii. The payment of premiums and receipt of any return premium and
 - iii. The acceptance of any endorsements to this **Policy**

16. Cancellation

- I. The policyholder may cancel this policy by giving 7 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

Period on risk	Rate of premium refunded
Up to one month	75% of annual rate
Up to three months	50% of annual rate
Up to six months	25% of annual rate
Exceeding six months	Nil

- II. 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.
- III. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.
- IV. If no claim has been made then We shall refund a pro-rata premium for the unexpired **Policy** Period.

17. Conditions for renewal of the contract

- a) The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
- b) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- d) 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.
- e) Coverage is not available during the grace period.

- f) Your Criticare Policy shall be renewable lifelong
- g) Applicable for Individual **Policy**- Upon the occurrence of an event of **Critical Illness** and (subject to the terms, conditions and exclusions of this **Policy**) without prejudice to the Company's obligation to make payment, this **Policy** shall immediately cease to exist with reference to that **Insured**.
- h) Applicable for family floater **Policy**- Upon the occurrence of an event of **Critical Illness** and (subject to the terms, conditions and exclusions of this **Policy**) for any **Insured** under the family floater **Policy**, without prejudice to the Company's obligation to make payment, this **Policy** shall immediately cease to exist. The rest of the **Family** members can opt for a separate **Critical Illness Policy** and they will be given continuity for the period they have been **Insured** under the Criticare **Policy**. In the event of the death of any of the **Insured** members subject to no **Critical Illness** claim being paid on the **Policy**, the cover ceases to exist for that **Insured** and the remaining members would continue to have the coverage until the end of the **Policy** period.

18. **Withdrawal of Policy**

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

19. **Examination of Books and Records:** We may examine Your books and records relating to the insurance under this **Policy** at any time during the **Policy Period** and up to three years after the **Policy** expiration, or until final adjustment (if any) and resolution of all claims under this **Policy**.

20. **Territorial Limits and Law**

- a. We cover **Critical Illness** of the **Insured** Person diagnosed during the **Policy Period** anywhere in India.
- b. The construction, interpretation and meaning of the provisions of this **Policy** shall be determined in accordance with Indian Law.
- c. The **Policy** constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the **Schedule**.

F. **CLAIMS ADMINISTERED BY:**

Generali Central Health (GCH)

Generali Central Insurance Co. Ltd.

Qubix Business Park, Building No. Block IT – 1, Ground Floor, Plot No. 2,

Blueridge Township, Near Rajiv Gandhi Infotech Park, Phase – 1,

Village Hinjawadi, Taluka Mulshi,

Pune, Maharashtra - 411057.

Email: GCH@generalicentral.com

G. **MANDATORY DISCLOSURES**

- a) The brochure / prospectus mentions the premium rates as per the age slabs/ sum insured. Insured would be charged as per the completed age at every renewal. In case of Family Floater, floater discounts will be applicable for the remaining members (other than primary insured) as per the table given under Section H (ii) of the Prospectus.
- b) The maximum sum insured eligibility for renewal:

Age	Max Sum insured option (INR)
66 years to 70 years	1,000,000
71 years to 75 years	5,00,000

Above 75 years	2,00,000
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- c) Terms for enhancing the Sum Insured
- i. No increase in Sum Insured during the currency of the Policy.
 - ii. Enhancement of sum insured will be subject to terms and conditions.
 - iii. For the enhanced sum insured, waiting periods will apply afresh.
- d) Detailed exclusions are given under Section D of the Prospectus.

H. PAYMENT OF PREMIUM

As per table annexed

This Prospectus shall form part of your proposal form. Please sign declaring that you have noted the contents of this Prospectus.

Name: _____

Signature: _____

Date: _____

Place: _____



Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.: 132 | CIN: U66030MH2006PLC165287
| Website: www.generalicentralinsurance.com |
Email ID: gcicare@generalicentral.com |
Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800
ISO No: GCH/HP/FCC/PRS/001

Premium illustration: (All figures in Rs.) Goods & Services Tax Extra

Sum Insured	6 - 25 yrs	26 - 30 yrs	31 - 35 yrs	36 - 40 yrs	41- 45 yrs	46 - 50 yrs	51 - 55 yrs	55 - 60 yrs	61-65 yrs
1 lakh	262	320	391	636	933	1746	2598	4614	5768
2 lakhs	487	601	740	1229	1821	3166	4869	8247	10309
3 lakhs	711	881	1090	1822	2709	4587	7140	11880	14850
4 lakhs	936	1162	1439	2415	3597	6374	9778	15513	19391
5 lakhs	1160	1442	1788	3009	4485	7795	12049	19147	23934
6 lakhs	1634	1972	2387	4238	6010	9207	14312	23364	29205
7 lakhs	1859	2253	2736	4831	6898	10627	16583	26997	33746
8 lakhs	2083	2533	3086	5424	7786	12048	18854	30630	38288
9 lakhs	2308	2814	3435	6017	8674	13469	21125	34264	42830
10 lakhs	2532	3094	3785	6610	9562	14889	23396	37897	47371
11 lakhs	2957	3519	4209	6648	9599	14927	23433	37899	47374
12 lakhs	3404	4078	4906	7832	11373	17766	27974	45163	56454
13 lakhs	3629	4359	5256	8425	12262	19187	30245	48797	60996
14 lakhs	3853	4639	5605	9018	13150	20607	32516	52430	65538
15 lakhs	4078	4920	5954	9611	14038	22028	34787	56063	70079
16 lakhs	4712	5610	6713	10614	15335	24285	37895	59691	74614
17 lakhs	4936	5890	7063	11207	16223	25706	40166	63325	79156
18 lakhs	5161	6171	7412	11800	17111	27127	42437	66958	83698
19 lakhs	5385	6451	7761	12393	17999	28547	44708	70591	88239
20 lakhs	5610	6732	8111	12986	18887	29968	46980	74224	100202
21 lakhs	5834	7013	8460	13579	19775	31388	49251	77858	105108
22 lakhs	6059	7293	8810	14172	20663	32809	51522	81491	110013
23 lakhs	6283	7574	9159	14765	21552	34230	53793	85124	114917
24 lakhs	6508	7854	9508	15358	22440	35650	56064	88757	119822
25 lakhs	6732	8135	9858	15951	23328	37071	58335	92391	124728
26 lakhs	7375	8834	10626	16963	24634	38483	60597	96015	129620
27 lakhs	7600	9114	10975	17556	25522	39903	62869	99648	134525
28 lakhs	7824	9395	11324	18149	26410	41324	65140	103282	139431
29 lakhs	8049	9675	11674	18742	27298	42745	67411	106915	144335
30 lakhs	8273	9956	12023	19335	28186	44165	69682	110548	149240
31 lakhs	8498	10236	12373	19928	29074	45586	71953	114182	154146
32 lakhs	8722	10517	12722	20521	29962	47006	74224	117815	159050
33 lakhs	8947	10798	13071	21114	30850	48427	76495	121448	163955
34 lakhs	9171	11078	13421	21707	31738	49848	78767	125081	168859
35 lakhs	9396	11359	13770	22301	32626	51268	81038	128715	173765
36 lakhs	9620	11639	14120	22894	33515	52689	83309	132348	191905
37 lakhs	9845	11920	14469	23487	34403	54110	85580	135981	197172
38 lakhs	10070	12200	14818	24080	35291	55530	87851	139615	202442
39 lakhs	10294	12481	15168	24673	36179	56951	90122	143248	207710
40 lakhs	10519	12761	15517	25266	37067	58372	92393	146881	212977
41 lakhs	10743	13042	15867	25859	37955	59792	94664	150514	218245
42 lakhs	10968	13323	16216	26452	38843	61213	96936	154148	223515
43 lakhs	11192	13603	16565	27045	39731	62633	99207	157781	228782
44 lakhs	11417	13884	16915	27638	40619	64054	101478	161414	234050
45 lakhs	11641	14164	17264	28231	41507	65475	103749	165047	239318
46 lakhs	11866	14445	17614	28824	42395	66895	106020	168681	244587
47 lakhs	12090	14725	17963	29418	43283	68316	108291	172314	249855
48 lakhs	12315	15006	18312	30011	44171	69737	110562	175947	255123
49 lakhs	12539	15286	18662	30604	45059	71157	112833	179581	260392
50 lakhs	12764	15567	19011	31197	45947	72578	115105	183214	265660

i. Family Floater Discounts: Premium for the primary insured remain as per the individual

table. For remaining dependent members discounts applicable as per the table below on their respective premium.

Age group	Premium Discounts
6 yrs to 25 yrs	50%
26 to 30 yrs	30%
31 to 35 yrs	30%
36 to 40 yrs	30%
41 to 45 yrs	20%
46 to 50 yrs	10%
Above 51 yrs	5%

ii. **Renewal premium:**

Following loadings in premium will be applicable for policies above 65 years of age for lifelong renewal:

1. Above 65 years up to 70 years – 10% (loading on 61-65 yrs age band)
2. 71 years to 75 years – 20% (loading on 61-65 yrs age band)
3. Above 75 years – 25% (loading on 61-65 yrs age band)