

PREAMBLE

This **Policy** is issued to **You** based on **Your Proposal** to **Us** and **Your** payment of the premium. **You** are eligible to be covered under this **policy** if **Your** age is between 6 months to 65 years with life long renewability. This **Policy** records the agreement between **Us** and sets out the terms of insurance and the obligations of each party.

A. DEFINITIONS

The following words or terms shall have the meaning ascribed to them wherever they appear in this **Policy**, and references to the singular or to the masculine shall include references to the plural and 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. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **¹AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
4. **²AYUSH Hospital:** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - a) Central or State Government AYUSH Hospital; or
 - b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
 - c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **³AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered.

¹ Inserted definition of AYUSH Treatment

² Inserted definition of AYUSH Hospital

³ Inserted definition of AYUSH Day Care Centre

AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
 - ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative
6. **Conditions precedent** shall mean a policy terms or conditions upon which the insurers liability under the policy is conditional upon.
7. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
- i. **Internal Congenital Anomaly** - Congenital Anomaly which is not in the visible and accessible parts of the body.
 - ii. **External Congenital Anomaly** - Congenital Anomaly which is in the visible and accessible parts of the body.
8. **Day care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under -
- i. has qualified nursing staff under its employment;
 - ii. has qualified medical practitioner/s in charge;
 - iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
 - iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
9. **Day care treatment** refer to medical treatment, and/or surgical procedure which is:
- i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
 - ii. which would have otherwise required hospitalization of more than 24 hours.
- Treatment normally taken on an out-patient basis is not included in the scope of this definition.
10. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
11. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
12. **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.
13. **Grace period** means the specified period of time immediately following the premium due date during which premium a payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available for during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurer shall offer coverage during the grace period, if the premium is paid in installments during policy period.

14. **Hospital** - A 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) and 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 in-patient 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 makes these accessible to the insurance company's authorized personnel;
15. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'Inpatient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
16. **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:
 - (i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 - (ii) it needs ongoing or long-term control or relief of symptoms
 - (iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - (iv) it continues indefinitely
 - (v) it recurs or is likely to recur
17. **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.
18. **Inpatient Care** means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.
19. **Intensive care unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
20. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

21. Maternity expense/treatment means:

- a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- b. expenses towards lawful medical termination of pregnancy during the policy period.

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

23. Medical expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of **Illness** or **Accident** on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

24. Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close Family members.

25. Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer

26. Portability means the right accorded to an 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.

27. 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 its reinstatement.
- 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 issued by the insurer or its reinstatement.

28. 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.

29. 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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

30. Unproven/ Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India.

II. Specific Definitions:

31. 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.

32. **Family** means and includes You, Your Spouse & Your dependent child/ children (up to the age of 25 years)
- (i) The maximum number of days of Hospitalisation as mentioned in the Schedule would float over all members under the Family Floater Policy.
- (ii) In the event of more than one **Family** member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole **Family** would be restricted to the number of days as mentioned in the Schedule (maximum number of days would float over the **Family**) under the Family Floater **Policy**
33. **Home City** means the city of residence.
34. **Other Than Home City** means the city other than the residential city of the insured.
35. **Policy** means the complete documents consisting of the Proposal, Policy wording, Schedule and Endorsements and attachments if any.
36. **Policy Period** means the period between commencement date and the expiry date specified in a schedule and include both commencement date as well as the expiry date.
37. **Proposal** means that portion of the policy which sets out your personal details, they type of insurance cover in force, the period and the sum insured.
38. **Schedule** means that portion of the Policy which sets out Your personal details, the type of insurance cover in force, the period and the sum insured. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule.
39. **You, Your, Yourself** means the Insured Person shown in the Schedule.
40. **We, Our, Us, Insurer** means Generali Central Insurance Company Limited.

Please note

- a) Insect and mosquito bites is not included in the scope of definition of **Accident**.
- b) **Medical Expenses** would include both medical treatment and/ or surgical treatment

B. POLICY BENEFITS:

In the event of Accidental Bodily Injury or illness first occurring or manifesting itself during the Policy Period and causing the Insured's Hospitalisation for Inpatient Care within the Policy Period, the Company will pay:

- I. the Hospital Cash benefit for each continuous and completed period of 24 hours of **Hospitalisation** necessitated solely by reason of the said Accidental **Bodily Injury** or Sickness, for a maximum of 30 days / 60 days /90 days/ 180 days as per the **schedule**.
- OR
- II. two times the Hospital Cash benefit for each continuous and completed period of 24 hours required to be spent by the Insured in the Intensive Care Unit of a Hospital situated in the Home city of the Insured, during any period of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Sickness for a maximum period of 10 days for each hospitalisation and 20 days during the policy period
- OR
- III. three times the Hospital Cash benefit for each continuous and completed period of 24 hours required to be spent by the Insured in the Intensive Care Unit of a Hospital situated in a city other than Home city of the Insured, during any period of Hospitalisation necessitated solely by reason

of the said Accidental Bodily Injury or Sickness for a maximum period of 10 days for each hospitalisation and 20 days during the policy period.

* *In case of Section II and III the maximum benefit payable in case of ICU whether in Home city / other than Home city, is limited upto 10 days for each hospitalisation and maximum of 20 days for all hospitalisations put together in the policy period. In case of the same hospitalisation involving ICU stay in both Home city as well as other than Home city, the benefits under the "other than home city" would have precedence over benefits under Home city while adjudication of claim.*

** *In case of Sec I, II and III the maximum benefits would however be restricted to 30 /60 / 90 /180 days as per the plan opted for each hospitalisation or all hospitalisations during the policy period.*

****In case the hospitalisation exceeds the maximum stipulated under Sec I as per the selected plan while adjudicating any claim the benefits under ICU would have precedence over non ICU hospitalisation.*

**** *In case the hospitalisation in ICU exceeds the per hospitalisation maximum limit of 10 days or the per policy period limit of 20 days, the remaining period of hospitalisation in ICU will be paid as per non ICU hospitalisation benefits subject to the overall policy maximum of 30/60/90 or 180 days.*

IV. A Fixed amount towards convalescence for **Hospitalization** beyond 10 consecutive days which is payable only once per **Hospitalization** event. This benefit is payable only if there is an admissible claim under any of the daily benefits.

C. EXCLUSIONS:

I. Waiting Periods:

We will not pay for any expenses incurred by **You** in respect of claims arising out of or howsoever related to any of the following:

1. Benefits will not be available for Any condition, ailment or **Injury** 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**, until 36 consecutive months have elapsed, after the date of inception of the first **Policy** with **Us**.

This Exclusion shall cease to apply if **You** have maintained the **Policy** with **Us** for a continuous period of 36 months, without break from the date of **Your** first Hospital cash **Policy** with **Us**.

This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the **Policy** is a **Renewal** of a Hospital cash **Policy** without break in cover

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.

2. Without derogation from the above point no. (1), any Hospitalisation during the first consecutive 24 months during which **You** have the benefit of a Health Insurance Policy with **Us** in connection with cataracts, benign prostatic hypertrophy, hernia of all types, hydrocele, all types of sinuses, fistulae, hemorrhoids, fissure in ano, dysfunctional uterine bleeding, fibromyoma, endometriosis, hysterectomy, all internal or external tumors/ cysts/ nodules/ polyps of any kind including breast lumps (except malignant conditions), Surgery for prolapsed inter vertebral disc unless arising from Accident, Surgery of varicose veins and varicose ulcers.

This exclusion shall apply for a continuous Period of 36 months from the date of **Your** first Hospital cash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared such **Illness** at the time of proposing the **Policy** for the first time.

This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the **Policy** is a **Renewal** of a Hospital cash **Policy** without break in cover

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.

3. Without derogation from the above point No.(1), any **Hospitalisation** during the first 12 months during which You have the benefit of a Health Insurance **Policy** with **Us** in connection with any types of gastric or duodenal ulcers, stones in the urinary and biliary systems, **Surgery** on ears/ tonsils/ adenoids.

This exclusion shall apply for a continuous period of 36 months from the date of **Your** first Hospital cash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared such **Illness** at the time of proposing the **Policy** for the first time.

This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the **Policy** is a **Renewal** of a Hospital cash **Policy** without break in cover

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.

4. **Hospitalisation** during the first consecutive 36 months during which You have the benefit of the **Policy** with **Us** in connection with joint replacement **Surgery** due to degenerative condition, Age related osteoarthritis and Osteoporosis unless such joint replacement **Surgery** is necessitated by accidental Bodily **Injury**.

This exclusion period shall apply for a continuous period of 36 months from the date of **Your** first Hospital cash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared such **Illness** at the time of proposing the **Policy** for the first time.

This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the **Policy** is a **Renewal** of a Hospital cash **Policy** without break in cover

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.

5. **Hospitalisation** for any **Illness** diagnosed or diagnosable within 30 days (1 month), of the commencement of the **Policy** Period except those incurred as a result of accidental bodily **Injury**.

This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the **Policy** is a **Renewal** of a Hospital cash **Policy** without break in cover

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

II. Standard Exclusions

We will not pay for any expenses incurred by You in respect of claims arising out of or howsoever related to any of the following:

a) Investigation & Evaluation- Code- Excl04

- i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

b) 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.

c) 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.

d) 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.

e) Code- Excl12

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

f) Code- Excl13

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or a Hospital where the Hospital has effectively become the Insured Person's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

g) Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

h) 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.

i) 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

j) Maternity : Code Excl18

- i. Medical treatment expenses traceable to child birth (including complicated deliveries and caesarean section incurred during hospitalization) except ectopic pregnancy;
- ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during policy period.

III. Specific Exclusions

- k) Injury or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not).
- l) Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an Accident.
- m) Vaccination (unless post bite treatment), inoculation
- n) Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental bodily Injury.
- o) The treatment of obesity (including morbid obesity) and other weight control programs , services and supplies.
- p) Hospitalisation for General debility, “Run-down” condition or rest cure, sexually transmitted disease other than HIV/AIDS, intentional self-Injury.
- q) Hospitalisation arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) and its variants or mutants.
- r) Congenital external Illness/disease/defect anomaly.
- s) Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.
- t) ⁴Costs incurred on all methods of treatment except Alternative and Allopathy treatments.
- u) Genetic disorders and stem cell implantation/surgery/storage.
- v) Hormone replacement therapy.
- w) Any treatment including Surgery to remove organs from the donor in case of a transplant surgery.

⁴ Modified the wording to cover AYUSH treatment into the scope of the Product

x) Any Hospitalisation received out of India.

D. 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. Complete Discharge

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

6. 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.

7. 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 cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

8. 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.

9. 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.

10. 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

11. 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 Limited.

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://www.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. Kindly refer the annexure on Grievance Redressal Procedures.

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

II. Specific Terms and clauses

1. Due Care

Where the Policy requires You to do or not to do something, then the complete satisfaction of that requirement by You or Someone claiming on your behalf is a precondition to any obligation under this Policy. If you or someone claiming on Your behalf fails to completely satisfy that requirement, then We may refuse to consider Your claim. You will cooperate with us at all times.

2. Insured

Only those persons named, as the Insured in the schedule shall be covered under this policy. The details of the insured are as provided by You. A person may be added as an Insured during the Policy period after his application has been accepted by Us, an additional premium has been paid and Our agreement to extend cover has been indicated by it, issuing an endorsement confirming the addition of such person as an Insured cover under this Policy shall be withdrawn from any Insured upon that Insured giving 14 days written notice to be recovered by Us.

3. Cost of Pre-insurance Medical examination

We will reimburse 50% of the cost of any pre-insurance medical examination once the Proposal is accepted and the Policy is issued for that Insured. We shall maintain a list of and the fee 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 policy holder at the time of pre insurance medical examination.

4. Communication

a) Any communications, meant for Us must be in writing and delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown

in the Schedule.

- b) All the notifications and declarations for us must be in writing and sent to the address specified in the schedule. Agents are not authorized to receive, notices or declarations on Our behalf.
- c) You must notify Us immediately for any change in address.

5. Claims Procedure

If You meet with any accidental Bodily Injury or suffer an Illness/ sickness 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 inform Us in writing immediately, and in any event within 48 hours of the aforesaid Illness or Bodily injury. You must immediately consult a Medical Practitioner and follow the Medical advice and treatment that he recommends.
- b) You must take reasonable steps or measure to minimise the quantum of any claim that may be made under this Policy.
- c) You shall expeditiously provide the Company with any and all information and documentation in respect of the hospitalization. The claim and/ Our liability hereunder that may be requested. You shall submit Yourself for examination by the Company's medical advisors as often as may be considered necessary by Us. The cost of such medical examination will be borne by Us.
- d) You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation (written details of the quantum of any claim along with certified copies of discharge card, hospital bill and receipt) and other information if We ask for, to investigate the claim or Our obligation to make payment for it.
- e) In the event of the death of the insured person, nominee claiming on his/ her behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 14 days.
- f) Mandatory documents required to process claim are:
 - Completely filled Hospicash Claim form (original)
 - Discharge certificate/ card from Hospital (photocopy)
 - Final Hospital bill with receipt (photocopy)
- g) The periods for intimation or submission of any documents as stipulated under (d) and (e) will be waived in case of any hardships being faced by the insured or his representative which is supported by some documentation

6. Settlement of Claims

- i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
- ii. 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.
- iii. 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.
- iv. 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)
- v. Our doctors will scrutinize the claims and flag the claims as Settled/Rejected/Pending within

the period of 30 days of the receipt of the last `necessary` documents.

- vi. Pending claims will be asked for submission of incomplete documents.
- vii. Rejected claims will be informed to the insured person in writing with the reason for rejection.

7. Basis of Claim Payment

- i. If You suffer a relapse within 45 days of the date when You last obtained medical treatment or consulted a Medical Practitioner and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.
- ii. If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two Policy period, including the deductibles for each policy period. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of the premium to be received for the Renewal/ due date of premium of health insurance Policy, if not received earlier.
- iii. We shall make payment in India in Indian Rupees only.
- iv. The Company shall only make payment under this policy to the insured or in the event of death or total incapacitation of the Insured to the Proposer/Nominee. 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 for such claim.
- v. A continuous and completed period of less than 24 hours of Hospitalization or Day care treatment consequent upon an insured event shall be deemed to be a continuous and completed period of 24 hours if such period extends to at least 12 hours.

8. Renewal

- 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) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- d) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- e) 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.
- f) Coverage is not available during the grace period.
- g) No loading shall apply on renewals based on individual claims experience
- h) Your Hospicash Policy shall be renewable lifelong
- i) Any hospitalisation as a result of accident /disease contracted during the break period will not be admissible under the policy.
- j) In case of Hospicash policy there will be no loading on premium for adverse claims experience (except for Group policies)

9. Cancellation

- a) 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

- b) 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.
- c) 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.
- d) if no claim has been made then, We shall refund a pro rata premium for the unexpired policy period.
- e) For Family floater policies, in the event of the death of any of the insured members, 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.
- f) In case of a group policies, the following would apply:
 - i. Discount percentage for a favourable claim ratio (bonus): Low claim ratio discount at the following scales will be allowed on the total premium at the renewal only, depending upon the incurred claim ratio for the entire group insured under the Group Hospicash Policy for up to preceding 3 years.

Incurring claim Ratio Under the Group Policy	Discount Percentage (%)
Up to 20%	20
21-35%	15
36-50%	10
51-55%	5

- ii. Loading percentage for High claims ratio (MALUS): The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the Group Hospicash Policy up to preceding 3 years.

Incurring claim Ratio Under the Group Policy	Loading Percentage (%)
Between 71% and 80%	25
Between 81% and 100%	50
Between 101% and 125%	85
Between 126% and 150%	115
Between 151% and 175%	150
Between 176% and 200%	180
Over 200%	Cover to be reviewed

10. Compliance with Policy Provisions

Failure by **You** or the Insured Person to comply with any of the provisions in this Policy may invalidate all claims hereunder.

11. Territorial Limits and Law

- a) We cover Hospital cash benefit due to Accidental **Bodily injury** or Sickness sustained by the Insured Person during the **Policy** Period anywhere in India only.
- 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**, for which approval shall be evidenced by an endorsement on the **Schedule**.

12. ⁵AYUSH Coverage:

Expenses incurred on hospitalization due to accident and illnesses under AYUSH system of medicine shall be covered. However, all preventive and rejuvenation treatments which are non-curative in nature shall not be covered.



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: gccare@generalicentral.com | Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800
ISO No: GCH/HP/HCP/PWG/001

⁵ Clause 12. newly inserted to cover AYUSH treatments at par with Allopathic Treatments, wherever applicable, in the product to provide an option for the Insured Persons to choose treatment of their choice

GRIEVANCE REDRESSAL PROCEDURE

Dear Customer,

At Generali Central Insurance, we continuously strive for service excellence to give you exceptional customer experience. This helps us build trust and long-term relationship with you.

We request you to read the policy document including the terms and conditions carefully. This will

help you understand your plan and drive maximum benefits. We want to ensure the plan is working for you and welcome your feedback.

What is a grievance?

"Complaint" or "Grievance" means written expression (includes communication in the form of electronic mail or voice based electronic scripts), of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.

"Complainant" means a policyholder or prospect or any beneficiary of an insurance policy who has led a complaint or grievance against an insurer or a distribution channel.

We are always here for your help. You may use any of the following channels to reach us-

Helpline	Website	Email	Branch GRO	Complaint Form
<p>Call us on 1800 220 233/ 1860 500 3333/022- 67837800</p> <p>Senior citizens can avail priority support by choosing the senior citizen option from the helpline menu.</p>	<p>Click here to know more</p>	<p>Write to us at GCIcare@generalicentral.com</p> <p>Senior citizens can avail priority support by writing to care.assure@generalicentral.com</p>	<p>Click here to know your nearest branch.</p>	<p>Click here to raise complaint.</p>

By when will my grievance be resolved?

- You will receive grievance acknowledgement from us immediately for your complaint.
- Final resolution will be shared with you within 2 weeks of receiving your complaint.
- Your complaint will be considered as closed if we do not receive any reply from you within 8 weeks from the date of receipt of response.

How do I escalate my complaint if I don't receive a response on time?

- You may write to our Grievance Redressal Officer at GCIGRO@generalicentral.com
- You may send a physical letter to our Grievance Redressal Cell, Head Office at the below address:

GENERALI CENTRAL INSURANCE COMPANY LIMITED (Formerly known as Future Generali India Insurance Company Limited)

Lodha I – Think Techno Campus, B Wing – 2nd Floor, Pokhran Road – 2, Off Eastern Express Highway Behind TCS, Thane West – 400607

GRIEVANCE REDRESSAL PROCEDURE

What if I am not able to register my grievance?

You can comfortably raise a grievance via any of the above-mentioned avenues. If you face any challenge, you may write to the provided email IDs for help.

If you still face any challenge, you may use any of the below options to raise a complaint with the Insurance Regulatory and Development Authority of India (IRDAI).

- **Call on toll-free number: 155255**
- **Click here** to register complaint online

Is there any special provision for senior citizen to raise grievance?

We understand our customers and their needs. Thus, have a separate channel to address the grievances of senior citizens. The concerns will be addressed to the senior citizen's channel (care.assure@generalicentral.com) as complaints for faster attention or speedy disposal of grievance, if any.

Insurance Ombudsman:

If you are still dissatisfied with the grievance redressal, you may approach the Office of the Insurance Ombudsman located in your vicinity, provided the same is under their purview. The guidelines for taking up a complaint with the Insurance Ombudsman, are available on the website a (<https://www.cioins.co.in/About>) of the Insurance Ombudsman. **Click here** to access the list of insurance Ombudsman offices.

You can also lodge an online complaint through the website of the Council for Insurance Ombudsmen(CIO): <https://www.cioins.co.in/>