Royal Sundaram General Insurance Co. Limited
Corp. Office: Vishranthi Melaram Towers,
No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097.
Regd. Office: 21, Patullos Road, Chennai - 600 002

Policy Terms and Conditions

1. PREAMBLE

This Policy is a contract of insurance issued by Royal Sundaram General Insurance Co. Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the company under all such claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the schedule.

3. DEFINITIONS

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

A Standard Definition-

3.1 Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3.2 Age means age of the Insured person on last birthday as on date of commencement of the policy.
3.3 Any One Illness means continuous period of illness and it includes relapse within forty-five days from the date of last consultation with the hospital where treatment has been taken.
3.4 AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga, and Naturopathy, Unani, Siddha and Homeopathy systems.
3.5 An **AYUSH Hospital** is a health care 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.

3.6 AYUSH Day Care Centre means and includes Community Health Care (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 registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criteria:

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.

3.7. Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

3.8. Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

3.9. Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.10. 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.

3.11. Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

3.12. Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

3.13. Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under.

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner (s) in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.14. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

i. Undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
ii. Which would have otherwise required a hospitalisation of more than twenty-four hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.15. Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

3.16. 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.

3.17. Emergency Care: Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

3.18. Family means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

i. Legally wedded spouse.
ii. Parents and Parents-in-law.
iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

3.19. Grace Period means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. If the premium is paid in instalments, coverage will still be available during the grace period.

3.20. Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under 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 ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen 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 shall make these accessible to the Company's authorized personnel.

3.21. **Hospitalisation** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

3.22. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to response 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.

ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics.

a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
b) It needs ongoing or long-terns control or relief of symptoms
c) It requires rehabilitation for the patient or for the patient to be special trained to cope with it
d) It continues indefinitely
e) It recurs or is likely to recur

3.23. 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.

3.24 In-Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

3.25 Insured Person means person(s) named in the schedule of the Policy.

3.26 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.

3.27 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensives charges.

3.28 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.29 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.

3.30 Medical Practitioner means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

3.31 Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

3.33 Network Provider means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cash less facility.

3.34 Non- Network Provider means any hospital that is not part of the network.

3.35 Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

3.36 Out-Patient (OPD) Treatment means treatment in which the insured visits a clinic/ hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.

3.37 Pre-Existing Disease (PED) : Pre-existing disease means any condition, aliment, 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 or its reinstatement.

3.38 Pre-hospitalisation Medical Expenses means medical expenses incurred during the period of 15 days preceding the hospitalisation of the insured person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.39 Post-hospitalisation Medical Expenses means medical expenses incurred during the period of 30 days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient hospitalisation claim for such hospitalisation is admissible by the insurance company.

3.40 Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured Person.

3.41 Policy period means period of one policy year as mentioned in the schedule for which the Policy is issued.

3.42 Policy Schedule means the Policy Schedule attached to and forming part of Policy.

3.43 Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve month commencing from the end of the previous policy year and lapsing on the last day of such twelve months period, till the policy period, as mentioned in the schedule.

3.44 Portability means the right accorded to an individual health insurance policyholder (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.

3.45 Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.46 Renewal: 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.

3.47 Room Rent means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

3.48 Sub-limit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

3.49 Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

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

3.51 Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

3.52 Waiting Period means a period from the inception of this Policy during which specified diseases/treatments are not

covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously relieved without any break.

B Specific Definition-

1. **Admissible amount-** The claim amount payable after deduction of non-payable expenses and after application of room rent sublimit and proportionate deduction.
2. **Preferred provider network (PPN)-** PPN network refers to specially defined network of hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide cashless facility with agreed rates and terms, tariffs and schedule of charges for room rent, ICU, investigations, professional fees etc. and the package cost of certain surgical procedures. Providers in PPN network provide optimum and cost-effective treatment to policyholders. The insurer shall revise the PPN network from time to time and same shall be made available for the policyholders in the Insurer's website and Customer portal.
3. **Proportionate Deduction-** In case if insured chooses to be admitted in a room/ICU/ICCU at rates exceeding the limits as specified in the policy document, he/she shall bear a rateable proportion of the total & Associated Medical Expenses *(including surcharge or taxes thereon) in the proportion of the difference between the Room Rent of the entitled room category/eligible Room Rent to the Room Rent actually incurred. However, this will not be applicable in respect of Medicines/Pharmacy/ Drugs, Consumables, Medical Devices/ implants and Cost of Diagnostics.

   ***Associated Medical Expenses-**

   - Doctor's fees / Consultant fees/RMO fees
   - Nursing expenses including administration charges/ transfusion charges/ injection charges
   - Surgeon fees / Assistance Surgeon fees
   - Anaesthesia fees
   - Procedure charges of any kind which includes: -Chemotherapy/Radiotherapy charges Nebulization
   - Haemodialysis PICC
   - Line insertion
   - Catheterization charges, Tracheostomy etc.
   - IV charges
   - Blood transfusion charges
   - Dialysis
   - Surgery Charges
   - OT charges including OT gas, equipment charges

4. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1 A. Hospitalization

The Company shall indemnify medical expenses incurred for In-patient Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for

a) Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home –Upto Rs. 3000 per day, with proportionate deduction
b) Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to Rs. 8000 per day, with proportionate deduction

c) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
d) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses
e) Expenses on Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
f) All day care treatment shall be covered up to 25% of Sum Insured
g) Expenses incurred on road Ambulance subject to a maximum of Up to Rs.750 per hospitalisation (payable within the sum insured)
h) Expenses on hospitalisation for specified surgical procedures shall be payable upto the limits as specified in clause 4.6 below

4.1.B. **Hospital daily cash benefit** - A daily cash benefit of Rs. 200 for every 24 hours of hospitalization in the PPN hospitals. Limited to a maximum of 10 days per hospitalization

4.1.C. Co-Payment (applicable on both reimbursement and cashless claims)

1) 25% co-pay on the admissible amount per claim* shall be applicable for any claim outside the preferred provider network.

2) 30% co-pay on the admissible amount per claim* shall be applicable for any claim for insured persons who have completed 61 years of age on the date of inception of the respective policy period.

3) Co-payment shall be applied as demonstrated below -

a) If the hospitalisation is within PPN network and the insured person is aged 61 years and above, then the co-payment will be 30% only

b) If customer has claimed outside PPN network (25%), aged 61 and above (30%) then total co-payment will be 47.5%

4) Co-payment will be applicable on any insured in the said age band irrespective of the entry age of the insured at the time of purchase of the policy.

*per claim denotes a single continuous hospitalisation and includes pre and post hospitalisation period as defined earlier in the policy.

4.2 AYUSH Treatment

Expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines is covered up to 100% of Sum Insured, during each policy year as specified in the policy schedule.

However, Co-payment shall be applicable as detailed in clause 4.1.C above and disease specific sublimits as detailed in clause 4.6

4.3 Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 15 days prior to the date of admissible hospitalization covered under the policy. The amount shall be limited to 25% sum insured.

4.4 Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy. The amount shall be limited to 25% of sum insured.

4.5 Modern Treatment

The following procedures will be covered (whichever medically indicated) either as in patient or as part of day care treatment in a hospital up to 20% of Sum Insured, specified in the policy schedule, during the policy period:

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

*__Note__-The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

4.6 Disease Specific Sublimits

The Claim amount payable per person towards the treatment of following disease, illness, medical condition or injury during the period of insurance is subject to a limit of:

Treatment	**Limit per claim (In Rs.)**
Appendectomy	65,000

Surgical management of Stones in Urinary and Biliary systems	65,000
Surgical management of Hernia	60,000
Surgical management of Hydrocele	50,000
Hysterectomy with BSO (Uterus and ovarian removal)	70,000
Dilation and curettage (D&C)	20,000
Surgery for removal of Lump/Cyst/Nodule/polyps	40,000
Surgical management of Tonsils/Adenoids	40,000
Surgery for IVDP, Spondylosis, Spondylitis	1,00,000
Surgical management of Anal Fissure, Fistula, Piles	50,000
Surgical management of Benign Prostatic Hypertrophy	60,000
Functional Endoscopic sinus surgery	55,000
Septoplasty (DNS)	45,000
Cataract surgery (only monofocal lens allowed)	25,000 per eye
Knee/Hip replacement (Unilateral) surgery	1,50,000
Knee/Hip replacement (Bilateral) surgery	2,00,000
Coronary Artery Bypass Grafting surgery	2,00,000

In case the admissible amount is higher than the disease specific capping, the amount payable for hospitalization shall be restricted at the amount specified above irrespective of age of the customer.

The Company will pay the actual expenses incurred during the hospitalisation (including pre and post hospitalisation expenses) or the sub-limits detailed above, which is less.

5. Cumulative Bonus (CB)

We will increase Your Sum Insured by 5% of Base Sum Insured per Policy Year up to a maximum of 25% of Base Sum Insured of renewed Policy, if the Policy is renewed with Us and provided that there are no claims paid/outstanding in the expiring Policy Year by any Insured Person.

If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

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

6. Standard Exclusions

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

a. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) lf the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

b. 30 Days Waiting Period (Code- Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of

granting higher sum insured subsequently.

c. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. The exclusion shall not be applicable for claims arising due to an accident.
b) ln case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures is as under:
    a) Cataract
    b) Stones in biliary and urinary systems
    c) Hernia / Hydrocele
    d) Hysterectomy for any benign disorder
    e) Lumps / cysts / nodules / polyps / internal tumours
    f) Gastric and Duodenal Ulcers
    g) Surgery on tonsils / adenoids
    h) Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse
    i) Fissure / Fistula / Haemorrhoid
    j) Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media
    k) Benign Prostatic Hypertrophy
    l) Knee/Hip Joint replacement
    m) Dilatation and Curettage
    n) Varicose veins
    o) Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis
    p) Chronic Renal Failure or end stage Renal Failure or Chronic liver failure

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

d. Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

e. Rest Cure, rehabilitation and respite care (Code- ExcI05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

f. Obesity/ Weight Control (Code- ExcI06)

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

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

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

Expenses related to any treatment, including surgical management, to change characteristics of the body of those of the opposite sex.

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

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

i. Hazardous or Adventure sports: (Code- ExcI09)

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.

j. Breach of law: (Code- Excl10)

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

k. Excluded Providers: (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded but the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of

life threating situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

l. Treatment for Alcoholism, drug or substance abuse, Tobacco Abuse or any addictive condition and consequences thereof**. (Code- Excl12)**

m. 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 where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

n. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**

o. Refractive Error. - **(Code- Excl15)**

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

p. 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.

q. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

r. Maternity Expenses (Code – Excl18):

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

7. Specific Exclusions

1. Personal Waiting Periods

A special waiting period not exceeding 36 months, may be applied to Individual Insured Persons depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule of Insurance Certificate and will be applied only after receiving Your specific consent.

2. Alternative treatment:

Any Alternative Treatment except for the benefits under Section A.1.8 (AYUSH Treatment)

3. Circumcision

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

4. Conflict and disaster

Treatment for any illness or injury resulting from nuclear or chemical contamination, war, riot, revolution, acts of terrorism or any similar event (other than natural disaster or calamity), if one or more of the following conditions apply:

a. The Insured Person put himself in danger by entering a known area of conflict where active fighting or insurrections are taking place
b. The Insured Person was an active participant in the above mentioned acts or events of a similar nature.
c. The Insured Person displayed a blatant disregard for personal safety

5. Congenital conditions

Treatment for any External Congenital Anomaly.

6. Convalescence and Rehabilitation

Hospital accommodation when it is used solely or primarily for any of the following purposes:

a. Convalescence, rehabilitation, supervision or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in Hospital.
b. receiving general nursing care or any other services that do not require the Insured Person to be in Hospital and could be provided in another establishment that is not a Hospital
c. receiving services from a therapist or complementary medical practitioner or a practitioner of Alternative Treatment.

7. Drugs and dressings for OPD Treatment or take-home use

Any drugs or surgical dressings that are provided or prescribed in the case of OPD Treatment, or for an Insured Person to take home on leaving Hospital, for any condition, except as included in Post-hospitalization expenses under Section A.1.3 above.

8. Items of personal comfort and convenience, including but not limited to:

A. Telephone, television, diet charges, (unless included in room rent) personal attendant or barber or beauty services, baby food, cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services.
B. Private nursing/attendant's charges incurred during Pre-hospitalization or Post-hospitalization.
C. Drugs or treatment not supported by prescription.
D. Issue of medical certificate and examinations as to suitability for employment or travel or any other such purpose.
E. Any charges incurred to procure any treatment/Illness related documents pertaining to any period of Hospitalization/Illness.

9. Ambulatory devices such as walkers, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic foot wear, glucometer/thermometer and similar items and also any medical equipment which is subsequently used at home.

10. OPD treatment

Any expenses incurred on OPD treatment

11. Preventive Care

    All preventive care, vaccination including inoculation and immunizations except in case of

12. Self-inflicted injuries

    Treatment for, or arising from, an injury that is intentionally self-inflicted, including attempted suicide.

13. Treatment for Alopecia

Any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

14. Treatments taken outside the geographical limits of India.
15. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

    a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
    b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
    c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

16. Ancillary Hospital Charges - Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, night charges, registration, documentation and filing, surcharges. Service charges levied by the Hospital under whatever head.
17. Charges for medical papers

Any charges incurred to procure any medical certificate, medical records, treatment or Illness/Injury related documents pertaining to any period of Hospitalization/Day Care Treatment undertaken for any Accident, Illness or Injury.

18. Artificial Life maintenance is not covered from the time Insured Person goes into vegetative state and a point of no recovery to Life.
19. The expenses that are not covered in this policy are placed under List-I of Annexure-A.
20. Impairment of Person's Intellectual faculties by usage of drugs, stimulants or depressants unless prescribed by a medical practitioner.

8. <u>Other Exclusion-</u>

Expenses for treatment directly arising from or consequent upon any Insured Person was under influence of alcohol whilst driving.

9. General Terms & Clauses

Standard General Terms and Clauses

1. Disclosure of Information

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.

2. Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

3. Claim Settlement (provision for Penal Interest)

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 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 15 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 15 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 15 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

4. Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the company to the extent of that amount for the particular claim.

5. Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Policy holder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

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 fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

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

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

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

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

7. Cancellation:

The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing.

The Company shall:
a. refund proportionate premium for unexpired policy period, if the term of policy is up to one year and there is no claim (s) made during the policy period.
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

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.

The Company may cancel the Policy at any time on grounds of misrepresentative, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to 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, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section D shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefits shall not apply to any other

additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the below link:-

https://www.royalsundaram.in/html/files/Modification-guidelines-on-standardization-in-health-insurance-Migration.pdf

9. Portability

The insured Person will have the option to port the policy to other insurers as an extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section E shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the below link: -

https://www.royalsundaram.in/health-insurance/health-insurance-portability

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due to renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 15 days in monthly and 30 days in case of quarterly, half- yearly and yearly payments to maintain continuity of benefits without break in policy. If the premium is paid in instalments, coverage will still be available during the grace period.
iv. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
v. If not renewed with in Grace Period after due renewal date, the Policy shall terminate.

No loading shall apply on renewals based on individual claims experience

11. 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.

12. Moratorium Period

After completion of five continuous years under this policy no look back would be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of five continuous years would be applicable from the date of enhancement of sum insured only on the enhanced limits. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

13. Premium Payment in Instalment

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of insurance, the following Conditions shall apply (not withstanding any terms contrary elsewhere in the Policy)

i. In case of monthly mode of premium payment, grace period of 15 days is allowed and would be given maximum two times in a policy period. In case of quarterly and half-yearly and yearly mode of premium payment, grace period will be allowed maximum only once for a period of 30 days for payment of the instalment premium due for the policy.
ii. If the premium is paid in instalments, coverage will still be available during the grace period.
iii. The Benefits provided under — “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged if the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. ln the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

14. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

15. Free look period

At the inception of the policy the Insured Person will be allowed a period of 30 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable. If Insured Person has not made any claim during the free look period, he will be entitled to the following, provided no claim has been settled or lodged for the period the policy has been in force:

a) A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured person and the stamp duty charges or;

b) where the risk has already commenced and the option of return of the policy is exercised, a deduction towards the proportionate risk premium for period on cover or;

c) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

d) Free-look will not be applicable for policies with tenure less than one year.

e) Free-look not applicable in case of renewals.

All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

16. Redressal of grievance

ln case of any grievance the insured person may contact the company through

Website: https://www.royalsundaram.in

Grievance Redressal: https://www.royalsundaram.in/customer-service

You may call us at – 1860 258 0000, 1860 425 0000

Email:

1. Please raise a complaint with us through e mail – care@royalsundaram.in, and we would come back to you with a response in 24 hours.
2. In case you are not satisfied with our response or have not received any response in 24 hours, you may write to manager.care@royalsundaram.in
3. If you feel you are not heard of or have not received any response in 2 business days, you may escalate it to head.cs@royalsundaram.in
4. In case you are not happy with our response or have not received any response in 2 business days, you may approach gro@royalsundaram.in - GRO Contact Number – 9500413094

Sr. Citizen can email us at : seniorcitizengrievances@royalsundaram.in - Senior Citizen Grievance Number - 9500413019 (A separate e-mail id for Senior Citizens has been created for the ease and convenience of Senior citizens)

Fax us at: 044 – 7117 7140

Courier us your complaint at:

Royal Sundaram General Insurance Co. Limited

Vishranthi Melaram Towers,

No.2/319, Rajiv Gandhi Salai (OMR)

Karapakkam, Chennai – 600097

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

Mr. T M Shyamsunder
Grievance Redressal Officer

Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers,
No.2/319, Rajiv Gandhi Salai (OMR)
Karapakkam, Chennai – 600097

For updated details of grievance officer, kindly refer the link http://www.royalsundaram.in

lf 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.

Insurance Ombudsman addresses -https://www.cioins.co.in/ContactUs

Grievance may also be lodged at –

Registration of Complaints in Bima Bharosa by Policyholders:

1. Can directly register complaint in the **Bima Bharosa Portal** https://bimabharosa.irdai.gov.in/
2. Can send the complaint through Email to complaints@irdai.gov.in.
3. Can call Toll Free No. **155255** or **1800 4254 732**.
4. Apart from the above options, if it is felt necessary by the complainant to send the communication in physical form, the same may be sent to IRDAI addressed to:

   General Manager
   Insurance Regulatory and Development Authority of India(IRDAI)
   Policyholder's Protection & Grievance Redressal Department – Grievance Redressal Cell.
   Sy.No.115/1, Financial District, Nanakramguda,
   Gachibowli, Hyderabad – 500 032.

No loading shall apply on renewals based on individual claims experience.

Insurance is the subject matter of solicitation.

17. 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. For Claim settlement under reimbursement, the Company will pay the policyholder. 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.

18. Specific Terms and Clauses

1. Alteration to the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement signed and stamped by Us. No one except Us can change or vary this Policy.

1. In case of non-disclosure of a condition, we can incorporate additional waiting period of not exceeding 36 months for the said undisclosed disease or condition from the date the un-disclosed condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.
2. Where the non-disclosed condition allows us to continue the coverage by levying extra premium or loading or Co-payment based on the objective criteria laid down in the Board approved underwriting policy, we shall levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, If the un-disclosed condition is surfaced before the expiry of the policy term, we may charge the extra premium or loading retrospectively from the first year of issuance of the policy or renewal, whichever is later.

2. Material Change

It is a Condition Precedent to Our liability under the Policy that the Policyholder shall immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business at his own expense (refer Annexure 5). We may, in its discretion, adjust the scope of cover and/or the premium paid or payable, accordingly. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the contract.

3. Change of Policyholder

The policyholder may be changed only at the time of Renewal of the Policy. The new Policyholder must be a member of the Insured Person's immediate family. The renewed Policy shall be treated as having been renewed without break.

The Policyholder may be changed upon request in case of his demise.

4. No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Policyholder/Insured Person which is in Our possession and not specifically informed by the Policyholder/Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

5. Limitation of Liability

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

6. Records to be maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period or until final adjustment (if any) and resolution of all Claims under this Policy.

7. **Territorial Jurisdiction**

The geographical scope of this Policy applies to events within India. All admitted or payable claims shall be settled in India in Indian rupees.

8. **Policy Disputes**

Any and all disputes or differences under or in relation to this Policy herein shall be determined by Indian law and shall be subject to the jurisdiction of the Indian Courts.

9. **Loading**

We shall apply a risk loading on the premium payable for certain specific conditions as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Schedule of Insurance Certificate. These loadings are applied from the inception of the initial Policy including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured).

We will inform You about the applicable risk loading through post/courier/email/phone. You shall revert to Us with your written consent and additional premium (if any), within 7 days of the issuance of such counter offer. In case, you neither accept the counter offer nor revert to Us within 7 days, we shall cancel Your application and refund the premium paid within the next 7 days.

10. **Renewal conditions**

i. This Policy will automatically terminate at the end of the Policy Period. This Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium. All Renewal application should reach Us on or before the Policy Period End Date.
ii. We may in Our sole discretion, revise the Product and Renewal premium payable under the Policy provided that revision to the Renewal premium are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
iii. The premium payable on renewal shall be paid to Us on or before the Policy Period End Date and in any event before the expiry of the Grace Period. For the purpose of this provision, Grace Period means a period of 15 days in case of monthly payments and 30 days in case of quarterly and half-yearly and yearly payments immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity benefits such as Waiting Periods and coverage of Pre Existing Diseases. If the premium is paid in instalments, coverage will still be available during the grace period,
iv. Renewal of the Policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by You.
v. We reserve the right to carry out underwriting in relation to any alterations like increase/decrease in Sum Insured, change in plan/coverage, addition/deletion of members, addition/deletion of Medical Conditions, request at the time of Renewal of the Policy. Any request for acceptance of changes on renewal will be subject to underwriting. The terms and conditions of the existing Policy will not be altered.
vi. This product may be withdrawn by Us after due approval from the IRDAI. In case this product is withdrawn by Us, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDAI. We

shall duly intimate You regarding the withdrawal of this product and the options available to You at the time of Renewal of this Policy.

vii. In case of floater policies, children attaining 25 years at the time of renewal will be moved out of the floater into an individual cover however all continuity benefits on the policy will remain intact. Cumulative Bonus earned will be suitably passed on the fresh policy of child.

11. **Communications & Notices**

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

i. To Us, at the address as specified in Schedule of Insurance Certificate
ii. The Policyholder's, at the address as specified in Schedule of Insurance Certificate
iii. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us
iv. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

12. **Overriding Effect of Policy Schedule**

In case of any inconsistency in terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

a. Policy Termination:

The policy can also be terminated by Us if:

a. Any insured person or any person acting on behalf of either has acted in a dishonest and fraudulent manner, under or in relation to this Policy;
b. You or any insured person has not disclosed any true, complete and all correct facts in relation to the Policy; and/or;
c. Continuance of the Policy poses a moral hazard.

The Policy will be automatically terminated in the following circumstances:

a. Individual Policy:
   The Policy shall automatically terminate in case of death of the insured person.
b. Family Floater Policy:
   The Policy shall automatically terminate in the case of death of all the insured persons

13. **Other Terms and Conditions**

1. Claim Procedure

Provided that the due adherence/observance and fulfilment of the terms and conditions of this Policy (conditions and all Endorsements hereon are to be read as part of this Policy) shall so far as they relate to anything to be done or not to be done by the Insured and / or Insured person be a condition precedent to any liability of the Company under this Policy. Cashless and Reimbursement both Claims will be settled through TPA. The Claims Procedure is as follows:

a. For admission in Network Hospital (Cashless Claims)

Insured Person shall call the TPA helpline and furnish Membership Number, Policy Number and the Name of the Patient within 72 hours before admission to hospital for planned hospitalization and not later than 48 hours of admission in case of emergency hospitalization. The insured shall also provide to the TPA by e-mail or through TPA's web portal, the details of hospitalization like diagnosis, name of hospital, duration of stay in hospital, estimated expenses of hospitalization etc. in the prescribed form available with the Insurance help desk at the Hospital. The Insured shall also provide any additional information or medical record as may be required by the medical panel of the TPA. After establishing the admissibility of the claim under the policy, the TPA shall provide a pre-authorization to the hospital guaranteeing payment of the hospitalization expenses subject to the sum insured, terms conditions and limitations of the policy. The difference between the amount of pre-authorization approved and the final hospital bill owing to deductions such as non-payable items, excluded items, policy sub-limits, co-pay amount, deductible amount etc, shall be borne by the insured.

b. For admission in Non-Network Hospital or into Network Hospital if cashless facility is not availed (Re-imbursement Claims)

- **Notice of claim:** Preliminary notice of claim with particulars relating to Policy number, Name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending hospital, should be given to the Insurer within 72 hours before admission in case of planned hospitalization, and not later than 48 hours or before discharge, in case of emergency hospitalization.
- **Submission of claim:** The insured shall submit the claim form along with attending physician's certificate duly filled and signed in all respects with the following claim documents not later than 30 days from the date of discharge.

Mandatory documents

1. Discharge summary (detailed) describing the nature of the complaints and its duration, treatment given, advice on discharge etc. issued by the Hospital.
2. Death summary in case of death of the insured person at the hospital.
3. First consultation papers
4. Doctor's prescriptions confirming diagnosis/advising hospitalization
5. All test reports such as X-rays, ECG, Scan, MRI, Pathology etc, including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought).
6. Hospital Final Bill and advance and final hospital payment receipts, in Original.
7. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.
8. F.I.R/MLC. in the case of Accidental injury and English translation of the same, if in vernacular language.
9. Detailed self-description stating the date, time, circumstances and nature of injury/Accident in case of claims arising out of injury (in the absence of FIR)
10. Legal heir certificate in the absence of nomination under the policy, in case of death of the proposer. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required.

11. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.
12. Complete medical records of past hospitalization/treatment, if any.
13. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital Or there is non availability of bed in the hospital near insured's place of stay.

Documents to be submitted if specifically sought:

1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart). (if available)
2. Copy of extract of Inpatient Register.
3. Attendance records of employer/educational institution.
4. Attending Physician's certificate clarifying
    - reason for hospitalization and duration of hospitalization
    - history of any self-inflicted injury
    - history of alcoholism, smoking
    - history of associated medical conditions, if any
6. Previous master health check-up records/pre-employment medical records, if any.
7. For b) Cataract claims - IOL sticker c) PTCA claims - Stent sticker. d) Implant sticker for surgeries involving implants
8. Any other document necessary in support of the claim on case to case basis.

The claim documents should be sent to the address stated in the policy schedule.

Disclosure:
All insured persons' personal information collected or held by Royal Sundaram may be used by Royal Sundaram for processing the claims and analysis related to insurance / reinsurance business.

14. **How to Buy Royal Sundaram Policy**

Royal Sundaram policy is sold through various channels like telesales team, direct team, individual agents, our website www.royalsundaram.in, licensed brokers and corporate agents.

1. You should go through the product brochure, policy benefits, exclusions etc to thoroughly understand the product before buying.
2. Proposal Form must be filled. You will be required to provide various information (as accurately as possible) such as;
    - Insured's' name, date of birth, and address.
    - As above for all dependents to be covered by the policy.

- Selection of sum insured & optional covers (if any).
- Disclosure of any Pre-existing Diseases with details.
- Medical history report for the proposed insured, if necessary.
- Height and weight for the proposed insured.
- Signature and date on application, wherever applicable.
- Premium payment collected and receipted
- Selection of Third Party Administrator (TPA)
- Electronic Insurance Account number

3. If You are required to undergo Tele-underwriting/medicals tests as per the chosen Age band, BMI or response to question No. 1 to 4 we would arrange the medical check-up's at Our network of diagnostic centres.

4. Based on the above information we will process Your proposal for Insurance and a policy kit containing the Benefit Schedule, Policy Terms and associated documents will be sent to you.

In case we are unable to underwrite Your proposal, we will intimate the same to You and refund any premium that has been collected. Upon assessment if there is any change in terms or premium is loaded then We will inform You about any revised terms through a counter offer letter. We will issue the Policy only once you accept the counter offer. Where You do not agree to the counter offer we will cancel your proposal and refund any premium collected.

What to do next: If you wish to know more about Royal Sundaram Group Health EcoAdvantage Policy and/or would like a personal quote, speak to our specially trained sales team or your local agent. They'll take time to fully understand your requirements and help you to select the right plan for you.

Web: www.royalsundaram.in

Disclaimer: This is only a summary of the product features and is for reference purpose only. The details of benefits available shall be as described in the policy document, and will be subject to the policy terms, conditions and exclusions. Please call our customer service if you require any further information or clarification.

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938); no person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to life or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or the tables of the insurer. Any person making default in complying with the provision of this section shall be punished with fine, which may extend to ten lakhs rupees.

15. **Annexures:**

Annexure 1 –

List-I – Items for which coverage is not available in the policy,
List II — Items that are to be subsumed into Room Charges,
List III — Items that are to be subsumed into Procedure Charges,

List IV — Items that are to be subsumed into costs of treatment
Annexure 2 – Product Benefits Table
Annexure 3 – Ombudsman Details
Annexure 4 – Premium Illustration
Annexure 5 - Format to be filled up by the proposer for change in occupation of the Insured

Annexure-1

List I – Items for which coverage is not available in the policy

SI No	Items
	BABY FOOD
	BABY UTILITIES CHARGES
	BEAUTY SERVICES
	BELTS/ BRACES
	BUDS
	COLD PACK/HOT PACK
	CARRY BAGS
	EMAIL / INTERNET CHARGES
	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES

23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT

51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II — Items that are to be subsumed into Room Charges

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB

7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)

36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III — Items that are to be subsumed into Procedure Charges

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure 2 – Product Benefit Table

Product Construct	**Group Health EcoAdvantage**	
Policy Period		
Policy Tenure	1 Years	

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Group Health EcoAdvantage
Policy Document

Eligibility and UW Criteria		
Cover Type	Both Individual and Family Floater	
Min Entry Age	Adult : 18 Yrs Child : 91 Days	
Max Entry Age	Adult: 70Yrs Child: 25 Yrs	After 25 years the person will be covered as an adult in a separate policy
Family definitions	2 adults and 4 children	
Base Covers		
Sum Insured	3lakhs| 4 lakhs |5 lakhs	
Room Rent	Upto Rs. 3000 per day, with proportionate deduction	
ICU	Upto Rs. 8000 per day, with proportionate deduction	
In-patient hospitalisation	Upto SI	
Day Care Procedures	Covered upto 25% of SI	
Hospital Daily Cash	A daily cash benefit of Rs. 200 for every 24 hours of hospitalization in the PPN hospitals. Limited to a maximum of 10 days per hospitalization	
Pre Hospitalisation Expenses	15 Days, Upto 25% SI	
Post Hospitalisation Expenses	30 Days, Upto 25% SI	
Road Ambulance	Up to Rs.750 per hospitalisation	

Co- Payment	1) Any claim outside the preferred provider network will attract 25% co-pay 2) Any insured above the age of 60 years will have a mandatory copayment of 30% 3) Copayment will be applicable on any insured in the said age band irrespective of the entry age of the insured	
Modern Treatment Coverage	20% of SI	
AYUSH Treatment	Upto SI	
Cumulative Bonus/ NCB	5% in respect of each claim free year subject to a maximum of 25% of SI, in the event of claim Cumulative Bonus shall be reduced at the same rate	
Health Check-ups	N/A	
Sublimits on Specific disease	The Claim amount payable towards the treatment of following disease, illness, medical condition or injury is subject to a limit of:	
	Treatment	**Limit per claim**
	Appendictomy	65,000
	Surgical management of Stones in Urinary and Biliary systems	65,000
	Hernia repair	60,000
	Hydrocele	50,000
	Uterus removal	70,000
	D & C	20,000

	Surgery for removal of Lump/Cyst/Nodule/polyps	40,000
	Tonsils/Adenoids surgery	40,000
	Surgery for IVDP, Spondylosis, Spondylitis	1,00,000
	Anal Fissure, Fistula, Piles	50,000
	Benign Prostatic Hypertrophy	60,000
	Fess (for Sinustis)	55,000
	Septoplasty (DNS)	45,000
	Cataract (only monofocal lens allowed)	25,000
	Knee/Hip replacement (Unilateral)	1,50,000
	Knee/Hip replacement (Bilateral)	2,00,000
	CABG	2,00,000
Waiting Periods		
Initial Waiting Period	30 Days	Except in case of accidents

Specific Waiting Period	24 months	a) Cataract b) Stones in biliary and urinary systems c) Hernia / Hydrocele d) Hysterectomy for any benign disorder e) Lumps / cysts / nodules / polyps / internal tumours f) Gastric and Duodenal Ulcers g) Surgery on tonsils / adenoids h) Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse i) Fissure / Fistula / Haemorrhoid j) Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media k) Benign Prostatic Hypertrophy l) Knee/Hip Joint replacement m) Dilatation and Curettage n) Varicose veins o) Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis p) Chronic Renal Failure or end stage Renal Failure
Pre Existing Disease Waiting Period	36 months	
Premium Payment Options		
Payment options	Mnthly/Quarterly/Half Yrly/Single Payment	
Note		
Treatment of Copayment	Co-payment shall be applied as demonstrated below - a) If the hospitalisation is within PPN network and the insured person is aged 61 years and above, then the co-payment will be 30% only b) If customer has claimed outside PPN network (25%), aged 61 and above (30%) then total co-payment will be 47.5%	

Annexure 3 – Ombudsman Details
The contact details of **Insurance Ombudsman Office** details are as below:

https://www.cioins.co.in/ContactUs

Contact Details:

Address:

COUNCIL FOR INSURANCE OMBUDSMEN

3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.
Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email: inscoun@ecoi.co.in
Website: http://www.ecoi.co.in/ombudsman.html
Shri M.M.L. Verma, Secretary General
Smt. Moushumi Mukherji, Secretary

WHAT IF I EVER NEED TO COMPLAIN?

We hope, of course, that you will never feel the need to complain. Nevertheless, sometimes things do go wrong. When they do, we want to know straight away, so we can put them right as quickly as possible, and take steps to make sure they don't happen again.

In all instances, call our Customer Services at our Chennai office at 1860 258 0000 or e-mail at care@royalsundaram.in or write us to Royal Sundaram General Insurance Co. Limited, Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

Royal Sundaram General Insurance Co. Limited

IRDAI Registration No.102. | CIN: U67200TN2000PLC045611

Annexure 4 – Premium Illustration

Illustration – 1

Age of Member	**Coverage opted on Individual basis covering each member of the family separately (at single point of time)**		**Coverage opted on Individual basis covering Multiple members of the family under single policy (Sum Insured is available for each member of policy)**				**Coverage opted on family floater basis with overall Sum Insured (Only one sum insured available for all members of family)** ***Premium is calculated as per eldest members age**			
	Premium (Rs)	**Sum Insured (Rs.)**	**Premium (Rs)**	**Discount, if any (Rs.)**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or consolidated premium for all members of family (Rs.)**	**Floater Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
47 43 20 18	NA		N/A				19,175	N/A		5,00,000
N/A			N/A				Total Premium when policy is opted on floater basis is Rs. 19175/-. Sum Insured of Rs. 5,00,000 is available for the entire family.			

Annexure 5

Format to be filled up by the proposer for change in occupation of the Insured

ROYAL SUNDARAM INSURANCE
Sundaram Finance Group

Group Health EcoAdvantage
Policy Document

Policy No	Name of the Insured	Date of birth/Age	Relationship with Proposer	City of residence	Previous Occupation or Nature of Work	New Occupation or Nature of Work

Place: _____

Date: _____

(DD/MM/YYYY)

Proposer's Signature_____

Name:_____