

Royal Sundaram General Insurance Co. Limited

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No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097.
Regd. Office : 21, Patullos Road, Chennai - 600 002

Policy Terms and Conditions

B. PREAMBLE

B.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.

B.2 OPERATIVE CLAUSE

Any amount payable under the policy shall be subject to the terms of coverage, exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured and Cumulative Bonus (if any) specified in the Schedule.

C 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 third gender and references to any statutory enactment includes subsequent changes to the same.

C.1 Standard Definitions

C.1.1 **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

C.1.2 **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

C.1.3 Day Care Treatment:

Day care treatment means medical treatment, and/or surgical procedure which is:

- i. undertaken under General or Local Anesthesia in a hospital/day care center 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.

C.1.4 **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.

- C.1.5 **Emergency Care:** Emergency care means management for an injury which results in symptoms which occurs 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.
- C.1.6 **Hospital**
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:
- has qualified nursing staff under its employment round the clock;
 - 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;
 - has qualified medical practitioner (s) in charge round the clock;
 - has a fully equipped operation theatre of its own where surgical procedures are carried out
 - maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
- C.1.7 **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.
- C.1.8 **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.
- C.1.9 **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.
- C.1.10 **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.
- C.1.11 **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 intensivist charges.
- C.1.12 **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
- C.1.13 **Medical Expenses** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of 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.
- C.1.14 **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.

- C.1.15 **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
- is required for the medical management of injury suffered by the insured;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a medical practitioner;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- C.1.16 **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.
- C.1.17 **Non- Network Provider** means any hospital that is not part of the network.
- C.1.18 **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.
- C.1.19 **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.
- C.1.20 **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- C.1.21 **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an 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.
- C.1.22 **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.

C.2 Specific Definitions

- C.2.1 **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
- C.2.2 **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
- C.2.3 **Family:** Family consists of the proposer and any one or more of the family members as mentioned below:
- 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.

C.2.4 Insured Person means person(s) named in the schedule of the Policy.

C.2.5 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.

C.2.6 Policy period means period of one policy year for which the Policy is issued.

C.2.7 Policy Schedule means the Policy Schedule attached to and forming part of Policy.

C.2.8 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.

D Benefits covered under the policy:

D.1 Base Covers:

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.

D.1.1 Death:

The Company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, on death of the insured person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of insured person following an accident, if after the payment of accidental death claim, it is found that the insured person has survived the accident, then the policyholder has to refund the payment back to the company in consideration of the obligatory guarantee as provided during the claim.

D.1.2 Permanent Total Disablement:

The company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

- a) Total and irrecoverable loss of sight of both eyes or
- b) Physical separation or loss of use of both hands or feet or
- c) Physical separation or loss of use of one hand and one foot or
- d) loss of sight of one eye and Physical separation or loss of use of hand or foot
- e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

b)

D.1.3 Permanent Partial Disablement:

The company shall pay the following percentage of Sum Insured, specified in the policy schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

	Loss Covered	Percentage of Sum Insured
1	Loss of Use/ Physical Separation:	
.	One entire hand	50%
.	One entire foot	50%
.	Loss of Sight of one eye	50%
.	Loss of toes – all	20%
.	Great both phalanges	5%
.	Great – one phalanx	2%
.	Other than great if more than one toe lost	1%
2	Loss of Use of both ears	50%
.		
3	Loss of Use of one ear	20%
.		
4	Loss of four fingers and thumb of one hand	40%
.		
5	Loss of four fingers	35%
.		
6	Loss of thumb	25%
.	- both phalanges	10%
.	one phalanx	
7	Loss of Index finger –three phalanges	10%
.	two phalanges	8%
.	one phalanx	4%
8	Loss of middle finger –three phalanges	6%
.	two phalanges	4%
.	one phalanx	2%
9	Loss of ring finger -three phalanges	5%
.	two phalanges	4%
.	one phalanx	2%
10	Loss of little finger –three phalanges	4%
.	two phalanges	3%
.	one phalanx	2%

1 1 .	Loss of metacarpus - first or second (additional) third, fourth or fifth(additional)	3% 2%
1 2 .	Any other permanent partial disablement	Percentage as as- sessed by the independent Medi- cal Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to sum insured chosen by the policyholder.

Note:

- a) The base sum insured chosen and cumulative bonus, if any, is applicable cumulatively for all the three covers specified under D.1.1, D.1.2 and D.1.3 above i.e, there is a single sum insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.
- b) If the accident occurs during the policy period, benefits covered under D.1.1, D.1.2 and D.1.3 above are payable, even if death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of policy period, but within 12 months from the date of accident.

D.2 Optional Covers:

The covers listed below are optional benefits and shall be available to Insured Persons in accordance with the terms set out in the Policy, if the listed cover is opted.

D.2.1 Temporary Total Disablement:

If the Insured Person sustains an Injury in an Accident during the Policy Period and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable of performing at the time of the Accident (Temporary Total Disablement), the company shall pay the benefit as specified in the policy schedule, till the time the insured person is able to return to work, provided that:

- (i) The period of temporary total disablement shall exceed four consecutive weeks from the date of accident, however, the benefit shall be reckoned from the date of accident and shall be payable for the entire duration of disablement.
- (ii) the compensation payable under this benefit mentioned under Section D.2.1 shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the Sum Insured.
- (iii) The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident.
- (iv) The compensation shall be paid by the company at quarterly intervals, after ascertaining the

amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period

- (v) During the course of payment under this benefit, the company shall have right to call for a certification from an independent medical practitioner with regard to the continuity of temporary total disability specified under this section.
- (vi) The insured shall notify the company immediately on resuming to his occupation/employment. Where it is found that the insured resumed to his occupation/employment without notifying to the company and received the compensation under this cover, the company shall have right to claim the recovery of such benefit paid.

Note: For the purpose of this benefit, “week” is a period of seven consecutive calendar days.

D.2.2 Hospitalisation Expenses due to Accident:

The Company shall indemnify medical expenses incurred for hospitalisation arising due to accident during the policy period, up to the limit of 10% of the base sum insured, specified in the policy schedule.

The hospitalisation expenses shall cover the following:

- i. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home,
- ii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
- iii. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.
(Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day.)
- iv. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
- v. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure carried out to treat the accidental injury covered under the policy.
- vi. Expenses incurred on hospitalization due to accident, under AYUSH (as defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

The following other expenses necessitated due to injury shall also be covered under the optional cover specified under Section D.2.2(b):

- i. Dental treatment.
- ii. Plastic surgery.
- iii. All the day care treatments.
- iv. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

Note: The expenses that are not covered under the section D.2.2 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.

D.2.3 Education Grant:

Following an admissible claim of the insured person under the policy towards Death or Permanent Total Disability of the insured person, the company shall pay a one-time educational grant of 10% of the Base Sum insured (specified in the policy schedule), per child to all dependent children of the Insured provided that:

- a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.
- b) Age of the child or children as the case shall not be more than 25 completed years. **Note:**
 - i. The benefits payable under each of the optional covers D.2.1 , D.2.2 and D. 2.3 are independent and over and above the base sum insured.
 - ii. Claim admissibility under the optional covers “Temporary total disablement” and “hospitalization due to accident” is independent of claim admissibility under the base covers.

D.3 Cumulative bonus:

Sum insured (excluding cumulative bonus) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

Notes:

- i. The cumulative bonus is applicable only in respect of base covers referred at Section D.1.1 , D.1.2 and D.1.2 Addition or reduction of cumulative bonus will be done only if claim made under base covers.
- ii. The CB shall be added and available individually to the insured persons under the policy, if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
- iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- iv. 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.

E EXCLUSIONS (applicable to all sections of the policy)

E.1 Specific Exclusions

E.1.1 EXCLUSIONS (applicable to all sections of the policy)

The Company shall not be liable to make any payments under this policy in respect of:

- (i) Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalisation of the insured person, directly or indirectly due to War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
- (ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person
 - a. from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;
 - b. Whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication.
 - c. Whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.

[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or other-

wise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]

- d. Arising or resulting from the Insured Person committing any breach of law with criminal intent.
- (ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person 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.
- (iv) Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:
 - A. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
 - B. Nuclear weapons material
 - C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
 - D. Nuclear, chemical and biological terrorism
- (v) Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

E.1.2 Exclusions specific to section D.2.2 "Hospitalisation Expenses due to Accident"

The Company shall not be liable to make any payments under this policy in respect of any expenses incurred by the insured person in connection with or in respect of:

- i. 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.
- ii. 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)
- iii. Expenses incurred for treatment of accidental injuries which does not warrant hospitalization.
- iv. Any expenses incurred on Domiciliary Hospitalization and OPD treatment.
- v. Treatment taken outside the geographical limits of India.
- vi. All expenses listed in Annexure-A (List I) of the Policy.

F General Terms and Clauses

F.1 Specific terms and clauses

F.1.1 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 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)

F.1.2 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.

F.1.3 Material Change

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

F.1.4 Automatic Termination of Insurance

This policy shall automatically terminate upon the Insured Person's death or payment of 100% Sum Insured. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

F.1.5 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.

F.1.6 Notice & Communication

- i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- ii. Such communication shall be sent to the address of the Company or through any other electronic mode specified in the Policy Schedule.
- iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

F.1.7 Territorial Limit

The coverage is worldwide except for the optional cover “Hospitalization expenses due to accident”.

The coverage of optional cover “Hospitalization expenses due to accident”, is limited to medical treatment taken in India only.

F.1.8 Multiple policies (Applicable to covers which offer fixed benefits)

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

F.1.9 Multiple policies (Applicable for Section D.2.2 Hospitalisation Expenses due to Accident)

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person 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.
- ii. Insured person 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 shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only have indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

F.1.10 Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

F.1.11 Cancellation

The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Period on Risk	Rate of Premium to be refunded
Up to 1 month	75% of Premium
Up to 3 months	50% of Premium
Up to 6 months	25% of Premium
>6 months	Nil premium

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 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.

F.1.12 Nomination:

The insured person 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.

F.1.13 Renewal of the 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.

- Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
- Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period
- 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.
- 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.
- If not renewed within Grace Period after due renewal date, the Policy shall terminate.

No loading shall apply on renewals based on individual claims experience

F.1.14 Possibility of revision of the premium rates:

The company, with prior approval of IRDAI, may revise or modify the premium rates.

F.1.15 Policy Disputes:

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

F.1.16 Arbitration:

- If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single

arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

- ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of the policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

F.1.17 Premium Payment in Instalments

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. In the event of a claim, all subsequent premium instalments shall immediately become due and payable. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy

F.1.18 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.

F.1.19 Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, insured person may contact the company through:

- i. Website : <https://www.royalsundaram.in/claims>

- ii. Toll Free : 1860 258 0000, 1860 425 0000
- iii. E-mail: care@royalsundaram.in
- iv. Fax : 91-44-7113 7114
- v. Courier :
Royal Sundaram General Insurance Co. Limited Accident & Health Claims Department Vish-
ranthi Melaram Towers
No.2/319 , Rajiv Gandhi Salai(OMR) Karapakkam, Chennai - 600097

F.1.20 Grievances

Grievances Redressal Procedure:

We promise to provide the service you want, but sometimes mistakes can happen. If you're not satisfied with our service, we're here to make it right. Your satisfaction is our main concern, especially when things haven't gone as planned.

Step 1 : Please raise a complaint with us through our Online form, and we would come back to you with a response in 2 business days.

Step 2 : In case you are not satisfied with our online response or have not received any response in 2 business days, you may approach our office at the following address:

Customer Services Team
Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers
No.2/319 , Rajiv Gandhi Salai(OMR) Karapakkam,
Chennai – 600097
Call us at
1860 425 0000
1860 258 0000
Drop us an email
care@royalsundaram.in

Step 3: In case you are not satisfied with our online response or have not received any response in 2 business days, you may approach our office at the following address:

Customer Services Team
Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers
No.2/319 , Rajiv Gandhi Salai(OMR) Karapakkam,
Chennai - 600097
Senior Citizen Redressal :
9500413019
Grievance Redressal Officer :
Mr. T M Shyamsunder, 9500413094
Drop us an email
manager.care@royalsundaram.in
Senior Citizen can Write to us at
seniorcitizengrievances@royalsundaram.in

Step 4 : In case you are not satisfied with our online response or have not received any response in 2 business days, you may approach our office at the following address:

Customer Services Team
Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers

No.2/319 , Rajiv Gandhi Salai(OMR) Karapakkam,
Chennai - 600097

<https://www.cioins.co.in/Ombudsman> Click here to view Office of the Executive Council of Insurers

Drop us an email

head.cs@royalsundaram.in

Step 5 : In case you are not satisfied with the decision/resolution of the Company, you may approach the
IRDAI Grievance Call Center

IRDAI Grievance Call Center

Insurance Regulatory & Development Authority of

India United India Tower, 9th floor, 3-5-817/818

Basheerbagh, Hyderabad- 500 029.

Contact Number: 040-66514888

Call us at

1860 425 0000

1860 258 0000

Drop us an email

gro@royalsundaram.in

Grievance may also be lodged at –

Registration of Complaints in Bima Bharosa by Policyholders:

Can directly register complaint in the Bima Bharosa Portal <https://bimabharosa.irdai.gov.in/>

Can send the complaint through Email to complaints@irdai.gov.in.

Can call Toll Free No. 155255 or 1800 4254 732.

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

F.1.21 Moratorium

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. 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. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

F.1.22 Sanctions Limitation and Exclusion Clause (LMA3100)

No (re)insurer shall be deemed to provide cover and no (re) insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provisions of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union,

United Kingdom or United States of America.

Exclusion Clause for Sanctioned Crude Oil

Notwithstanding anything to the contrary contained herein, the cover provided under this policy expressly excludes any loss of and / or damage to crude oil in stocks sourced or purchased from any country or entity which is a target of sanction, prohibition or restriction to which any (re) insurer may be subject pursuant to the Sanctions and Embargo Clause (hereby referred to as Sanctioned Crude Oil).

In the event of a recoverable loss emanating from an area storing Sanctioned Crude Oil, which spreads and/or impacts other areas of the plant/ stock, subject at all times to the Sanctions and Embargo Clause cover shall be provided for all such areas of the plant/stock including the storage tanks where Sanctioned Crude Oil is stored and the non-Sanctioned Crude Oil in stock that may be in the same storage tank(s) and only the Sanctioned Crude Oil in stock will be excluded.

Subject always to the terms, conditions and exclusions of the policy, any processed product that contains Sanctioned Crude Oil shall, to the extent permitted under the Sanctions and Embargo Clause be covered under this policy.

To the extent permitted under the Sanctions and Embargo Clause if any (re) insurer is not able to cover and/or pay claim due the Sanctions and Embargo Clause, only that amount not payable due to the Sanctions and Embargo Clause shall be excluded.

In the event of a loss hereunder to crude oil stocks, the indemnity amount shall, to the extent permitted under the Sanctions and Embargo Clause, be calculated by making an adjustment to exclude Sanctioned Crude Oil in accordance with the latest import / blending log as maintained by the Scheduling and Planning department (or equivalent) at the Refinery location of the incurred loss.

G Other terms and conditions

G.1 CLAIM PROCEDURE

G.1.1 Notification of claim:

- i. Intimation about an event or occurrence that may give rise to a claim under this policy must be given within 30 days of its happening.
- ii. Claims for insurance benefits must be submitted to the Company not later than one (1) month after the completion of the treatment or after transportation of the mortal remains/ burial in the event of Death.
- iii. If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency, the company shall be informed within 24 hours of the admission of the insured person in Hospital.

Note: The Company will examine and relax the time limit mentioned herein above depending upon the merits of the case.

G.1.2 Documents to be submitted:

G.1.2.I Basic documents required for All claims

- i. Duly completed claim form

- ii. Photo Identity Proof of the insured person
- iii. Copy of FIR/ Panchnama /Police Inquest Report (wherever these reports are required as per the circumstance of the Accident) duly attested by the concerned Police Station
- iv. Copy of Medico Legal Certificate (wherever it is required as per the circumstance of the Accident) duly attested by the concerned Hospital
- v. Any other relevant document required by the Company for assessment of the claim

G.1.2.II Documents required in case of Death covered under Section D.1.1

- i. Death certificate;
- ii. Post Mortem Report (if conducted);
- iii. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.
- iv. Copy of FIR/ Panchnama /Police Inquest Report (wherever these reports are required as per the circumstance of the Accident) duly attested by the concerned Police Station
- v. Panchanama / Accident report
- vi. Chemical analysis report of viscera / blood sample
- vii. Admission / Discharge / Death summary issued by hospital authority
- viii. English translation of vernacular documents

G.1.2.III Documents required in case of Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD), covered under Sections D.1.2 and D.1.3

- i. Original treating Medical Practitioner's certificate describing the disablement
- ii. Original Discharge summary from the Hospital
- iii. Disability certificate issued by treating Medical Practitioner
- iv. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable.
- v. Copy of FIR/MLC/Accident register

G.1.2.IV Documents required in case of Temporary Total Disablement (TTD), covered under Section D.2.1

- i. Original treating Medical Practitioner's certificate confirming the disability
- ii. Original Discharge summary from the Hospital
- iii. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable
- iv. Leave/Absence Certificate from Employer (If Employed)
- v. Medical Practitioner's certificate confirming the Injury and advising rest/ unfit to work for specified number of days
- vi. Fitness Certificate issued by the treating doctor.
- vii. Copy of FIR/MLC/Accident register

G.1.2.V Documents required for coverage under Section D.2.2 - Hospitalisation Expenses due to Accident:

- i. Discharge Summary from The Hospital

- ii. Medical & Investigation reports
- iii. Prescriptions, and consultation papers of the treatment
- iv. Any other medical, investigation reports, as applicable

G.1.2.VI Documents required for coverage under Section D.2.3 - Education Grant:

- i. Proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate.
- ii. Photo Identity Proof of Child
- iii. Age proof of Child
- iv. Bonafide Certificate issued by the educational institution confirming that he/she is a fulltime student of the institution

G.1.3 Claim Settlement

- 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 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.
- v. (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)

G.1.4 Payment of Claim

All claims under the policy shall be payable in Indian currency only

G.2 TABLE OF BENEFITS

Name	Saral Suraksha Bima, Royal Sundaram General Insurance Co. Limited
Product Type	Individual
Category of Cover	All the covers are benefit based except the optional cover “Hospitalisation Expenses due to Accident” which is indemnity based.
Sum insured	On Individual basis – SI shall apply to each individual family member
Policy Period	1 year
Base covers	<ul style="list-style-type: none"> i. Death ii. Permanent total disablement iii. Permanent partial disablement
Optional	<ul style="list-style-type: none"> i. Temporary total disablement ii. Hospitalisation Expenses due to Accident iii. Education grant

covers	
Cumu- lative bonus	Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured.

Annexure-A

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

S I N o	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	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 BEDCHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES

8	
2	CONVEYANCE CHARGES
9	
3	MEDICAL CERTIFICATE
0	
3	MEDICAL RECORDS
1	
3	PHOTOCOPIES CHARGES
2	
3	MORTUARY CHARGES
3	
3	WALKING AIDS CHARGES
4	
3	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
5	
3	SPACER
6	
3	SPIROMETRE
7	
3	NEBULIZER KIT
8	
3	STEAM INHALER
9	
4	ARMSLING
0	
4	THERMOMETER
1	
4	CERVICAL COLLAR
2	
4	SPLINT
3	
4	DIABETIC FOOT WEAR
4	
4	KNEE BRACES (LONG/ SHORT/ HINGED)
5	
4	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
6	
4	LUMBO SACRAL BELT
7	
4	NIMBUS BED OR WATER OR AIR BED CHARGES
8	
4	AMBULANCE COLLAR
9	
5	AMBULANCE EQUIPMENT
0	
5	ABDOMINAL BINDER
1	
5	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
2	
5	SUGAR FREE Tablets
3	
5	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medicalpharmaceuticals payable)
4	
5	ECG ELECTRODES
5	
5	GLOVES

6	
5	NEBULISATION KIT
7	
5	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RE-
8	COVERY KIT, ETC]
5	KIDNEY TRAY
9	
6	MASK
0	
6	OUNCE GLASS
1	
6	OXYGEN MASK
2	
6	PELVIC TRACTION BELT
3	
6	PAN CAN
4	
6	TROLLY COVER
5	
6	UROMETER, URINE JUG
6	
6	VASOFIX SAFETY
7	

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

S r N o	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
1 0	Slippers
1 1	Tissue Paper
1 2	Tooth Paste
1 3	Tooth Brush
1 4	Bed Pan
1 5	Face Mask
1 6	Flexi Mask
1 7	Hand Holder
1 8	Sputum Cup
1 9	Disinfectant Lotions
2 0	Luxury Tax
2 1	Hvac
2 2	House Keeping Charges
2 3	Air Conditioner Charges
2 4	Im Iv Injection Charges
2 5	Clean Sheet
2 6	Blanket/Warmer Blanket
2 7	Admission Kit
2 8	Diabetic Chart Charges
2 9	Documentation Charges / Administrative Expenses
3 0	Discharge Procedure Charges
3 1	Daily Chart Charges
3 2	Entrance Pass / Visitors Pass Charges
3 3	Expenses Related To Prescription On Discharge

3 4	File Opening Charges
3 5	Incidental Expenses / Misc. Charges (Not Explained)
3 6	Patient Identification Band / Name Tag
3 7	Pulseoxymeter Charges

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

S r N o .	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
1 0	Arthroscopy And Endoscopy Instruments
1 1	Microscope Cover
1 2	Surgical Blades, Harmonicscalpel,Shaver
1 3	Surgical Drill
1 4	Eye Kit
1 5	Eye Drape

1 6	X-Ray Film
1 7	Boyles Apparatus Charges
1 8	Cotton
1 9	Cotton Bandage
2 0	Surgical Tape
2 1	Apron
2 2	Torniquet
2 3	Orthobundle, Gynaec Bundle

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

S r N o .	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\Spirit\ Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges- Diet Charges
1 0	Hiv Kit
1 1	Antiseptic Mouthwash

1 2	Lozenges
1 3	Mouth Paint
1 4	Vaccination Charges
1 5	Alcohol Swabes
1 6	Scrub Solution/ Sterillium
1 7	Glucometer& Strips
1 8	Urine Bag

Council for Insurance Ombudsmen

Contact details:

Address:

Council for Insurance Ombudsmen,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

INSURANCE OMBUDSMAN OFFICE LIST

The contact details of **Insurance Ombudsman Office** details are as below:

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

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

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