UIN:IRDA/NL-HLT/FGII/P-H/V.I/72/13-14
BAP UIN: FGIHLIP14002V021314

A. Salient Features of the policy

1. If **You** contract any disease or suffer from any **Illness** or **Accident** and if such **Illness** or **Accident** shall require **You** to incur **Inpatient care**/**Emergency Care** expenses for medical/ surgical treatment at any **Hospital** in India, upon **Medical Advice** of the duly qualified **Medical Practitioner**, **We** will pay **You** the amount of such expenses in excess of the **Deductible** per hospitalisation that are the reasonable charges which are medically necessarily and incurred in respect by or on behalf of **You** up to limits indicated but not exceeding the **Sum Insured** during the period stated in the Policy **Schedule**. In the event of any claims becoming admissible under the **Policy**, **We** will pay to **You** or the Nominee as under:
2. **Room Rent**, Board & Nursing Expenses as provided by the **Hospital**/ **Nursing Home** charges.
3. Surgeon, Anaesthetist, **Medical Practitioner**, Consultants, Specialists Fees.
4. Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Cost of Pacemaker, prosthesis/ internal implants and any **Medical Expenses** incurred which is integral part of the operation.
5. Pre– hospitalisation **Medical Expenses** incurred within 60 days prior to **Hospitalisation** due to **Illness**/ **Injury** sustained.
6. Post– hospitalisation **Medical Expenses** incurred within 90 days after the date of discharge from the **Hospital**.

Deductible amount stated in the **Schedule** shall be borne by **You** in respect of each and every Claim made under this **Policy**. **Our** liability to make any payment under the **Policy** is in excess of the **Deductible**. For the purpose of calculation of the **Deductible** per hospitalisation any expenses incurred on room and boarding, nursing expenses, surgeon's, anesthetist, **Medical Practitioner**s, consultants and specialist's fees, anesthesia, Blood, Oxygen, Operation theater charges, surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, cost of Pacemaker and similar expenses will be taken into account. However Pre-hospitalisation and Post- hospitalisation expenses will not be taken into account.

B. Definitions

1) **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2) **Any one Illness** means continuous Period of **Illness** and it includes relapse within 45 days from the date of last consultation with the **Hospital**/**Nursing Home** where treatment may have been taken.
3) **Day care expenses** means the medical treatment costs necessary and reasonable in scope for a Day Care Procedure preauthorized by **Us** and done in a network **Hospital** to the extent that such cost does not exceed the **Reasonable and Customary Charges** in the locality for the same Day Care Procedure.
4) **Day care treatment** refers to medical treatment, and/or **Surgical Procedure** which is:
   i. undertaken under General or Local Anesthesia in a **Hospital**/**Day Care Centre** in less than 24 hrs because of technological advancement, and
   ii. which would have otherwise required a hospitalisation of more than 24 hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition.
5) **Deductible** is a cost-sharing requirement under a health insurance **Policy** that provides that the **Insurer** will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/ hours in case of **Hospital** cash policies which will apply before any benefits are payable by the **Insurer** . A **Deductible** does not reduce the **Sum Insured**.
6) **Diagnostic Centre** means the diagnostic centers which have been empanelled by **Us** as per the latest version of the **Schedule** of diagnostic centers maintained by **Us**, which is available to **You** on request.
7) **Family** means and includes **You**, **Your** Spouse and **Your** two **Dependant Child/Children** up to the age of 25 years.
8) **Hospital/Nursing Home** means any institution established for in-patient care and **Day care treatment** of **Illness** and/ or **Injuries** and which has been registered as a **Hospital** with the local authorities under Clinical Establishments (Registration and Regulation)Act,2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

   -has qualified nursing staff under its employment round the clock;

   -has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;

   -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 will make these accessible to the insurance company's authorized personnel.
9) **Hospitalisation** means admission in a **Hospital** for a minimum period of 24 **Inpatient care** consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.
10) **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.
11) **Medical Practitioner** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence. The registered practitioner should not be the insured or close **Family** members.
12) **Network Provider** means **Hospitals** or health care providers enlisted by an **Insurer** or by a TPA and **Insurer** together to provide medical services to an insured on payment by a **Cashless facility**.
13) **Primary Insurer** means the **Insurer** with whom the insured person first lodges his claim for hospitalisation expenses.
14) **Policy** means the complete documents consisting of the **Proposal**, Policy wording, **Schedule** and Endorsements and attachments if any.
15) **Policy Period** means the period commencing with the start date mentioned in the **Schedule** till the end date mentioned in the **Schedule**.
16) **Pre-hospitalisation Medical Expenses** means **Medical Expenses** incurred immediately before the Insured Person is Hospitalised, 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.
17) **Post-hospitalisation Medical Expenses** means **Medical Expenses** incurred immediately after the Insured Person is discharged from the **Hospital** 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.
18) **Pre-existing Disease** means any condition, ailment or **Injury** or related condition(s) for which **You** had signs or symptoms, and / or were diagnosed, and / or received **Medical Advice** / treatment within 48 months to prior to the first **Policy** issued by the **Insurer**.

19) **Proposal** means the standard application form for insurance cover submitted to the **Insurer** along with all information for the purpose of enabling the **Insurer** to decide whether or not it is willing to grant cover and, if so, the terms on such cover.

20) **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.

21) **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the **Illness** / **Injury** involved.

22) **Schedule** means that portion of the **Policy** which sets out **Your** personal details, the type of insurance cover in force, the period and the **Sum Insured**. Any Annexure or Endorsement to the **Schedule** shall also be a part of the **Schedule**.

23) **Sum Insured** means the amount stated in the **Schedule**, which is the maximum amount **We** will pay for claims made by **You** in one **Policy Period** in excess of the **Deductible** amount, irrespective of the number of claims **You** make.

24) **Surgery** or **Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an **Illness** or **Injury**, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a **Hospital** or **Day Care Centre** by a **Medical Practitioner**.

25) **We, Our, Us, Insurer** means Future Generali India Insurance Company Limited.

26) **You, Your, Yourself** means the Insured Person shown in the **Schedule**.

27) **Co-payment** is a cost-sharing requirement under a health insurance **Policy** that provides that the policyholder/ insured will bear a specified percentage of the admissible claim amount. A **Co-payment** does not reduce the **Sum Insured**.

28) **Dependant Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

29) **Domiciliary Hospitalisation** means medical treatment for an **Illness**/disease/**Injury** which in the normal course would require care and treatment at a **Hospital** but is actually taken while confined at home under any of the following circumstances:

a. the condition of the patient is such that he/ she is not in a condition to be removed to a **Hospital**, or

b. the patient takes treatment at home on account of non availability of room in a **Hospital**.

30) **Emergency Care** means management for a severe **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.

31) **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a **Policy** in force without loss of continuity benefits such as waiting periods and coverage of preexisting diseases. Coverage is not available for the period for which no premium is received.

32) **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.

33) **Inpatient care** means treatment for which the insured person has to stay in a **Hospital** for more than 24 hours for a covered event.

34) **Medically Necessary** treatment is defined as any treatment, tests, medication, or stay in **Hospital** or part of a stay in **Hospital** which

a. is required for the medical management of the **Illness** or **Injury** suffered by the insured;

b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. must have been prescribed by a **Medical Practitioner**,

d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

35) **Non- Network** means any **Hospital**, **Day Care Centre** or other provider that is not part of the network.

36) **OPD treatment** is one 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.

37)

a. **Acute condition** - is a disease, **Illness** or **Injury** that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ **Illness**/ **Injury** which leads to full recovery.

b. **Chronic condition** - A chronic condition is defined as a disease, **Illness**, or **Injury** that has one or more of the following characteristics:

i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

ii) it needs ongoing or long-term control or relief of symptoms

iii) it requires **Your** rehabilitation or for **You** to be specially trained to cope with it

iv) it continues indefinitely

v) it comes back or is likely to come back.

38) **Day Care Centre** means any institution established for **Day care treatment** of illness and / or injuries or a medical set -up 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:-

-has qualified nursing staff under its employment

-has qualified **Medical Practitioner**/s in charge

-has a fully equipped operation theatre of its own where surgical procedures are carried out

-maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

39) **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**.

40) **Medical Advice** means any consultation or advice from a **Medical Practitioner** including the issue of any prescription or repeat prescription.

41) **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.

42) **New Born Baby** means baby born during the **Policy Period** and is aged between 1 day and 90 days, both days inclusive.

43) **Cumulative Bonus** shall mean any increase in the **Sum Insured** granted by the **Insurer** without an associated increase in premium.

44) **Maternity Expense** shall include –a)medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation)

b) expenses towards lawful medical termination of pregnancy during the policy period.

45) **Dental Treatment** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and **Surgery** excluding any form of cosmetic **Surgery**/ implants.

46) **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.

47) **Unproven/ Experimental Treatment -** Treatment including drug experimental therapy which is not based on established medical practice in India is unproven or experimental treatment.

48) **Condition Precedent** shall mean a **Policy** term or condition upon which the **Insurer**'s liability under the **Policy** is conditional upon.

49) **Notification of Claim** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

50) **Disclosure to information norm:** The **Policy** shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

51) **Cashless facility** means a facility extended by the **Insurer** to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the **Network Provider** by the **Insurer** to the extent pre-authorization approved.

52) **Subrogation** shall mean the right of the **Insurer** to assume the rights of the insured person to recover expenses paid out under the **Policy** that may be recovered from any other source.

53) **Contribution** is essentially the right of an **Insurer** to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of **Sum Insured**.

This clause shall not apply to any Benefit offered on fixed benefit basis.

54) **Renewal** defines 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 all waiting periods.

55) **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for **Pre-existing** conditions and time-bound exclusions if he/she chooses to switch from one **Insurer** to another.

56) **Room rent** means the amount charged by a **Hospital** for the occupancy of a bed on per day (24 hours) basis and shall include associated **Medical Expenses**.

57) **Alternative Treatments** are forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

C. GENERAL EXCLUSIONS

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

1. **Pre-existing** diseases/ condition: Benefits will not be available for Any condition, ailment or **Injury** or related condition(s) for which **You** have been diagnosed, received medical treatment, had signs and/ or symptoms, prior to inception of **Your** first High Deductible Health Insurance Policy, until 48 consecutive months have elapsed, after the date of inception of the first High deductible Health Insurance Policy.

   This Exclusion shall cease to apply if **You** have maintained the Health Insurance Policy .with **Us** for a continuous period of a full 4 years, without break from the date of **Your** first similar **Policy** (high deductible policy)**.**

   In case of change in plan from a lower **Deductible** plan to higher **Deductible** plan this

   Exclusion shall apply afresh only to the extent of the amount by which the limit of indemnity has been increased (i.e. enhanced **Sum Insured**) if the **Policy** is a **Renewal** of similar (high deductible policy) **Policy** without break in cover.

2. **30-day Exclusion: Medical Expenses** incurred for any **Illness** diagnosed or diagnosable within 30 days of the commencement of the **Policy Period** except those incurred as a result of accidental Bodily Injury. This Exclusion shall apply only to the extent of the amount by which the limit on indemnity has been increased if the **Policy** is a **Renewal** of similar **Policy** (high deductible policy) without break in cover.

3. **Waiting period for specified diseases/ ailments/ conditions:**

   3.1. **Medical Expenses** incurred during the first three consecutive annual periods during which **You** have the benefit of a similar High deductible Policy with **Us** in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such joint replacement surgery is necessitated by accidental Bodily Injury.

   3.2. In case of change in plan from a lower **Deductible** plan to higher **Deductible** plan this Exclusion shall apply afresh only to the extent of the amount by which the limit of indemnity has been increased (i.e. enhanced **Sum Insured**) if the **Policy** is a **Renewal** of similar High **Deductible Policy** without break in cover.

4. **Permanent Exclusions: We** will not pay for any expenses incurred by **You** in connection of the following:

   4.1. **Injury** or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not).

   4.2. Circumcision, unless necessary for treatment of a disease, not excluded hereunder or as may be necessitated due to an **Accident**. Vaccination (except post- bite) inoculation, cosmetic treatments (for change of life or cosmetic or aesthetic treatment of any description), plastic surgery other than as may be necessitated due to an **Accident** or as a part of any **Illness**, refractive error corrective procedures, **Unproven/ Experimental treatment**, investigational or unproven procedures or treatments, devices and pharmacological regimens of any description.

   4.3. Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces, stocking, Glucometer and the like), namely that equipment used externally for the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose, such cost of all appliances/ devices whether for diagnosis or treatment after discharge from the **Hospital**.

   4.4. **Dental Treatment** or **Surgery** of any kind unless requiring **Hospitalisation** as a result of accidental Bodily injury.

   4.5. The treatment of obesity (including morbid obesity) and other weight control programs, services and supplies.

   4.6. Expenses incurred towards treatment of **Illness**/ disease/ condition arising out of alcohol use/ misuse or abuse of alcohol, substance or drugs (whether prescribed or not).

   4.7. Convalescence, general debility, ''Run-down'' condition or rest cure, venereal disease, intentional self-injury.

   4.8. Invitro fertilization (IVF), Gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation; voluntary medical termination of pregnancy; any treatment related to infertility and sterilization.

   4.9. **Maternity Expenses** for treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of this, including caesarian section. However, this exclusion will not apply to abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and Certification by Gynecologist that it is a life threatening.

   4.10. All expenses arising out of any condition directly or indirectly caused to or associated with Human T - Cell Lymph tropic

Virus type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or Human Immunodeficiency Virus or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.

4.11. Congenital Internal and/ or external **Illness**/ disease/ defect anomaly.

4.12. Charges incurred at **Hospital** or **Nursing Home** primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or **Injury**, for which confinement is required at a **Hospital**/ Nursing Home.

4.13. Vitamins, tonics, nutritional supplements unless forming part of the treatment for **Injury** or disease as certified by the attending Physician.

4.14. **Injury** or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.

4.15. Costs incurred on all methods of treatment including **Alternative Treatments** other than Allopathy.

4.16. Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.

4.17. Any treatment received in convalescent home, convalescent **Hospital**, health hydro, nature care clinic or similar establishments.

4.18. Outpatient Diagnostic, Medical and Surgical procedures or treatments (OPD treatment), non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.19. Doctor's home visit charges during pre and post hospitalisation period, Attendant Nursing charges

4.20. Expenses related to donor screening, treatment, excluding **Surgery** to remove organs from the donor in case of a transplant surgery. **We** will not pay the donor's pre- and post- hospitalisation expenses or any other medical treatment for the donor consequent to **Surgery**.

4.21. **Surgery** to correct deviated septum and hypertrophied turbinate.

4.22. Treatment for any mental illness or psychiatric **Illness**.

4.23. Personal comfort and convenience items or services such as television, telephone, barber or beauty service guest service and similar incidental services and supplies

4.24. Standard list of excluded items as notified by IRDA attached as annexure 1.

D. Eligibility :

1. **Age Eligibility**

a. Age of entry: 3 Months – 65 Years. Renewable lifelong

b. Children from 3 Months - 5years can be covered if both the parents are insured with **Us**

c. Children from 6 years to 18 years can be covered if either of the parents is covered with **Us**.

d. Children from 18yrs to 25yrs can be covered as self proposer or as dependents.

2. **Pre Acceptance Medical Tests**

a. **Pre-acceptance medical tests** are not required for all proposers less than 55 years, if the **Proposal** form is clean.

b. For age 55 years and above medical tests are required.

c. In case the **Policy** is issued for that particular client, the client is eligible for 50% of reimbursement of pre-acceptance medical tests charges.

d. All pre-acceptance medical tests will have to be done in Future Generali empanelled diagnostic centers only. The reports would be valid for a period of 30 days from the date of test conducted.

e. **We** shall maintain a list of and the fees chargeable by, institutions where such pre-insurance medical examination may be conducted, the reports from which will be accepted by **Us**. Such list shall be furnished to the prospective policyholder at the time of pre-insurance medical examination.

E. Portability

i) **Portability** will be granted to policy holders of a similar Health Indemnity policy of another **Insurer** to Future Health Surplus policy as per **Portability** guidelines.

ii) **Portability** will be granted subject to the policyholder desirous of porting his **Policy** to Future Health Surplus Policy applying to Future Generali India Insurance Company Ltd at least 45 days before the premium **Renewal** date of his/ her existing **Policy**.

iii) **We** will not be liable to offer **Portability** if policyholder fails to approach **Us** at least 45 days before the premium **Renewal** date.

iv) Where the outcome of acceptance of **Portability** is still awaited from **Us** on the date of **Renewal** the existing policyholder should extend his existing **Policy** with the existing **Insurer** on a short period basis as per the **Portability** guidelines.

v) **Portability** will be allowed for all individual Health Insurance policies issued by non-life insurance companies including family floater policies.

vi) Individual members, including the **Family** members covered under Group Health policy of similar type, of Future Generali India Insurance Company shall have the right to migrate from such a group policy to an Individual/ Family Floater Health Surplus Policy with the same **Insurer**.

F. Claims Procedure

If **You** meet with any accidental Bodily Injury or suffer an **Illness** that may result in a claim, then as a **Condition Precedent** to **Our** liability, **You** must comply with the following:

i) Cashless treatment is only available at a Network Provider. In order to avail of cashless treatment, the following procedure must be followed by **You**:

a) Prior to taking treatment and/or incurring **Medical Expenses** at a Network **Hospital**, **You** must call **Us** and request pre-authorisation by way of the written form **We** will provide.

b) After considering **Your** request and after obtaining any further information or documentation **We** have sought, **We** may if satisfied send **You** or the Network **Hospital**, a pre-authorisation letter. The pre-authorisation letter, the ID card issued to **You** along with this **Policy** and any other information or documentation that **We** have specified must be produced to the Network **Hospital** identified in the pre-authorisation letter at the time of **Your** admission to the same.

c) If the procedure above is followed, **You** will not be required to directly pay for the **Hospitalisation** Expenses above the **Deductible** in the Network **Hospital** that **We** are liable to indemnify under Section II above and the original bills and evidence of treatment in respect of the same shall be left with the Network **Hospital**. Pre-authorisation does not guarantee that all costs and expenses will be covered. **We** reserve the right to review each claim for **Hospitalisation** Expenses and accordingly coverage will be determined according to the terms and conditions of this **Policy**. **You** shall, in any event, be required to settle all other expenses directly.

ii) If pre-authorization is denied by **Us** or if treatment is taken in a Non-Network **Hospital** or if **You** do not wish to avail **Cashless facility**, then:

a) **You** or someone claiming on **Your** behalf must give **Notification of Claim** in writing immediately, and in any event within 48 hours of the aforesaid Illness or Bodily Injury. **You** must immediately consult a **Medical Practitioner** and follow the advice and treatment that he recommends.

b) **You** must take steps or measure to minimise the quantum of any claim that may be made under this **Policy**.

c) **You** must have **Yourself** examined by **Our** medical advisors if **We** ask for this, at the insurers cost.

d) **You** or someone claiming on **Your** behalf must promptly and in any event within 30 days of discharge from a **Hospital** give **Us** the necessary documents (written details of the quantum of any claim along with all original supporting documentation, including but not limited to first consultation letter, original vouchers, bills and receipts, birth/ death certificate (as applicable)) and other information **We** ask for to investigate the claim or **Our** obligation to make payment for it.

e) In the event of the death of the insured person, someone claiming on his behalf must inform **Us** in writing immediately and send **Us** a copy of the post mortem report (if conducted) within 30 days.

f) The periods for intimation or submission of any documents as stipulated (**a**), (**d**), and (**e**) will be waived in case of any hardships being faced by the insured or his representative which is supported by some documentation.

*Note: Waiver of conditions (a) and (e) may be considered where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit. This would also be considered in case of every claim where insured may have intimated **Primary Insurer** only; as he may not know initially that his claim will cross **Deductible**.

iii) In case the originals are required by the primary insurer, **We** would return the original documents to the **Primary Insurer** after stamping the documents for the amount **We** have settled under the **Policy**.

iv) **Settlement of Claims:**

a. **Our** doctors will scrutinize the claims and flag the claim as settled/ Rejected/ Pending within the period of 30 days of the receipt of the last 'necessary' documents.

b. Pending claims will be asked for submission of incomplete documents.

c. Rejected claims will be informed to the Insured Person in writing with reason for rejection.

d. Upon acceptance of an offer of settlement as stated in sub-regulation (5) of the Protection of Policyholders' Interest Regulations, 2000, by **You**, **We** will make payment of the amount due within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, **We** shall be liable to pay interest at a rate which is 2% above the Bank rate prevalent at the beginning of the financial year.

v) **Basis of claims payment**

a) If **You** suffer a relapse within 45 days of the date when **You** last obtained medical treatment or consulted a **Medical Practitioner** and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.

b) If the claim event falls within two **Policy** periods, the claims shall be paid taking into consideration the available **Sum Insured** in the two **Policy** periods, including the deductibles for each **Policy** period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the **Renewal**/due date of premium of health insurance **Policy**, if not received earlier.

c) **We** shall make payment in Indian Rupees only.

G. Fraud

If **You** or any of **Your Family** members make or progress any claim knowing it to be false or fraudulent in any way, then this **Policy** will be void and all claims or payments due under it shall be lost and the premium paid shall become forfeited.

H. Free Look Period

i) The insured will be allowed a period of at least 15 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

ii) If the insured has not made any claim during the free look period, the insured shall be entitled to-

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

b) where the risk has already commenced and the option of return of the **Policy** is exercised by the policyholder, 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.

I. Renewal & Cancellation

i) **Your Policy** shall be renewable lifelong except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured.

ii) This **Policy** may be renewed by mutual consent every year and in such event, the **Renewal** premium shall be paid to **Us** on or before the date of expiry of the **Policy** or of the subsequent **Renewal** thereof. A **Grace Period** of 30 days is permissible for **Renewal**s. Any **Medical Expenses** incurred as a result of disease condition/ **Accident** contracted during the break period would not be admissible under the **Policy**. **We** shall not be bound to give notice that such **Renewal** premium is due.

iii) For **Renewal Proposal** received after completion of **Grace Period** of 30 days, all waiting periods including for Health Check-up, would apply afresh.

iv) There will be no loading on premium for adverse claims experience.

v) There is no **Cumulative Bonus** available under the **Policy**.

vi) **We** may cancel this insurance by giving **You** at least 15 days written notice, and if no claim has been made then **We** shall refund a pro-rata premium for the unexpired Policy Period.

vii) **You** may cancel this insurance by giving **Us** at least 15 days written notice, and if no claim has been made then the **We** shall refund premium on short term rates for the unexpired **Policy Period** as per the rates detailed below.

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

viii) For Family floater policies, in the event of the death of any of the insured members, the cover ceases to exist for that insured and the remaining members would continue to have the coverage until the end of the policy period. Refund in case of the deceased member will be as per pro- rate premium, subject to no claim.

ix) The brochure/ prospectus mentions the premium rates as per the age slabs/ **Sum Insured** for the completed age at every **Renewal** and are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent **Renewal**s and with due notice whenever implemented.

J. Contribution (In case of Multiple Policies)

If **You** or any of **Your Family** members covered under the **Policy** hold two or more policies from one or more insurers to indemnify treatment costs, **We** will not apply the contribution clause, and **You** will have the right to require a settlement of **Your** claim in terms of any of the policies **You** or **Your Family** members hold with any **Insurer**.

i) In all such cases if **You** or **Your Family** members covered choose to claim under **Our Policy** then **We** shall settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the **Policy**.

ii) If the amount claimed under **Our Policy** exceeds the **Sum Insured** after considering the deductibles or co-payment, then **You** shall have the right to choose other concurrent insurers by whom the claim can be settled. In such cases, **We** will settle the claim with contribution clause.

iii) Except in benefit policies, in cases where **You** have policies from more than one **Insurer** to cover the same risk on indemnity basis, **You** shall only be indemnified the hospitalisation costs in accordance with the terms and conditions of **Our Policy**.

iv) If **Your Policy** is renewed with **Us** and the claim event of the insured member (covered in both these policies) falls within these two **Policy** periods, the claims shall be paid taking into consideration the available **Sum Insured** in the two **Policy** periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured subject to the premium being received for the **Renewal** of the health insurance **Policy**.

K. Subrogation

The insured person and any claimant under this **Policy** shall do whatever is necessary to enable the Company to enforce any rights and remedies or obtain relief from other parties to which the Company would become entitled or subrogated upon the Company paying for or making good any loss under this **Policy** whether such acts and things shall be or become necessary or required before or after the insured person's indemnification by the Company. This section is not applicable to any benefit cover if given under the **Policy**.

L. Mandatory Disclosures

a) **Your** Health Surplus policy shall be renewable lifelong if renewed continuously without any break in insurance.

b) The brochure/ prospectus mentions the premium rates as per the age slabs/ **Sum Insured**. Insureds would be charged as per the completed age at every **Renewal**. In case of Family Floater, floater discounts will be applicable for the remaining members (other than primary insured) as per the table given under Section m (ii) of the Prospectus.

c) The premiums as shown in the prospectus/ brochure are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent **Renewal**s and with due notice whenever implemented.

d) **Renewal**s will not be refused or cancellation will not be invoked by **Us** except on ground of fraud, moral hazard or misrepresentation. If **You** prefer to cancel the **Policy** the cancellation will be on short period basis.

e) There will be no loading on premium for adverse claims experience.

f) Terms for enhancing the **Sum Insured**:

i. No increase in **Sum Insured** during the currency of the **Policy**.

ii. In case of change in plan from a lower **Deductible** plan to higher **Deductible** plan Exclusions shall apply afresh only to the extent of the amount by which the limit of indemnity has been increased (i.e. enhanced **Sum Insured**).

g) Detailed exclusions are given under Section c of the Prospectus.

M. Payment of Premium

As per table annexed

This prospectus shall form part of your proposal form, hence please sign as you have noted the contents of this prospectus

Name: _____

Signature: _____

Date: _____

Place: _____

Premium illustration: (All figures in Rs) Goods & Service Tax extra

Plan	A	B	C	D	E
Sum Insured (in Rs)	3 lakhs	5 lakhs	5 lakhs	7 lakhs	10 lakhs
Deductible (in Rs)	2lakhs	2 lakhs	3 lakhs	3 lakhs	5 lakhs
3 months -17 years	**1008**	**1430**	**1414**	**1885**	**2172**
18-35 years	**1248**	**1596**	**1514**	**2207**	**2530**
36-45 years	**1759**	**2477**	**2386**	**3450**	**3909**
46-55 years	**2912**	**3905**	**3810**	**4680**	**5427**
56-65 years	**4596**	**5977**	**5733**	**6772**	**7738**
66-70 years	**7888**	**9555**	**9430**	**11325**	**14308**
71-75 years	**10944**	**12777**	**12044**	**14611**	**18278**
76-80 years	**15777**	**16711**	**15777**	**19044**	**24178**
81- 85 years	**18144**	**19217**	**18144**	**21901**	**27804**
86- 90 years	**16329**	**17296**	**16330**	**19711**	**25024**
91 years & Above	**1377**	**1761**	**1670**	**2207**	**2790**

Family Floater Discounts: Premium for the primary insured remains as per table above.

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

Age	Floater Discount
3 months -17 years	60%
18-35 years	55%
36-45 years	50%
46-55 years	45%
56-65 years	40%
66-70 years	35%
71-75 years	30%
76-80 years	25%
81- 85 years	20%
86- 90 years	20%
91 years & Above	20%

FGH/UW/RET/60/03

CIN: U66030MH2006PLC165287

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

IO No	
App No	
Client Code	
Receipt No	
Payer ID	

UIN:IRDA/NL-HLT/FGII/P-H/V.I/72/13-14
BAP UIN: FGIHLIP14002V021314

FUTURE HEALTH SURPLUS PROPOSAL FORM

IMPORTANT GUIDELINES: 1. Insurance is the contract of utmost good faith requiring of the Proposer and the Insured not only to disclose all material facts but also not to suppress any material facts in response to the questions in the proposal form. 2. It is important to fill all questions, Information for fields marked with asterisk [*] is mandatory. 3. Cover shall commence not earlier than the date and the time of acceptance and subsequent to payment of the premium

Received Date: _____ **Branch Code:** _____ **Branch Name**: _____

Period of Insurance desired: From: dd/mm/ yyyy **To** dd/mm/ yyyy

SECTION I: DETAILS OF THE INSURED/ PROPOSER

1. PROPOSER DETAILS*: Name: ☐Mr. ☐Ms. ☐M/s

2. ADDRESS AND OTHER DETAILS*:

State		**Pin code**	
Telephone no.		**Fax no.**	
Email id			
PAN *		**Aadhaar Number***	
PAN Enrolment Form number		**Aadhaar Enrolment Form number**	

Note: If PAN / Aadhaar numbers are not available and applied for the same kindly provide the enrolment form numbers OR
- *If you doesn't hold PAN and not applied for PAN then kindly submit FORM 60 / 61 as per your income status.*

In case proposer is resident of in the States of Jammu and Kashmir, Assam or Meghalaya and does not submit the Permanent Account Number, needs to submit any one "Officially Valid Document" – please seek your sales person assistance for the form to get signed by designated person.

e-IA Number (e-Insurance Account Number)	*If not available request you to kindly download the form from our website and request you to kindly submit along with this proposal form*

3. GENDER*: ☐ Male ☐ Female

4. DATE OF BIRTH*: ___/____/_____

5. AGE*: _____

6. NATIONALITY*: _____

7. MARITAL STATUS*: ☐Married ☐Single ☐Widow ☐Divorced

8. OCCUPATION*: ☐Service ☐Self Employed ☐Others:____

SECTION II: PRODUCT DETAILS*

Note: For Family Floater plan: - Family means- Self, Spouse and your 2 dependent children up to the age of 25 yrs
Type: ☐ Individual ☐ Family Floater
Plan details

Plan	A	B	C	D	E
Sum Insured (in Rs)	3 lakhs	5 lakhs	5 lakhs	7 lakhs	10 lakhs
Deductible (in Rs)	2lakhs	2 lakhs	3 lakhs	3 lakhs	5 lakhs

SECTION III: DETAILS OF THE INSURED*

DETAILS	PRIMARY INSURED	SPOUSE	CHILD 1	CHILD 2
Name				
Gender				
Date of Birth/ Age				
Height & Weight				
Marital Status				
Nationality				
Educational Qualification				
Occupation				
Organization				
Income				
Nominee Name*				
Relationship with Proposer				
Plan option required in case of individual				
In case of floater (a single plan to be selected)				
Premium				

*In case the nominee is a minor, please provide the name of the guardian also.If parents are covered concurrently child above the age of 90 days can be covered under this policy

SECTION IV: HEALTH DETAILS* (Please answer by writing "yes" or "no" against each of the questions. A mere dash is not sufficient.)

Sr. No.	Question	Primary Insured		Insured 2		Insured 3		Insured 4	
1	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity?	Y/N		Y/N		Y/N		Y/N	
2	Do you regularly consume /smoke Tobacco, Alcohol ?(If yes, specify the details separately in the format below)	Y/N		Y/N		Y/N		Y/N	
	Substance	Qty/ day	No of years since consuming	Qty/ day	No of years since consuming	Qty/ day	No of years since consuming	Qty/ day	No of years since consuming
	Tobacco								
	Alcohol								
3	**Have you ever suffered or are suffering from any of the following:**								
a	Diabetes Mellitus	Y/N		Y/N		Y/N		Y/N	
b	High Blood Pressure, Heart disease including Ischaemic Heart Disease (IHD)/ Rheumatic Heart Disease	Y/N		Y/N		Y/N		Y/N	
c	Chest pain, stroke, asthma, any respiratory condition, cancer or tumor or lump of any kind, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy), slipped disc, backache, any congenital/ birth defects/ disease, AIDS or tested positive for HIV	Y/N		Y/N		Y/N		Y/N	
4	Have you ever received any treatment/ medication due to any medical condition?	Y/N		Y/N		Y/N		Y/N	
5	Any other diseases or ailments not mentioned above?	Y/N		Y/N		Y/N		Y/N	

If answer to any of above is "Yes", please provide details: (For additional information please attach separate sheets)

Details	Primary Insured	Insured 2	Insured 3	Insured 4
Details of the Treating/ Family Doctor	Name: Address:	Name: Address:	Name: Address:	Name: Address:
Name of disease/ illness/ injury suffering from				
Treatment/ medication/ received/ receiving				
When first treated				
Is fully cured?				

SECTION V: OTHER HEALTH INSURANCE INFORMATION*(Details of cover from Future Generali India Insurance Company Ltd or any other Health Insurance)

Details	Primary Insured	Insured 2	Insured 3	Insured 4
Insured member				
Policy or Proposal No				
Company Name				
Basic Sum Insured				
Period of Insurance	From: dd/mm/yy To: dd/mm/yy	From: dd/mm/yy To: dd/mm/yy	From: dd/mm/yy To: dd/mm/yy	From: dd/mm/yy To: dd/mm/yy
Cumulative Bonus amount				
Cumulative Bonus %				
Claims received for				
Claims received/ receivable (Rs.)				

SECTION VI: DECLARATION & AUTHORIZATION*

1. I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
2. I/We understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.
3. I/We further declare that I/we will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
4. I/We declare and consent to the company seeking medical information from any doctor or from a hospital who at anytime has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
5. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory authority."
6. I/We also authorise the insurer to pay claim in case of the insured person's death or if he/she is incapacitated, to the nominee mentioned in the proposal form.
7. I/We hereby acknowledge that I/we have read and understood the contents of the prospectus and have been explained the features, contents and terms of the *Prospectus/Product by the Intermediary/Agent to my/our satisfaction.
8. I agree that this proposal and the declaration shall be the basis of the contract between me and FUTURE GENERALI INDIA INSURANCE CO LTD and I/We agree to accept a policy, subject to the conditions prescribed by FUTURE GENERALI INDIA INSURANCE CO LTD.
9. I hereby authorize the company to authenticate and/or verify my Aadhaar number for e-KYC purpose

☐ I/ We hereby declare that the premium for the said policy is paid out of the legally declared and assessed sources of my/ our income OR

☐ I/ We hereby declare that the premium is paid from the Bank Account of Mr. /Ms. _____, the payment is allowed under the Income Tax Act 1961, and there is insurable interest with the payee.

I/we am/are (please tick all that are applicable) ☐ High Net Worth Individual/s ☐ Non Residential Indian/s ☐ Politically Exposed Person/s ☐ Jeweller/s ☐ Non Governmental Organization ☐ Film Actor/s ☐ Producer/s

IMPORTANT NOTE: The company reserves the right to reject the said proposal or to terminate the insurance contract unilaterally and/or freeze the funds if the Customer, or persons associated with him/her, found to be named in any recognized black list.

Date: _____ Place: _____ Proposer's Name _____ **Proposer's Signature**:_____

I hereby confirm that the product features and terms of the above product have been explained to the prospect in detail (including product suitability) and to the prospects' complete satisfaction. (In case prospect signs in a different language/or is not literate)

Intermediary/Agent Name_____ Intermediary/Agent Signature _____ Prospect's Thumb Impression_____

SECTION VII: PAYMENT DETAILS:

Premium paid by Cash/Cheque No _____Date _____Bank _____ Amount (Rs)_____

GSTIN: _____ (If more than one GSTIN, kindly attach an annexure with details)

Please fill up the request for authorization form attached with this proposal form to receive Claim/ Refund payments if any, directly into your bank account through NEFT if the Premium is more than Rs 25000/-

SECTION VIII: FOR OFFICE USE ONLY:

Intermediary's Name:	**Intermediary's Code:**
Sales Manager's Name:	**Sales Manager's Code:**

SECTION 41. OF INSURANCE ACT, 1938-PROHIBITION OF REBATES:

No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of 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 prospectuses or tables of the Insurer. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.