FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

POLICY WORDINGS
Alpa Bima – Group

Preamble

This Policy is issued to You based on Your Proposal and declarations together/followed by, with any other documents to Us and Your payment of the premium on behalf of all the persons to be insured. This Policy records the contract between Us and You and/or any Insured Person and sets out the terms of insurance and the obligations of each party. Now this contract witnesses to the definitions terms, conditions and exclusions contained herein, or endorsed or otherwise expressed hereon and sets out as stated in Schedule of this policy/contract to the said Insured Person/s claiming payment or upon the happening of an event upon which one or more benefits become payable under the sum insured as stated in the Schedule will be paid by the Company.

A. DEFINITIONS

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

I. Standard Definitions

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

2. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

3. [1]**AYUSH Hospital:** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a) Central or State Government AYUSH Hospital; or
   b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c) AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

4. [2]**AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered.
   AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

6. **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.

7. **Day care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under -
   a. has qualified nursing staff under its employment;
   b. has qualified medical practitioner/s in charge;
   c. has fully equipped operation theatre of its own where surgical procedures are carried out;
   d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

8. **Day care treatment** means medical treatment, and/or surgical procedure which is:
   a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological

[1] Inserted definition of AYUSH Hospital
[2] Inserted definition of AYUSH Day Care

advancement, and
b. 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.

9. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

10. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

11. **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 .

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

13. **Hospital**: A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

14. **Hospitalization** means admission in a **Hospital** for a minimum period of 24 consecutive ***'In- patient Care'*** hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

15. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
    b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        (i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        (ii) it needs ongoing or long-term control or relief of symptoms
        (iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        (iv) it continues indefinitely
        (v) it recurs or is likely to recur

16. **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.

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

18. **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.

19. **Maternity expense/treatment** means**:**
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b. expenses towards lawful medical termination of pregnancy during the policy period.

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

21. **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.

22. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council

of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close Family members.

23. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i. is required for the medical management of the illness or injury suffered by the insured;
    ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. must have been prescribed by a medical practitioner;
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

25. **New Born baby** means baby born during the Policy Period and is aged upto 90 days.

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

27. **Pre-existing Disease** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

28. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

29. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

II. Specific Definitions

31. **Accidental Death** means death due to **Accident**.
[3]
32. **Bank Rate means** Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

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

34. **Family** means and includes **Primary Insured**, **Primary Insured's** Spouse & dependent child/ children (up to a maximum of three children and up to the age of 25 years)
    i. The maximum number of days of **Hospitalisation** as mentioned in the **Schedule** would float over all members of each Family under the **Policy**.
    ii. In the event of more than one **Family** member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole **Family** would be restricted to the number of days as mentioned in the **Schedule** (maximum number of days would float over the **Family**) under the **Policy**

35. **Fingers** or **Toes**, whether in the singular or plural, means the digits of a hand or foot.

36. **Limb** whether in singular or plural, means an arm at or above the wrist or a leg at or above the ankle

37. **Permanent Partial Disablement** means a bodily **Injury** caused by accidental, external, violent and visible means, which as a direct consequence thereof, disables any part of the **Limbs** or organs of the body of the **Insured Person** and which falls into one of the categories listed in the "Table of Events" set out in the **Policy**.

38. **Permanent Total Disablement** means a bodily **Injury** caused by accidental, external, violent and visible means, which as a direct consequence thereof totally disables and prevents the **Insured Person** from attending to any business or **Occupation** of any and

[3] Removed the Specific Definitions – Alternative Treatment

every kind or if he/she has no business or **Occupation**, from attending to his/her usual and normal duties that last for a continuous period of twelve calendar months from the date of the **Accident**, with no hopes of improvement at the end of that period.

39. **Policy** means the complete documents consisting of the Proposal, Policy wording, Schedule and Endorsements and attachments if any.

40. **Policy Period** means the period commencing with the start date mentioned in the Schedule till the end date mentioned in the Schedule**.**

41. **Proposal form** means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

42. **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**.

43. **Survival Period**: At any point of time during the term of the **Policy**, any benefit shall be payable only if the **Insured** is alive for a period of more than or equal to 28 days from the date of the first diagnosis of the Critical illness/ Undergoing for the first time of the **Surgical Procedures**/ for the first time of occurrence of medical events.

44. **Waiting Period**: At no point of time during the term of the **Policy**, any benefit shall be payable for the claim which occurs or where the signs and/ or the symptoms of **Illness**/ condition for the claim has occurred within 90 days of first **Policy** issue Date. **Waiting Period** is not applicable for the subsequent continuous renewals.

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

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

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

B. SCOPE OF COVER

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

I. The Hospital Cash benefit for each continuous and completed period of 24 hours of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Illness, for a maximum of 5 days/ 10 days/ 15 days/ 20 days/ 25 days/ 30 days as per the Schedule.

OR

II. Two times the Hospital Cash benefit for each continuous and completed period of 24 hours required to be spent by the Insured in the Intensive care unit of a Hospital, during any period of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Illness. The benefit would be limited for a maximum period as mentioned in the table below:

	Options					
	5 days	10 days	15 days	20 days	25 days	30 days
Daily Hospital Cash	Maximum up to 5 days during the policy period	Maximum up to 10 days during the policy period	Maximum up to 15 days during the policy period	Maximum up to 20 days during the policy period	Maximum up to 25 days during the policy period	Maximum up to 30 days during the policy period
Daily ICU Cash Benefit	Maximum up to 5 days for each hospitalization and maximum up to 5 days during the policy period	Maximum up to 5 days for each hospitalization and maximum up to 10 days during the policy period	Maximum up to 10 days for each hospitalization and maximum up to 10 days during the policy period	Maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period	Maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period	Maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period

a) In case of Sec I and II, the maximum benefits would however be restricted to 5 days/ 10 days/ 15 days/ 20 days/ 25 days/ 30 days as per the plan opted for each Hospitalisation or all Hospitalisations during the Policy period, for both sections individually or put together.
b) In case the Hospitalisation exceeds the maximum stipulated under Sec I as per the selected plan while adjudicating any claim the benefits under ICU would have precedence over non ICU Hospitalisation.
c) In case the Hospitalisation in ICU exceeds the per Hospitalisation maximum limit of 5 days/ 10 days (as per the plan opted)

or the per Policy period limit of 5 days/ 10 days/ 20 days (as per the plan opted), the remaining period of Hospitalisation in ICU will be paid as per non ICU Hospitalisation benefits subject to the overall Policy maximum of 5 days/ 10 days/ 15 days/ 20 days/ 25 days/ 30 days.

d) For Family Floater cover:
   - The maximum number of days of Hospitalisation as mentioned in the Schedule would float over all members of each Family under the Policy
   - In the event of more than one Family member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole Family would be restricted to the number of days as mentioned in the Schedule (maximum number of days would float over the Family) under the Policy

e) An insured event shall be deemed to be a continuous and completed period of 24 hours as mentioned below:
   i. continuous and completed period of minimum 12 hours of Day Care Treatment, or
   ii. continuous and completed period of minimum 24 hours of Hospitalisation (other than Day Care Treatment)

III. Convalescence Benefit**:**
We will pay a fixed amount only once per Hospitalisation event, as specified in the Policy Schedule, towards convalescence for Hospitalisation more than 10 consecutive days. This benefit is payable only if there is an admissible claim under any of the daily benefits.

This benefit will be applicable for the following options:
(i) 15 days (ii) 20 days (iii) 25 days (iv) 30 days.

The benefit will vary as per the plan opted.

IV. Maternity Benefit Expense Cover:
We will pay for the Hospital Cash benefit for each continuous and completed period of 24 hours of **Hospitalisation** arising from or traceable to pregnancy, childbirth including normal or caesarean section and complications of maternity (including and not limited to medical complications), for a maximum of **5 days / 10 days /15 days/ 20 days/ 25 days/ 30 days** as per the **Schedule**

This benefit is admissible only if incurred in Hospital as in-patient in India.

This benefit will be applicable only for Self or Spouse in a Policy.

a. Claim in respect of delivery for only first two children and/ or operations associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit. In case the first delivery is a twin (more than 1child) delivery, then the second delivery will not be covered.
b. Pre-natal and post-natal expenses including expenses for the new born baby are not covered.
c. No Individual (Employee or Dependent) can be covered more than once in a Policy.

V. Pre-Existing Disease Cover:
We will pay for the Hospital Cash benefit for each continuous and completed period of 24 hours of **Hospitalisation** arising from any condition, ailment or **Injury** which is Pre-Existing, for a maximum of **5 days / 10 days /15 days/ 20 days/ 25 days/ 30 days** as per the **Schedule**

Further, there will be no waiting periods applicable under this policy.

VI. Personal Accident Cover:
It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy that following an **Accidental Bodily Injury** to **Primary Insured Person** which results in any of the events listed in the Table of Events, **We** will pay the **Primary Insured Person** such percentage stated against the event in the Table of Events of the sum insured stated in the **Schedule**.

This benefit will be applicable only for **Primary Insured Person** in a Policy.

The Personal Accident Cover includes the following benefits:
a. **Accidental Death**
b. **Permanent Total Disablement**
c. **Permanent Partial Disablement**

a. Accidental Death
If during the **Policy Year**, the **Primary Insured Person** sustains **Injury** which directly and independently of all other causes results in death of the **Primary Insured Person** within twelve (12) months from the date of **Accident**, then **We** will pay the **Sum Insured** as stated in the **Schedule**.

We will pay the percentage of the Sum Insured shown in the table below:

Event	Percentage of Sum Insured
Accidental Death	**100%**

b. Permanent Total Disablement

If during the **Policy Year**, the **Primary Insured Person** sustains **Injury** which directly results in **Permanent Total Disablement** within twelve (12) months from the date of **Accident**, then **We** agree to pay the percentage of the **Sum Insured** shown in the Table of Events below and as specified in the **Schedule**.

It is clarified that for the purpose of this cover, **Permanent Total Disablement** shall entail one of the following:
i. Permanent total loss of sight of both eyes
ii. Permanent total loss of sight of one eye and physical separation of or the loss of ability to use either one hand or one foot
iii. Permanent total loss and physical separation of or the loss of ability to use both hands or both feet
iv. Permanent total loss and physical separation of or the loss of ability to use one hand and one foot

We will pay the percentage of the Sum Insured shown in the table below:

Event	**% of Permanent Total Disablement Sum Insured**
Permanent Total Disablement:	**100%**
Permanent total loss of sight of both eyes	100%
Permanent total loss of sight of one eye and physical separation of or the loss of ability to use either one hand or foot	100%
Permanent total loss and physical separation of or the loss of ability to use both hands or both feet	100%
Permanent total loss and physical separation of or the loss of ability to use one hand and one foot	100%

c. Permanent Partial Disablement
If during the Policy Year, the **Primary Insured Person** sustains **Injury** which directly results in **Permanent Partial Disablement** within twelve (12) months from the date of **Accident**, then **We** agree to pay the percentage of the **Sum Insured** shown in the Table of Events below and as specified in the **Schedule**. The Table of Events below sets out the events which constitute 'Permanent Partial Disablement'.

We will pay the percentage of the Sum Insured shown in the table below:

Event	**Percentage of Sum Insured**
Permanent Partial Disablement:	**As Follows**
An arm at the shoulder joint	75%
An arm above the elbow joint	70%
A hand at the wrist	50%
An arm beneath the elbow joint	60%
A thumb	25%
An index **Finger**	10%
Any other **Finger**	5%
A leg above mid-thigh	75%
A leg up to mid-thigh	60%
A leg up to beneath the knee	50%
A leg up to mid-calf	45%
A foot at the ankle	40%
A large **Toe**	5%
Any other **Toe**	2%
Permanent loss of sight of one eye	50%
Hearing of one ear	25%
Hearing of both ears	75%
Sense of smell	10%
Sense of taste	5%
Shortening of leg by at least 5%	7%

If the **Permanent Partial Disablement** event not listed above, then the disability percentage certified by the Government Civil Surgeon would be considered under this section.

If there is more than one **Permanent Partial Disablement** due to an **Injury**, the claim amount payable for all such losses put together should not exceed the **Sum Insured** as opted by the **Primary Insured Person** under this section

VI.1 Special Conditions Applicable To Personal Accident Cover
i. If a claim has already been settled for any of the sections under Personal Accident Cover, the amount payable for the subsequent claim/s shall be reduced by the amount/s already paid. Regardless of one or more claims during the Policy Period, the maximum amount payable shall be restricted to the Sum Insured of Personal Accident cover.
ii. If more than one loss results from any Accident, only the one amount, the largest, will paid.
iii. This cover shall immediately cease on payment of a claim for Accidental Death or Permanent Total Disablement of the Insured Person.

VII. <u>Critical illness Cover:</u>

It is hereby declared and agreed that notwithstanding anything to the contrary in the **Policy**, We will pay the **Primary Insured Person** the Sum Insured as a lump sum amount mentioned in the **Policy Schedule**, in case the **Primary Insured Person** is diagnosed as suffering from the listed Critical Illness, provided it occurs or manifests itself during the policy period as a first incidence.

This benefit will be applicable only for **Primary Insured Person** in a Policy.

"Critical Illness", for the purpose of this Policy, includes the following:

A. Cancer of specified severity

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

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

B. Kidney failure requiring regular dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

C. Multiple sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple loss confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

D. Major organ/bone marrow transplant

I. The actual undergoing of a transplant of:

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

II. The following are excluded:

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

E. Open chest CABG (coronary artery bypass graft)

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

F. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

G. Myocardial Infarction (First heart attack of specified severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

H. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s)

The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

I. Permanent Paralysis of limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

VII.1 Special Conditions Applicable To Critical Illness Cover

a. Upon the occurrence of an event of Critical Illness and (subject to the terms, conditions and exclusions of this Policy) without prejudice to the Company's obligation to make payment, this cover shall immediately cease.

C. EXCLUSIONS

C.1. Standard General Exclusions applicable to all sections:

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

a) **Investigation & Evaluation- Code- Excl04**

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

b) **Rest Cure, rehabilitation and respite care- Code- Excl05**

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

(i) Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
(ii) Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

c) **Change-of-Gender treatments: Code- Excl07**

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

d) **Cosmetic or Plastic Surgery: Code- Excl08**

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

e) **Hazardous or Adventure sports: Code- Excl09**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

f) **Breach of law: Code- Excl10**

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

g) **Code- Excl12**

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

h) **Code- Excl13**

Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or a Hospital where the Hospital has effectively become the Insured Person's

home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

i) **Code- Excl14**
Dietary supplements and substances which are available naturally and 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 hospitalisation claim or day care procedures.

j) **Unproven Treatments**: **Code- Excl16**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

k) **Birth control, Sterility and Infertility: Code- Excl17**
Expenses related to Birth Control, sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

C.2. Specific General Exclusions applicable to all sections:

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).
2. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an **Accident**.
3. Vaccination (unless post bite) inoculation, refractive error corrective procedures.
4. Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of Injury.
5. The treatment of obesity (including morbid obesity) and other weight control programs, services and supplies.
6. Hospitalisation for General debility, sexually transmitted disease other than HIV/ AIDS, intentional self-Injury.
7. Hospitalisation arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphtropic Virus type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or Human 5 Immunodeficiency Virus or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome.
8. Congenital external Illness/disease/defect anomaly.
9. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/materials.
10. Costs incurred on all methods of treatment [4]except for Allopathy and AYUSH Treatments.
11. Stem cell implantation/surgery/storage.
12. Any Hospitalisation arising from Insured's participation in any hazardous activity including but not limited to parachuting, hang gliding, and rock or mountain climbing.
13. Hormone replacement therapy.
14. Any treatment including Surgery to remove organs from the donor in case of a transplant surgery.
15. Any Hospitalisation received out of India.
16. Standard list of excluded items as mentioned in our website https://general.futuregenerali.in

C.3. Exclusions specific to Personal Accident Cover:
We will not pay for any compensation, benefit or expenses in respect of Accidental Death, Injury or Disablement of the Insured Person as a consequence of the following:

a. Participation in an actual or attempted felony, riot, crime, misdemeanor or civil commotion.
b. Any Accident of which a contributing cause was the Insured Person's actual or attempted commission of, or wilful participation in, an illegal act or any violation or attempted violation of the law or his resistance to arrest.
c. Whilst engaging in Aviation or Ballooning or whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as passenger(fare paying or otherwise) in any duly licensed standard type of aircraft.
d. Participating in motor racing or trial run as a driver, co-driver or passenger
e. Curative treatments or interventions that the Insured Person carries out or have carried out on his body
f. Pregnancy and childbirth, miscarriage, abortion or complications arising out of any of these
g. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage or under the order of any government or public authority
h. Nuclear energy, radiation
i. Any existing disablement prior to the inception of the Policy
j. Any Medical expenses, services, supplies or treatment or Hospital stay which were not recommended or approved as Medically Necessary by a Medical Practitioner.
k. Expenses incurred for emergency medical evacuation, unless specifically insured
l. Any claim caused by osteoporosis (porosity and brittleness of the bones due to loss of protein from the bones matrix) or pathological fracture (any fracture in an area where Pre-Existing Disease has caused the weakening of the bone) or chronic degenerative diseases if osteoporosis or bone disease or chronic degenerative diseases diagnosed prior to the commencement date of the Policy

[4] Modified the Wording to cover AYUSH treatment into the scope of the Product

m. Expenses incurred on neck belts, wrist bandages, walking sticks, abdomen belts, CPAP and any other similar external aid/ devices, the use of which has been necessitated following an accident, unless specifically insured
n. Bodily Injury caused by or arising from terrorism, except in case where the policy holder is a victim of terrorist act and not abetting terrorism

C.4. Exclusions specific to Critical Illness Cover:
Without prejudice to the exclusions mentioned elsewhere in this document, the following exclusions shall apply to the benefits admissible under this policy:
a. Benefits will not be available for Any Pre- Existing conditions or related condition(s) for which You have been diagnosed, received medical treatment, prior to inception of Your first Policy, unless such a condition is stated in the proposal form and specifically accepted by the Company and endorsed thereon.
b. The Company shall not be liable to make any payment under this Policy in connection with or in respect of any Insured Event, as stated in this Section, occurred or suffered before the commencement of Period of Insurance or arising within the first 90 days of the commencement of the Period of Insurance.
c. Any medical procedure or treatment, which is not medically necessary or not performed by a Doctor.
d. Any treatment relating to birth defects external congenital Illnesses.
e. Treatment by a family member and self-medication .
f. Attempted suicide (whether sane or insane) or intentionally self-inflicted Injury or Illness, or nervous disorder or sexually transmitted conditions other than, Acquired Immune Deficiency Syndrome (AIDS), Human Immune deficiency Virus (HIV) infection.
g. Being under the influence of drugs, alcohol, or other intoxicants or hallucinogens unless properly prescribed by a Physician and taken as prescribed.
h. Diagnosis outside India; unless reaffirmed by Physician in India and subject to presentation of all Claim documents in English.

D. GENERAL TERMS AND CLAUSES

I. Standard General Terms and Clauses

1. **Disclosure to information norm**:
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

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

3. **Migration**
The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get all the accrued continuity benefits in waiting periods as per the IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
https://general.futuregenerali.in/general-insurance/pdf/Guide_to_Portability_and_Migration_25-Mar-2020.pdf

4. **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.

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b. the active concealment of a fact by the insured person having knowledge or belief of the fact;
c. any other act fitted to deceive; and
d. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6. **Nomination**

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

7. **Redressal of Grievance**

In case of any grievance the insured person may contact the company through
Website: https://general.futuregenerali.in/
Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800
Email: Fgcare@futuregenerali.in
Courier: Grievance Redressal Cell, Future Generali India Insurance Company Ltd.
Lodha I –Think Techno Campus, B Wing –2nd Floor, Pokhran Road –2, Off Eastern Express Highway Behind TCS, Thane West – 400607

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

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

For updated details of grievance officer, kindly refer the link
https://general.futuregenerali.in/customer-service/grievance-redressal

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

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

II. Specific General Terms and Clauses

1. **Condition Precedent to the contract**

i. **Entire Contract**

The **Policy** and the proposal form constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by **Us**, for which approval shall be evidenced by an endorsement on the **Schedule**.

ii. **Due Care**

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

2. **Conditions applicable during the contract**

i. **Insured**

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

ii. **Addition and Deletion of members**

a) The new members of Alpa Bima – Group policy can be added at periodic intervals. However the insurance coverage for every member of the Alpa Bima – Group policy shall not exceed the maximum policy term.
b) The Company may issue multiple group insurance policies in tranches to the Group Organizer, subject to minimum group size and maximum policy term, for providing insurance coverage to the new members on an ongoing basis.
c) All members of the group will be issued a Certificate of Insurance giving the details of the benefits, important conditions and exclusions.

iii. **Cancellation**

a) Cancellation will not be invoked by the Company except on ground of fraud, moral hazard or misrepresentation or non-cooperation by the Insured.
b) The Company may cancel this insurance by giving the Insured Person at least 15 days written notice, and if no claim has been made then the Company shall refund a pro-rata premium for the unexpired Policy Period.

c) The Insured Person may cancel this insurance by giving the Company at least 15 days written notice, and if no claim has been made then 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 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

iv. **Policy Period**
The Policy can be issued for a tenure of 1 year.

v. **Arbitration Clause**
The parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this policy.
Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

vi. **Territorial limit**
a) We cover Hospital Cash benefit due to Accidental Bodily Injury or Illness sustained by the Insured Person during the Policy Period anywhere in India only.
b) The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian Law.

vii. **Communication**
a) Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule.
b) All notifications and declarations for Us must be in writing and sent to the address specified in the Schedule. Agents are not authorized to receive notices and declarations on Our behalf.
c) You must notify Us of any change in address.

viii. [5]**AYUSH Coverage:**
Expenses incurred on hospitalization due to accident and illnesses under AYUSH system of medicine shall be covered. However, all preventive and rejuvenation treatments which are non-curative in nature shall not be covered.

3. **Conditions when a claim arises**

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

ii. **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:

a) You or someone claiming on Your behalf must inform Us in writing immediately, and in any event within 48 hours of hospitalisation. You must immediately consult a Medical Practitioner and follow the Medical Advice and treatment that he recommends.
b) You must take reasonable steps or measures to minimise the quantum of any claim that may be made under this Policy.
c) You shall expeditiously provide the Company with any and all information and documentation in respect of the Hospitalisation. The claim and/ Our liability hereunder that may be requested, and You shall submit Yourself for examination by the Company's medical advisors as often as may be considered necessary by Us. The cost of such medical examination will be borne by Us.
d) You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation (written details of the quantum of any claim along with certified copies of discharge card, Hospital bill and receipt.) and other information if We ask for, to investigate the claim or Our obligation to make payment for it.
e) In the event of the death of the Insured person, nominee claiming on his/ her behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 14 days.
f) Mandatory necessary documents required to process claim are

i. Completely filled Alpa Bima – Group Policy Claim form (original)
ii. Discharge certificate/ card containing all the relevant details from Hospital (photocopy)
iii. Final Hospital bill with receipt (photocopy)
iv. All reports and prescriptions (photocopy)
v. First Prescription / Consultation Letter from your Doctor
vi. Original Money Receipt duly signed with a Revenue Stamp
vii. Copy of Proposer/Employee Photo ID Proof & Address Proof

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

g) The periods for intimation or submission of any documents as stipulated under (d) and (e) will be waived in case of any hardships being faced by the Insured or his representative which is supported by some documentation.
h) On receipt of claim documents as mentioned above or any other relevant document as required by the company from You, We shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of clam, the Company will make the payment of benefit as per the contract. In case if the claim is repudiated, We will inform the claimant about the same in writing with reason for repudiation

iii. Claim Settlement

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)
v. **Our** doctors will scrutinize the claims and flag the claim as settled/ rejected/ pending within the period of 30 days of the receipt of the last 'necessary' documents.
vi. Settled claims will be forwarded for payment
vii. Pending claims will be asked for submission of incomplete documents.
viii. Rejected claims will be informed to the Insured person in writing with reason for rejection.

iv. **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) We shall make payment in India in Indian Rupees only.
c) The Company shall only make payment under this Policy to the Insured or in the event of death or total incapacitation of the Insured to the proposer/ nominee. Any payment made in good faith by the Company as aforesaid shall operate as a complete and final discharge of the Company's liability to make payment under this Policy for such claim.
d) An insured event shall be deemed to be a continuous and completed period of 24 hours as mentioned below
   i. continuous and completed period of minimum 12 hours of Day Care Treatment, or
   ii. continuous and completed period of minimum 24 hours of Hospitalisation (other than Day Care Treatment)
e) Deductible will be applicable for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once subject to the terms and conditions of the Policy.
f) **For Family Floater cover:**
   - The maximum number of days of Hospitalisation as mentioned in the Schedule would float over all members of each Family under the Policy
   - In the event of more than one Family member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole Family would be restricted to the number of days as mentioned in the Schedule (maximum number of days would float over the Family) under the Policy

v. **Claims settlement process applicable to Personal Accident Cover**:

If the **Insured Person** meets with an **Accidental Bodily Injury** that may result in a claim, then:

a. The Insured Person or someone claiming on his/her behalf must inform Us in writing immediately and in any event within 15 days.
b. The Insured Person must submit to examination by Our medical advisors if We ask for this and as often as We consider this to be necessary.

i. Claim Documents applicable for Personal Accident Cover:

The Insured / Insured Person or his / her legal representatives as the case may be, is required to submit the following documents while lodging a claim under the Policy. The documents mentioned below are an indicative list. Additional documents may be asked, if required, for specific claims.

Photocopies of any document submitted must be attested by the Future Generali Branch Manager/ Gazetted Officer.

- Duly Completed Claim Form signed by Insured/ Nominee along with completely filled Attending Physician's Statement
- Photocopy of Policy Schedule
- Copies of medical documents supporting the accidental injury and treatment taken related to the same
- Disability Certificate
  - For Physical Disabilities related with separation of limbs or complete loss of organs - Copy of Disability Certificate issued by Orthopedic Surgeon mentioning the type and percentage of disability
  - For Physical Disabilities NOT related with separation of limbs or complete loss of organs - Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel only
  - For Non - Physical Disabilities - Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel only for the related speciality (e.g. Loss of memory, sense organs, vision, hearing etc.)

- Original Investigation Reports and copies of reports, X - Ray films supporting the accidental injury. Post-Operative X-ray films, if any
- Photographs of the Insured Person highlighting the injury / disability
- Copy of FIR / MLC (if registered)/ Panchnama, wherever applicable
- Copy of Photo ID and Address Proof of Insured Member for whom Claim is lodged
- Copy of Photo ID, Address Proof and Recent Photograph of Proposer *(if claimed amount is above INR 1 Lakh).*
- Copy of Death Summary, Treatment Papers & Investigation Reports, in case of Death Claim
- Copy of Death Certificate, in case of Death Claim
- Copy of Post Mortem / Viscera Report, in case of Death Claim
- Copy of Final Police Investigation Report, in case of Death Claim
- Photographs and Newspaper reports related to the accident, in case of Death Claim
- Original Discharge Summary of Hospital mentioning the date of admission, date of discharge, presenting complaints with duration, clinical condition, detailed line of treatment, final diagnosis and past medical and surgical history with duration, wherever applicable
- Original final hospital bill for hospitalization period, with pre numbered paid receipt with hospital seal and signature of authorized signatory, wherever applicable
- Original pharmacy bills along with copies of prescriptions, wherever applicable
- Legal Heir Certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (**Mandatory** if Nominee name is not mentioned on policy schedule)

vi. Claims Procedure applicable to Critical Illness Cover:

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

- Insured Person or someone claiming on Insured Person's behalf must give Notification of Claim to us in writing immediately, and in any event within 60 days of the aforesaid Illness/ condition/ surgical event but after the Survival Period of 28 days.
- In the event of the death of the insured person post the survival period, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 14 days.
- List of mandatory documents required for processing of the Claims are: (You need to submit all documents in original and photocopy. The original documents would be returned to you post verification if requested by You)
  i) Claim form
  ii) Discharge certificate/ card from the Hospital
  iii) Attending Doctor's/ Consultant's/ Specialist's/ Anesthetist's certificate regarding diagnosis.
  iv) Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt
  v) Indoor case papers from the Hospital
- Lack of documents or medical certificates confirming the diagnosis of illness or undergoing of medical/ surgical procedure will result in forfeiture of the claim.
- We 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.
  i) Pending claims will be asked for submission of incomplete documents.
  ii) Rejected claims will be informed to the Insured Person in writing with reason for rejection

4. **Conditions for renewal of the contract**

a) This Policy may be renewed by mutual consent and in such event; the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof.

b) The Policyholder, shall throughout the period of insurance keep and maintain a record containing the names of all the insured persons. The Policyholder shall declare to the company any additions in the number of insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed.

c) It is hereby agreed and understood that, this insurance being a group policy availed by the Insured covering members, the benefit thereof would not be available to members who cease to be part of the group for any reason whatsoever. Such members may obtain further individual insurance directly from the Company and any claims shall be governed by the terms thereof.

d) The premium rates or loadings for the product would not be changed without approval from Authority. However the performance of the product will be reviewed annually and further pricing will be done on experience basis.

E. SCHEDULE OF BENEFITS

Plans A, B, C, D can be offered for different options 5 days/ 10 days/ 15 days/ 20 days/ 25 days/ 30 days.

Option – 5 Days					
Sno	**Benefits**	**Plans**			
		A	**B**	**C**	**D**
1	Daily Hospital Cash (in INR), maximum upto 5 days during the policy period	300	500	700	1000
2	Daily ICU Cash (in INR), subject to maximum upto 5 days for each hospitalization and maximum up to 5 days during the policy period	600	1000	1400	2000
3	Maternity Benefit Expenses Cover without 9 months waiting period	Covered			
4	Pre-Existing Disease Cover	Covered			
5	Personal Accident Cover - Accidental Death, Permanent Total Disablement, Permanent Partial Disablement	100000/ 150000/ 200000			
6	Critical Illness Cover	25000/ 50000/ 75000/ 100000			

Option – 10 Days					
Sno	**Benefits**	**Plans**			
		A	**B**	**C**	**D**
1	Daily Hospital Cash (in INR), maximum up to 10 days during the policy period	300	500	700	1000
2	Daily ICU Cash (in INR), subject to maximum up to 5 days for each hospitalization and maximum up to 10 days during the policy period	600	1000	1400	2000
3	Maternity Benefit Expenses Cover without 9 months waiting period	Covered			
4	Pre-Existing Disease Cover	Covered			
5	Personal Accident Cover - Accidental Death, Permanent Total Disablement, Permanent Partial Disablement	100000/ 150000/ 200000			
6	Critical Illness Cover	25000/ 50000/ 75000/ 100000			

Option – 15 Days					
Sno	**Benefits**	**Plans**			
		A	**B**	**C**	**D**
1	Daily Hospital Cash (in INR), maximum up to 15 days during the policy period	300	500	700	1000
2	Daily ICU Cash (in INR), subject to maximum up to 10 days for each hospitalization and maximum up to 10 days during the policy period	600	1000	1400	2000
3	Convalescence Benefit, Fixed amount (in INR) more than 10 consecutive days will be payable once per Hospitalisation event	1500/ 2000/ 5000			
4	Maternity Benefit Expenses Cover without 9 months waiting period	Covered			
5	Pre-Existing Disease Cover	Covered			
6	Personal Accident Cover - Accidental Death, Permanent Total Disablement, Permanent Partial Disablement	100000/ 150000/ 200000			
7	Critical Illness Cover	25000/ 50000/ 75000/ 100000			

Option – 20 Days					
Sno	**Benefits**	**Plans**			
		A	**B**	**C**	**D**
1	Daily Hospital Cash (in INR), maximum up to 20 days during the policy period	300	500	700	1000
2	Daily ICU Cash (in INR), subject to maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period	600	1000	1400	2000
3	Convalescence Benefit, Fixed amount (in INR) more than 10 consecutive days will be payable once per Hospitalisation event	1500/ 2000/ 5000			
4	Maternity Benefit Expenses Cover without 9 months waiting period	Covered			
5	Pre-Existing Disease Cover	Covered			
6	Personal Accident Cover - Accidental Death, Permanent Total Disablement, Permanent Partial Disablement	100000/ 150000/ 200000			
7	Critical Illness Cover	25000/ 50000/ 75000/ 100000			

Option – 25 Days					
Sno	**Benefits**	**Plans**			
		A	**B**	**C**	**D**
1	Daily Hospital Cash (in INR), maximum up to 25 days during the policy period	300	500	700	1000
2	Daily ICU Cash (in INR), subject to maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period	600	1000	1400	2000
3	Convalescence Benefit, Fixed amount (in INR) more than 10 consecutive days will be payable once per Hospitalisation event	1500/ 2000/ 5000			
4	Maternity Benefit Expenses Cover without 9 months waiting period	Covered			
5	Pre-Existing Disease Cover	Covered			
6	Personal Accident Cover - Accidental Death, Permanent Total Disablement, Permanent Partial Disablement	100000/ 150000/ 200000			
7	Critical Illness Cover	25000/ 50000/ 75000/ 100000			

Option – 30 Days					
Sno	**Benefits**	**Plans**			
		A	**B**	**C**	**D**
1	Daily Hospital Cash (in INR), maximum up to 30 days during the policy period	300	500	700	1000
2	Daily ICU Cash (in INR), subject to maximum up to 10 days for each hospitalization and maximum up to 20 days during the policy period	600	1000	1400	2000
3	Convalescence Benefit, Fixed amount (in INR) more than 10 consecutive days will be payable once per Hospitalisation event	1500/ 2000/ 5000			
4	Maternity Benefit Expenses Cover without 9 months waiting period	Covered			
5	Pre-Existing Disease Cover	Covered			
6	Personal Accident Cover - Accidental Death, Permanent Total Disablement, Permanent Partial Disablement	100000/ 150000/ 200000			
7	Critical Illness Cover	25000/ 50000/ 75000/ 100000			

a) In case of Sec I (Daily Hospital Cash) and II (Daily ICU Cash) the maximum benefits would however be restricted to **5 days / 10 days /15 days/ 20 days/ 25 days/ 30 days** as per the plan opted for each **Hospitalisation** or all **Hospitalisations** during the **Policy** period.

b) In case the **Hospitalisation** exceeds the maximum stipulated under Sec I (Daily Hospital Cash) as per the selected plan while adjudicating any claim the benefits under ICU would have precedence over non ICU **Hospitalisation**.

c) In case the **Hospitalisation** in ICU exceeds the per **Hospitalisation** maximum limit of 5 days/ 10 days or the per **Policy** period limit of 5 days/ 10 days/ 20 days *(as per the plan opted)*, the remaining period of **Hospitalisation** in ICU will be paid as per non ICU **Hospitalisation** benefits subject to the overall **Policy** maximum of **5 days / 10 days /15 days/ 20 days/ 25 days/ 30 days**

d) **For Family Floater cover:**
   - The maximum number of days of **Hospitalisation** as mentioned in the **Schedule** would float over all members of each Family under the **Policy**
   - In the event of more than one **Family** member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole **Family** would be restricted to the number of days as mentioned in the **Schedule** (maximum number of days would float over the **Family**) under the **Policy**

e) Personal Accident Cover and Critical Illness cover will be applicable only for Self in a Policy.

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Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287. Regd. And Corp. Office: e 801 and 802, 8th floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai – 400083
Call us at: 1800-220-233 | Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in | Email: fgcare@futuregenerali.in.
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Grievance Redressal Procedure

Dear Customer,

At Future Generali, we continuously strive for service excellence to give you exceptional customer experience. This helps us build trust and a long-term relationship with you.
We request you to read the policy document including the terms and conditions carefully. This will help you understand your plan and drive maximum benefits. We want to ensure the plan is working for you and welcome your feedback.

What is a Grievance?
"Complaint" or "Grievance" means expression (includes communication in the form of electronic mail or other electronic scripts, Inbound Call, SMS, Letter), of dissatisfaction by a complainant with insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities.

- Explanation: An inquiry/ query or request does not fall within the definition of the 'complaint' or 'grievance'.

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

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

Helpline	Website	Email	Branch GRO	Complaint form
Call us on 1800 220 233/ 1860 500 3333/ 022-67837800	**Click here** to know more	Write to us at fgcare@futuregenerali.in	**Click here** to know your nearest branch.	**Click here** to raise a complaint

By when will my grievance be resolved?
- You will receive grievance acknowledgement from us within 3 business days for your complaint.
- Final resolution will be shared with you within 2 weeks of receiving your complaint.
- Your complaint will be considered as closed if we do not receive any reply from you within 8 weeks from the date of receipt of response.

How do I escalate my complaint if I don't receive a response on time?
- You may write to our Grievance Redressal Office at fggro@futuregenerali.in
- You may send a physical letter to our Grievance Redressal Cell,
  Head Office at the below address-

Future Generali India Insurance Company Ltd.
Lodha I – Think Techno Campus, B Wing – 2nd Floor, Pokhran Road – 2,
Off Eastern Express Highway Behind TCS, Thane West – 400607

What if I am not able to register my grievance?
You can comfortably raise a grievance via any of the above-mentioned avenues. If you face any challenge, you may write to the provided email IDs for help.
If you still face any challenge, you may use any of the below options to raise a complaint with the Insurance Regulatory and Development Authority (IRDAI)-
- Call toll-free number 155255.
- **Click here** to register complaint online.

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

Insurance Ombudsman:
If you are still dissatisfied with the resolution provided, you may opt to approach the Office of the Insurance Ombudsman, provided the same is under their purview.
Click here to know the guidelines for taking up a complaint with the Insurance Ombudsman.

In case you wish to send your complaint to the Insurance Ombudsman.
Click here to access the list of insurance ombudsman offices.