FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

FUTURE CRITICARE POLICY WORDINGS

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Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287.
Regd. and Corp. Office: 801 and 802, 8th floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai – 400083. Call us at: 1800-220-233 / 1860-500-3333 / 022-67837800| Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in |Email: fgcare@futuregenerali.in.

FGH/UW/RET/65/11

Preamble

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

A. Definitions

The following words or terms shall have the meaning ascribed to them wherever they appear in this **Policy**, and references to the singular or to the masculine shall include references to the plural or 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. **Condition Precedent** shall mean a **Policy** term or condition upon which the Insurer's liability under the **Policy** is conditional upon.

3. **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.

4. **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.

5. **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) of the said Act OR complies with all minimum criteria as under:
   i. has qualified nursing staff under its employment round the clock;
   ii. has at least 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
   iii. has qualified medical practitioner(s) in charge round the clock;
   iv. has a fully equipped operation theatre of its own where **Surgical Procedure**s are carried out
   v. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

6. **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:
      1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
      2. it needs ongoing or long-term control or relief of symptoms
      3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
      4. it continues indefinitely
      5. it recurs or is likely to recur

7. **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.

8. **Insured** means the person specified in the **Schedule** who is **Insured** by the Company under this **Policy**.

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

10. **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

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

12. **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

13. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or
    b) For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy or its reinstatement.

14. **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

15. **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

II. Specific Definitions

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

17. **Consultant/ Specialist** means a qualified **Medical Practitioner** holding a valid and subsisting license, granted by the appropriate licensing authority, and acting within the scope of his license, expert in the field of medicine for which he carries the status of a **Consultant**. The **Consultant** should not be related to the **Insured** or the Named **Insured** by blood or marriage.

18. **Critical Illness** means an **Illness**, sickness or a disease or a corrective measure as specified in Section B of this **Policy**.

19. **Critical Illness Benefit** means the amount specified in the **Schedule**, which is the maximum amount for which the Company may be liable to make

payment for any or all Critical Illnesses covered under this **Policy**

20. **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.

21. **Family** means and includes You, Your Spouse, Your first two dependent children and your two dependent parents. At any point of time the family floater cannot exceed for more than 6 members. The sum insured, as mentioned in the **Schedule**, would be shared among all the members of the Family Floater.

22. **Proposer** means the person specified in the Schedule who is the owner of the Policy at any point of time.

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

24. **Policy Period** means the date between the commencement date specified in the Schedule and, in respect of any Insured, the earlier of (a) the expiry date specified in the Schedule and (b) the occurrence of an event of Critical Illness

25. **Schedule** means the Schedule, and any annexure to it, attached to and forming part of this Policy.

26. **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.

27. **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.

Please note
a) Insect and mosquito bites is not included in the scope of definition of **Accident**.

B. Benefits of the Policy

For the purposes of this Section and the determination of the Company's liability under it, the **Insured Event** in relation to the **Insured**, shall mean any **Illness**, medical event or **Surgical Procedure** as specifically defined below whose signs or symptoms first commence more than 90 days after the commencement of Period of Insurance and shall only include:

a) First Diagnosis of the below-mentioned **Illnesses** more specifically described below:
   1. Cancer (cancer of specified severity)
   2. Kidney failure requiring regular dialysis
   3. Primary (Idiopathic) pulmonary hypertension
   4. End Stage Liver failure
   5. Multiple sclerosis with persisting symptoms

   Or

b) Undergoing for the first time of the following **Surgical Procedures**, more specifically described below:
   1. Major organ/bone marrow transplant
   2. Open chest CABG (coronary artery bypass graft)
   3. Aorta graft Surgery

   Or

c) Occurrence for the first time of the following medical events more specifically described below:
   1. Stroke resulting in permanent symptoms
   2. First heart attack (myocardial infarction)- of specified severity
   3. Coma of specified severity
   4. Total blindness

The **Insured** Event under this Section and the conditions applicable to the same are more particularly defined below:

1. **CANCER** (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;

2. **KIDNEY FAILURE REQUIRING REGULAR DIALYSIS**
   End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a **Specialist** medical practitioner.

3. **PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION**
   I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:
i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

4. **END STAGE LIVER FAILURE**
I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.
II. Liver failure secondary to drug or alcohol abuse is excluded.

5. **MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS:**
I. The unequivocal diagnosis of Definite Multiple Sclerosis 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.

6. **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 hematopoietic 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.

7. **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

8. **Aorta Graft Surgery:** Aorta Graft **Surgery** is defined as the actual undergoing of **Surgery** for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

Exclusions:
a) **Surgery** following traumatic **Injury** to the aorta.
b) **Surgery** to treat peripheral vascular disease of the aortic branches is excluded even if a portion of the aorta is removed during the operative procedures.
c) **Surgery** performed using only minimally invasive or intra-arterial techniques such as percutaneous endovascular aneurysm with insertion of a stent graft.

9. **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.

10. **MYOCARDIAL INFARCTION** (First Heart Attack of specific 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.

11. **COMA OF SPECIFIED SEVERITY:**
I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
i. No response to external stimuli continuously for at least 96 hours;
ii. Life support measures are necessary to sustain life; and
iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a **Specialist** medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

12. **TOTAL BLINDNESS:**
I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:
i. corrected visual acuity being 3/60 or less in both eyes or ;
ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

C. Exclusions

Without prejudice to the exclusions mentioned elsewhere in this document, the following exclusions shall apply to the benefits admissible under this **Policy**; No benefit shall be paid for the following circumstances and for the following conditions/ tests/ treatments:

1. Benefits will not be available for Any Pre- Existing conditions or related condition(s) for which You have been diagnosed, received medical treatment, had signs and/ or symptoms, prior to inception of Your first **Policy**, unless such a condition is stated in the proposal form and specifically accepted by the Company and endorsed thereon.

2. 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.

i. Standard Exclusions:

3. **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.

4. **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.

5. **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.

6. **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

7. **Code- Excl12**
   Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

8. **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.

ii. Specific Exclusions:

9. Any medical procedure or treatment, which is not medically necessary or not performed by a Doctor.

10. Any treatment relating to birth defects and external .

11. Hormone replacement therapy.

12. Treatment by a **Family** member and self-medication .

13. Ayurvedic, Homeopathy, Unani, naturopathy, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, rolfing, massage therapy, aroma therapy or any other treatments including **Alternative treatments** other than Allopathy / western medicines.

14. Attempted suicide (whether sane or insane) or intentionally self inflicted **Injury** or **Illness**, nervous disorder or sexually transmitted conditions, other than Acquired Immune Deficiency Syndrome (AIDS), Human Immune deficiency Virus (HIV) infection.

15. War, civil War, invasion, insurrection, revolution, act of foreign enemy, hostilities (whether War be declared or not), rebellion, mutiny, use of military power or usurpation of government or military power.

16. Participation in winter sports, skydiving/parachuting, hang gliding, bungee jumping, riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), participation in any Professional Sports, any bodily contact sport or any other hazardous or potentially dangerous sport for which You are untrained.

17. Loss caused directly or indirectly, wholly or partly by infections (except pyogenic infections which shall occur through an Accidental cut or wound) or any other kind of Disease.

18. 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. **Free Look Period**

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/ migrating the policy.
The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

4. **Migration**

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

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

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. **Moratorium Period**

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

7. **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.

8. **Possibility of Revision of Terms of the Policy Including the Premium Rates**

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

9. **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. For updated details of Insurance Ombudsman, kindly refer the Annexure on Grievance Redressal Procedures.

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

ii. Specific Terms And Conditions:

10. **Due Observance**

The due observance of and compliance with the terms, provisions, warranties and conditions of this **Policy** in so far as they relate to anything to be done or complied with by the **Insured** and/or the **Proposer** shall be a **Condition Precedent** to the Company's liability under this **Policy**.

11. **Duties and Obligations of the Insured and/or Named Insured Upon the Diagnosis of an Event of Critical Illness**

It is a **Condition Precedent** to the company's liability to make any payment under this **Policy** that, upon the diagnosis of an event of critical Illness:

a. The **Insured** and /or the Named **Insured** shall immediately and in any event within 60 days provide the Company with written notification of a claim, and
b. The **Insured** and/or the Named **Insured** shall expeditiously provide the Company with any and all information and documentation in respect of the critical Illness. The claim and/or the Company's liability hereunder that may be requested, and the **Insured** shall submit himself for examination by the Company's medical advisors as often as may be considered necessary by the company. The cost of such medical examination will be borne by the company.
c. The company shall be under no obligation to make any payment under this **Policy** until such time as the **Insured** has taken all necessary steps to satisfy the company that here has been an event of **Critical Illness** within the terms of this **Policy** and this diagnosis has been confirmed by the Company's medical advisors.
d. In case of premium paid under the mode other than the annual mode, the Company reserves the right to deduct the premium cost equivalent to the unpaid premium amount for the **Policy** year from the eligible claim amount.

12. **Cost of Pre-insurance Health Check up**

We will reimburse 50% of the cost of any pre-insurance medical examination once the proposal is accepted and **Policy** issued for that **Insured**. 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.

13. **Payment of claims**

If You 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, you must comply with the following:

a. You or someone claiming on Your 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.
b. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary.
c. You or someone claiming on Your behalf must give Us the documentation and other information We ask for to investigate the claim or Our obligation to make payment for it.
d. List of necessary 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**/ Anaesthetist'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**

e. 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.
f. The Company shall make payment under this **Policy** in the name of or the benefit of the **Insured** by delivering the same to the **Insured**/**Proposer** in case of minors/ Nominee in case of the death of the **Insured**.
g. 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**, and the named **Insured** agrees to and shall hold the company harmless against any and all claims, costs and expenses that may result because of any failure to make payment of all or part of the sum due under this **Policy** to the **Insured**.
h. Lack of documents or medical certificates confirming the diagnosis of **Illness** or undergoing of medical/**Surgical Procedure** will result in forfeiture of the claim.
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.
j. Pending claims will be asked for submission of incomplete documents.
k. Rejected claims will be informed to the **Insured** Person in writing with reason for rejection.
l. 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 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.
m. 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.
n. 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)
o. We will make all claim payments in Indian rupees within India only.

14. **Notifications & Declarations**

a. All notices and declarations for the attention of the Company shall be submitted in writing and shall be delivered to the address specified in the **Schedule**.
b. All notices and declaration for the attention of the **Insured** or the Named **Insured** shall be posted and addressed to the **Insured**'s address as stated in the **Schedule** or last known address as per our records.
c. The **Insured** and **Proposer** agree that the **Proposer** shall also act on behalf of the **Insured** as to
   i. The giving and receiving of any notice or declaration under or in respect of this **Policy** (including notice of cancellation),
   ii. The payment of premiums and receipt of any return premium and
   iii. The acceptance of any endorsements to this **Policy**

15. **Cancellation**

I. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

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

II. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.
III. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.
IV. If no claim has been made then We shall refund a pro-rata premium for the unexpired **Policy** Period.

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

a) The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
b) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
e) Coverage is not available during the grace period.
f) Your Future Criticare Policy shall be renewable lifelong
g) Applicable for Individual **Policy**- 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 **Policy** shall immediately cease to exist with reference to that **Insured**.
h) Applicable for family floater **Policy**- Upon the occurrence of an event of **Critical Illness** and (subject to the terms, conditions and exclusions of this **Policy**) for any **Insured** under the family floater **Policy**, without prejudice to the Company's obligation to make payment, this **Policy** shall immediately cease to exist. The rest of the **Family** members can opt for a separate **Critical Illness Policy** and they will be given continuity for the period they have been **Insured** under the Future Criticare **Policy**. In the event of the death of any of the **Insured** members subject to no **Critical Illness** claim being paid on the **Policy**, 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.

17. **Withdrawal of Policy**

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break.

18. **Examination of Books and Records:** We may examine Your books and records relating to the insurance under this **Policy** at any time during the **Policy Period** and up to three years after the **Policy** expiration, or until final adjustment (if any) and resolution of all claims under this **Policy**

19. **Territorial Limits and Law**

a. We cover **Critical Illness** of the **Insured** Person diagnosed during the **Policy Period** anywhere in India.
b. The construction, interpretation and meaning of the provisions of this **Policy** shall be determined in accordance with Indian Law.
c. The **Policy** constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the **Schedule**.

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

HEALTH INSURANCE CLAIM FORM

Toll Free Phone: 1800 103 8889 Toll Free Fax: 1800 103 9998 Email: fgh@futuregenerali.in

ALL FIELDS IN THIS FORM ARE MANDATORY AND THE CLAIM WILL BE NOT BE PROCESSED IF ANY OF THE DETAILS ARE MISSING

Claim Number (For FGH Use Only)	

POLICY / INSURED DETAILS

Policy No : _____ **Health Card No. of Patient** _____

Policy Start Date _____ **Policy End Date** _____ **Date of Joining the Policy** _____

Corporate Name : _____**(Only for Group Policies) Employee ID** _____

PERSONAL DETAILS OF EMPLOYEE/PROPOSER

1.	**Name of the Employee / Individual:**
2.	**E-Mail address of the Employee/Individual:**
3.	**Mobile No:**
4.	**Permanent Account Number (PAN):**

CLAIMANT / PATIENT DETAILS

1.	**Name of the Patient:**		
2.	**Relationship with the Employee / Proposer** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Others _____		
3.	**Date of Birth of Claimant:** _____ **Age** _____ **Years**	**Gender**	☐ Male ☐ Female
4.	**Residential Address**		

CLAIM DETAILS

Total Claimed Amount: | | | | | | | | | | |

Claimed Amount in Words: Rupees _____

1. Diagnosis		
2. Admission Date: DD / MM / YYYY	Discharge Date: DD / MM / YYYY	
3. Name of Treating Doctor:		
4. Mobile No. of Treating Doctor:		
5. Name of Family Physician:		
6. Mobile No. of Family Physician:		

Enclosure Check List:

1. Original Discharge Summary containing all relevant details
2. All Original Bills and their Receipts
3. Copies of all Reports & prescriptions
4. First Prescription / Consultation Letter from your Doctor.
5. Original Money Receipt duly signed with a Revenue Stamp.
6. Copy of Proposer/Employee Photo ID Proof & Address Proof

CONSENT REQUIREMENT FOR ACCESS TO TREATMENT PAPERS / INDOOR CASE SHEETS / MEDICAL RECORDS / INVESTIGATOR VISIT

I hereby authorize Future Generali India Insurance or any agency / individual authorized by them to obtain copies or review in person all my medical records including but not limited to admission notes, treatment sheets, indoor case papers, investigation reports, prescriptions and all other documents present in the hospital case file. Details related to my past hospitalisations in your hospital can also be provided / shown to Future Generali or its authorized representatives. I agree that all information provided above by me in the claim documents is true and that if I have provided any false or untrue information, my right to claim the reimbursement of expenses shall be absolutely forfeited.

Name of Patient / Relative: _____

Relationship with Patient: _____

Signature of Patient / Relative: _____

Date: DD / MM / YYYY

Please attach this form in Original to the hospital bill and other claim documents. Separate claim form required for each claim. PLEASE ENCLOSE A PHOTOCOPY OF THE FUTURE GENERALI HEALTH ID CARD.

AUTHORIZATION FOR TRANSFER OF CLAIM AMOUNT BY NATIONAL ELECTRONIC FUND TRANSFER

Name as per Bank Account											
Bank Name											
Branch Name & Address											
Branch Phone No.											
Branch MICR Code											
Branch IFSC Code for NEFT											
(Please attach a Photocopy of a cheque or a blank cheque of your bank duly cancelled for ensuring accuracy of the bank name, branch name, account number & name of account holder printed)											
Account Type (Please Tick)	☐ Savings ☐ Current ☐ Cash / Credit										
Account No. (As appearing in Cheque Book)											
HR Authorization & Stamp					Bank Authorization & Stamp						

Date from which the mandate should be effective: _____

I hereby declare that the particulars given above are correct and complete and request you to remit any amount due to me, if any to the aforesaid bank account. I herewith further declare that if any transaction is delayed or not effected at all or is wrongly credited to any other account for reasons of incomplete or incorrect information as provided above, I shall not hold Future Generali India Insurance Company Ltd ("Company") or any of its directors, employees or agents responsible for the same. I also declare that the remittance of any dues to the aforesaid bank account shall be considered as full and valid discharge of its obligations by the company. I also undertake to advise any change in the particulars of my bank account to facilitate updation of records for the purpose of credit of any amount due, through NEFT.

Name of Employee/ Proposer: _____ Signature of Employee / Proposer: _____
Policy No. _____ Claimant Name: _____ Date: _____

FEEDBACK AND SUGGESTIONS

We thank you for choosing Future Generali as your Insurance provider. We always strive to ensure that our service levels exceed our customer's expectations. In the spirit of this endeavour, we will greatly appreciate your valuable inputs and feedback. Kindly provide your feedback on your experience with Future Generali and any suggestions for improving our services. We value your time and promise to evaluate your suggestions for improvement of our service.

Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287.
Regd. and Corp. Office: 801 and 802, 8th floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai – 400083. Call us at: 1800-220-233 / 1860-500-3333 / 022-67837800 | Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in | Email: fgcare@futuregenerali.in. Trade Logo displayed above belongs to M/S Assicurazioni Generali - Societa Per Azioni and used by Future Generali India Insurance Co Ltd. under license.

Grievance Redressal Procedures

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.