Health Total Prospectus

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

A. Salient Features of the Policy

DEFINITIONS

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

2. Alternative Treatments mean alternative forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

3. Any one illness means a continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

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

5. Congenital Anomaly means 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.

6. Contribution means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

7. Condition Precedent means a policy term or condition upon which the insurer's liability under the policy is conditional upon.

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

9. Cumulative Bonus means any increase in the sum insured granted by the insurer without an associated increase in premium.

10. Day Care Centre means any institution established for Day Care Treatment of Illness and/or injuries or a medical set-up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-

a) has qualified nursing staff under its employment;

b) has qualified Medical Practitioner/s in charge;

c) has a 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.

11. Day Care Treatment means medical treatment and/or Surgical Procedure which is:

a) Undertaken under general or local anaesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement; and

b) Which would have otherwise required Hospitalisation of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

12. Diagnostic Centre means the diagnostic centers which have been empanelled by Us as per the latest version of the schedule of diagnostic centers maintained by Us, which is available to You on request.

13. Dependent Spouse means Your legally married spouse as long as he/she continues to be married to You.

14. Dependent Child means Your child (natural or legally adopted), who is financially dependent on You and does not have his/her independent sources of income.

15. Dependent sibling means your brother or sister if they are unmarried and still financially dependent on You.

16. Dependent Parents means Your father or mother who are financially dependent on You.

17. 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.

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

a) the condition of the patient is such that he/she is not in a condition to be removed to a Hospital; or

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

19. Disclosure to Information Norm

The Policy shall be void and all premium paid hereon shall be forfeited to the Insurer, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

20. Emergency Care means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner

to prevent death or serious long term impairment of the Insured Person's health.

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

22. 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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

a) has qualified nursing staff under its employment round the clock;

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

c) has qualified Medical Practitioner(s) in charge round the clock;

d) has a fully equipped operation theatre of its own where Surgical Procedures are carried out; and

e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

23. Hospitalisation means admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

25. 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.

26. Inpatient Care means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

27. Insured Person means a person named in the Schedule who is covered under this Policy, for whom the insurance is proposed and the appropriate premium has been received.

28. 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 Medical Practitioner should not be the insured or close family members.

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

30. Medically Necessary means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which:

a) Is required for the medical management of the Illness or Injury suffered by the insured;

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

c) Must have been prescribed by a Medical Practitioner; and

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

31. Maternity Expenses/Treatment means expenses including:

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.

32. 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 Medical Practitioners in the same locality would have charged for the same medical treatment.

33. Network Provider means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a Cashless Facility.

(Please note: The Hospitals which have been empanelled by Us as Network Providers are as per the latest version of the schedule of Hospitals maintained by Us, which is available to You on request.)

34. Non-Network Provider means any hospital, day care centre or other provider that is not part of the network.

35. Newborn Baby means baby born during a Policy Year and is aged between 1 day and 90 days, both days inclusive.

36. Notification of Claim

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

37. OPD Treatment means one in which the insured visits a clinic/ Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The person is not admitted for Day Care Treatment or in-patient.

38. Proposal means that portion of the Policy which sets out Your/ Insured Person's personal details, the type of insurance cover in force, the Policy Period and the Sum Insured.

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 starting with the commencement date mentioned in the Schedule till the end date mentioned in the Schedule.

41. Policy Year means every annual period within the Policy Period starting with the commencement date.

42. Pre-hospitalization Medical Expenses means Medical

Expenses incurred immediately before the Insured Person is Hospitalised provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and

b) The in-patient Hospitalization claim for such Hospitalization is admissible under the Policy.

43. Post-hospitalization Medical Expenses means Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and

b) The in-patient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

44. Pre-existing Disease means any condition, ailment or Injury or related condition(s) for which You/Insured Person had signs or symptoms, and/or were diagnosed and/ or received Medical Advice/treatment, within 48 months prior to inception of Your/ Insured Person's first Policy issued by the insurer.

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

46. Pre-Natal Medical Expenses means medical expenses incurred for the insured mother during the maternity period prior to delivery.

47. Post-Natal Medical Expenses means medical expenses incurred for the insured mother post the delivery.

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

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

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

51. 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 all waiting periods.

52. 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.

53. Schedule means that portion of the Policy which sets out Your/ Insured Person's personal details, the type of insurance cover in force, the period and the Sum Insured under the Policy. Any annexure or endorsement to the Schedule shall also be a part of the Schedule.

54. Schedule of Benefits means that portion of the Policy which sets out the three Plans of the Policy that may be opted by the Insured Person and the benefits available to You/Insured Person under each Plan in accordance with the terms of the Policy.

55. Sum Insured means the amount specified in the Schedule which is Our maximum, total and cumulative liability under this Policy for any and all claims arising under this Policy in a Policy Year in respect of the Insured Person(s).

56. Subrogation means the right of the insurer to assume the rights of the Insured Person to recover expenses paid out under the policy that may be recovered from any other source.

57. Unproven/Experimental Treatment means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

58. Voluntary Deductible means the Deductible You have opted for, and is the amount stated in the Schedule, which shall be borne by the Insured Person in respect of each and every Hospitalization claim incurred in the Policy Year. Our liability to make any payment for each and every claim under the Policy is in excess of the Deductible. Each and every Hospitalization would be considered as a separate claim.

59. We, Our or Us means Future Generali India Insurance Company Limited.

60. You or Your means the policyholder shown in the Schedule who has concluded the Policy with Us.

B. Scope of cover

Insurance Plans: This Policy provides You options of 3 (three) plans namely Vital Plan, Superior Plan and Premiere Plan with each Plan having further Sum Insured options as specified in the Schedule of Benefits. The Schedule will specify the Sum Insured and the Plan which is in force for each of the Insured Persons. For a complete description of the benefits available under the applicable Plan as well as any specific limits on the amount payable under any particular benefit under the applicable Sum Insured and Plan, please refer to the "Schedule of Benefits" attached to this Policy.

Benefits: The Policy covers the Reasonable and Customary Charges incurred towards the medical treatment taken by the Insured Person during the Policy Period following an Illness or Injury that occurs during the Policy Period, subject always to the availability of the Sum Insured and any specific limits specified in the Schedule of Benefits and the terms, conditions and exclusions specified in this Policy document.

The benefits available under the Policy are listed below. The applicable Plan specified in the Schedule of Benefits will specify whether the benefit in respect of which a claim arises is in force under the applicable Plan for the Insured Person.

Benefit 1. Hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Medical Expenses that are incurred during the Hospitalisation of the Insured Person for Medically Necessary treatment required due to an Illness or Injury sustained by the Insured Person during the Policy Period.

Benefit 2.
Day Care Treatment expenses

We will pay the Reasonable and Customary Charges for Medically Necessary Day Care Treatment taken by the Insured Person on advanced technological Surgical Procedures requiring less than 24 hours of Hospitalization as listed out in Section IV(21) of the Policy clause.

Benefit 3.
Pre-hospitalisation Medical Expenses

We will pay the Reasonable and Customary Charges for Pre-hospitalisation Medical Expenses that are incurred with respect to the Insured Person for up to 60 days immediately prior to the date of the Insured Person's admission to Hospital that is specified under the applicable Plan/Sum Insured for the Insured Person, provided that We have accepted a claim for Hospitalisation Medical Expenses under Benefit 1.

Benefit 4.
Post-hospitalisation Medical Expenses

We will pay the Reasonable and Customary Charges for Post-hospitalisation Medical Expenses that are incurred with respect to the Insured Person for up to the period immediately following the Insured Person's discharge from Hospital that is specified under the applicable Plan/Sum Insured for the Insured Person, provided that We have accepted a claim for Hospitalisation Medical Expenses under Benefit 1.

Benefit 5.
Maternity Expenses

We will pay the Reasonable and Customary Charges for Maternity Expenses/Treatment incurred for the Insured Person's delivery, subject to the following:

a) If the Insured Person is Your Dependent Spouse, this benefit will be applicable only if We have received at least 3 continuous annual premiums under the Health Total Insurance Policy in respect of You and Your Dependent Spouse and provided that at least 24 months of continuous coverage have elapsed from the inception of the first Health Total Policy with Us.

b) If the Insured Person is You , this benefit will be applicable only if We have received at least 5 continuous annual premiums under the Health Total Policy in respect of You and provided that at least 48 months of continuous coverage have elapsed from the inception of the first Health Total Policy with Us.

c) Our maximum liability per pregnancy (delivery/termination) will be subject to the specifi sub-limit as shown in the Schedule of Benefi

d) We will cover Reasonable and Customary Charges for Pre-natal Medical Expenses incurred on Hospitalisation for a period of 90 days immediately prior to the date of delivery and Reasonable and Customary Charges for Post-natal Medical Expenses incurred on Hospitalisation for upto a period of 45 days immediately following the date of delivery provided that this benefit is applicable only if Superior Plan or Premiere Plan are in force for the Insured Person.

e) Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report would not be covered under this Benefi but would be considered a claim made under Benefi 1.

Benefit 6.
Organ Donor Expenses

We will pay the Reasonable and Customary Charges incurred for an organ donor's treatment for the harvesting of the organ donated provided that:

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994 and the organ donated is for the use of the Insured Person;

b) We will not pay the donor's screening expenses or pre and post hospitalisation expenses or for any other medical treatment for the donor consequent on the harvesting;

c) We have accepted claim under Benefit 1 for the Insured Person and the Insured Person has been Medically Advised to undergo an organ transplant;

d) Costs directly or indirectly associated with the acquisition of the donor's organ will not be covered.

Benefit 7.
Patient Care

We will pay for the Reasonable and Customary Charges for a Qualified Nurse for the Insured Person for a period of up to 10 days immediately following the Insured Person's discharge from Hospital provided that:

a) the Insured Person is above 60 years of age;

b) the Insured Person's Hospitalisation was due to Illness or Injury sustained during the Policy Period;

c) the treating Medical Practitioner has recommended that the nursing charges are Medically Necessary;

d) We will not be liable to make payment under this Benefit in excess of the per day limits specified in the Schedule of Benefits;

e) We will not be liable to make payment under this Benefit for any Insured Person in excess of 30 days during a Policy Year.

Benefit 8.
Accidental Hospitalization

We will increase the Sum Insured by 25% of the available balance of the Sum Insured (excluding the Cumulative Bonus, if any) if the Insured Person is Hospitalised during the Policy Year due to an Accident which occurred during the Policy Year provided that no increase to the Sum Insured will exceed ₹10,00,000 and this increase to the Sum Insured will only be available for claims arising under Benefit 1.

Benefit 9.
Accompanying Person

We will make payment of the amount specifi in the Schedule of Benefi for each completed day of Hospitalisation for the Accompanying Person of an Insured Person provided that the Insured Person is a Dependent Child who is less than 12 years of age and the Dependent Child is undergoing Medically Necessary Hospitalisation due to an Injury or Illness that occurred during the Policy Period. We will not make payment under this Benefi in respect of an Insured Person for more than 30 days in any Policy Year.

For the purpose of this Benefit, "Accompanying Person" means the

Insured Person's mother, father, grandmother or grandfather or any immediate family member of the Insured Person.

Benefit 10.
Road Ambulance Charges

We will reimburse ambulance charges from home to Hospital or between Hospitals .We will reimburse payments up to a maximum of the amount specified in the Schedule of Benefits per Hospitalisation if Vital Plan is in force and actual expenses in case of Hospitalization in a Network Provider if Superior Plan or Premiere Plan are in force. In case of Hospitalization in a Non Network Provider We will reimburse upto the amount specified in the Schedule of Benefits depending on the Plan in force. We will reimburse payments under this Benefit only in respect of ambulance services of a Hospital or a registered service provider and only upon You producing the bills in original.

Benefit 11.
Emergency Medical Evacuation (applicable for Superior Plan and Premiere Plan only)

We will reimburse expenses up to a maximum of 5% of the Sum Insured (excluding the Cumulative Bonus, if any) incurred in a Policy Year for the Insured Person's Medically Necessary medical evacuation in an emergency, provided that:

a) the evacuation is recommended by a Medical Practitioner who certifies that the severity of the Insured Person's Injury or Illness warrants the medical evacuation for receipt of Emergency Care.

b) It is a Condition Precedent that these expenses are authorized by Us if the evacuation is required in respect of an Insured Person's Illness and the medical evacuation is from the place of local hospitalization to any other Hospital within India.

c) For medical evacuation following an Accident during the Policy Period, We will reimburse under this Benefit expenses incurred for medical evacuation from the place where the Accidental Injury occurred or the place of local Hospitalisation immediately following the Accident to any other Hospital within India.

d) For medical evacuation following an Illness during the Policy period, We will reimburse expenses under this Benefit expenses incurred for medical evacuation from the place of local Hospitalisation to any other Hospital within India.

e) For claims made under this Benefit, We will reimburse expenses for transportation of the Insured Person and Medical Expenses incurred during the course of evacuation provided that it is Medically Necessary that treatment is provided to the Insured Person en route.

Benefit 12.
Domiciliary Hospitalisation Expenses

We will reimburse Reasonable and Customary Charges up to a maximum of 10% of the Sum Insured (excluding the Cumulative Bonus, if any) for Medical Expenses incurred on the Domiciliary Hospitalisation of the Insured Person for an Illness or Injury which occurred during a Policy Year provided that:

a) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the Reasonable and Customary Charges of any Medically Necessary treatment for the entire period subject to other terms of the Policy;

b) Expenses incurred for pre and post Domiciliary Hospitalisation treatment will not be payable;

c) No payment will be made if the condition for which the Insured Person requires medical treatment is:

(i) Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, cough and cold or Influenza;

(ii) Arthritis, Gout or Rheumatism;

(iii) Chronic Nephritis or Nephritic Syndrome;

(iv) Diarrhoea or any type of dysentery, including Gastroenteritis;

(v) Diabetes Mellitus or Insipidus;

(vi) Epilepsy;

(vii) Hypertension;

(viii) Psychiatric or Psychosomatic disorders of all kinds;

(ix) Pyrexia of unknown origin.

Benefit 13.
OPD Treatment (applicable for Superior Plan and Premiere only)

We will reimburse the Reasonable and Customary Charges arising from Medical Expenses incurred on OPD Treatment for consultation, diagnostic tests and medications for prescribed drugs for the Insured Person due to an Illness, Injury or a pregnancy covered under Benefit 5 provided that diagnostic tests and medications must be prescribed by a Medical Practitioner. Our liability under this Benefit will be restricted to the following:

a) If Superior Plan is in force We shall reimburse expenses towards consultation and diagnostic tests prescribed by the Medical Practitioner.

b) If Premiere Plan is in force We shall reimburse expenses towards consultation, diagnostic tests and medications prescribed by the Medical Practitioner.

c) In case of bills for any prescribed drugs/medicines Our liability will be restricted to 80% of admissible bills.

d) In case of dental consultations and diagnostics Our liability will be restricted to 70% of admissible bills.

e) Expenses under (a) to (d) individually or in aggregate cannot exceed the Out Patient Medical Expenses limit specified in the Schedule of Benefits.

f) Only Allopathic treatment will be covered under this Benefit.

Benefit 14.
Child Vaccination Benefits (applicable for Premiere Plan only)

We will cover Reasonable and Customary Charges for vaccinations of the Insured Person up to the per annum limit specified in the Schedule of Benefits provided that the Insured Person is a Dependant Child who is less than 12 years of age.

Benefit 15.
Newborn Baby (applicable for Superior Plan and Premiere Plan only)

If We have accepted a maternity benefits claim under Benefit 5, then We will also:

a) Cover the Reasonable and Customary Charges for Medical Expenses towards the Medically Necessary treatment of the Insured Person's Newborn Baby while Insured Person is Hospitalised as an in-patient for delivery and cover the Newborn Baby as an Insured Person until the expiry date of the Policy Year in which the Newborn Baby is born, within the Sum Insured as applicable for the Insured Person (mother) without payment of any additional premium.

b) Cover the Reasonable and Customary Charges for vaccination expenses of the Newborn Baby upto the specified sublimit under the Schedule of Benefits for vaccinations, until the Newborn Baby completes one year of age. If the Policy ends before the Newborn Baby has completed one year, then, We will only cover such vaccinations until the Newborn Baby completes one year, and only if We have accepted the Newborn Baby as an Insured Person at the time of Renewal of the Policy and We have received the premium accordingly.

c) Include the Newborn Baby as an Insured Person under the Policy from the Policy Year immediately succeeding the Policy Year in which the Newborn Baby is born provided that We have received the premium due to include the Newborn Baby as an Insured Person.

Benefit 16.
E-Opinion in respect of an Illness or Injury

a) If an Insured Person suffers an Illness or Injury during the Policy Period in respect of which a claim has been admitted under Benefit 1, then at the Insured Person's request We will arrange a maximum of two e-opinions (in a Policy Year) from a Medical Practitioner selected by the Insured Person from Our panel. The e-opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.

b) While claiming under this Benefit and deciding to obtain an e-opinion, each Insured Person expressly agrees that:

(i) It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner in Our panel to take the e-opinion and the use (if any) to which the e-opinion so obtained is put.

(ii) We do not provide an e-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the E-opinion is put.

(iii) We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner in Our Panel or in any e-opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

Benefit 17.
Alternative Treatment

We will reimburse Reasonable and Customary Charges for Medical Expenses incurred with respect to the Insured Person for Hospitalization under Ayurveda, Unani, Siddha or Homeopathy provided that the Treatment has been undergone in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health for that Alternative Treatment.

Specific Exclusions applicable to this Benefit:

a) All preventive and rejuvenation treatments (non-curative in nature) including without limitation, treatments that are not Medically Necessary are excluded.

b) Pre-hospitalisation Medical Expenses, Post-hospitalisation Medical Expenses, Day Care Treatment and outpatient Medical Expenses are excluded.

c) Any Alternative Treatment other than Ayurveda, Unani, Siddha or Homeopathy.

Benefit 18.
Medical Treatment Abroad (applicable for Premiere Plan only)

a) The benefits under this Section will be available if the Insured Person has been continuously covered under Premiere Plan of Health Total Policy for a continuous period of 48 months.

b) We shall reimburse the Reasonable and Customary Charges for Medical Expenses for treatment of the Insured Person incurred outside India for the following diseases subject to the terms below:

(i) Craniotomy & Craniectomy: only as a treatment for cancers;

(ii) Lung Lobectomy that involves removal of one of the three divisions of the lungs for lung cancer;

(iii) Liver Lobectomy that involves removal of 70% of liver mass in case of liver failure;

(iv) Major organ transplant;

(v) Bone marrow transplant;

(vi) Repair of Aortic Aneurysm;

(vii) Heart valve replacement;

(viii) Coronary Artery Bypass Graft.

c) We shall cover only those Medical Expenses that would otherwise have been payable under Benefit 1. For the purpose of this Benefit, Hospital shall mean "Any institution established for Inpatient care and Day Care Treatment of Accidental Injury or Illness and which has been registered as a hospital as per the laws, rules and regulations applicable for the country where the treatment is taken." The term 'Hospital' shall not include a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics or a hotel, health spa or massage centre or the like.

d) Any payments under this Benefit shall always be made in India, in Indian rupees and on a reimbursement basis only. The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of Hospitalisation, shall be used for conversion of foreign currency amounts into Indian rupees for payment of any claim under this Benefit. If on the date of Hospitalisation the RBI rates are not published, the rates next published by the RBI shall be considered for conversion.

e) It is a Condition Precedent that a prior written notice of at least 15 days is given to Us before the treatment described in this Benefit is taken outside India.

f) The exclusion under Section III(3)(p) of the Policy clause is superseded to the extent covered under this Benefit.

Benefit 19.
Wellness Care

The Insured Person will be eligible for certain "Wellness Benefits" as per the Plan in force under the Policy. These wellness benefits will include health risk evaluation and annual health checkups as applicable for respective Plans, the updated details of which would be available on Our website. These would be conducted through Our tie up arrangements.

The annual health checkup can be conducted from 2nd year of the policy with Us , for the insured persons who were already covered under the policy . The annual heath checkup would include tests as given below as applicable for respective plans:

Vital Plan: Complete Blood count, Urine Routine, Random Blood Sugar (maximum two insured persons per policy /per policy year irrespective of family size)

Superior Plan: Complete Blood Count, Urine Routine, Fasting blood Sugar, Post Prandial Blood Sugar, ECG, Serum Creatinine (maximum three insured persons per policy /per policy year irrespective of family size)

Premiere Plan: Complete Blood Count, Urine Routine, Fasting blood Sugar, Post Prandial Blood Sugar, ECG, Serum Creatinine (maximum four insured persons per policy/ per policy year irrespective of family size)

While availing the wellness benefits, each Insured Person expressly agrees that:

a) Annual health checkups will be provided at Our Diagnostic Centres only.

b) All decisions regarding which wellness benefi to avail and to what use to put the same to are to be solely made by the Insured Person;

c) We do not provide/assume responsibility for:

(i) the wellness benefits or make any representation as to the adequacy or accuracy of the same;

(ii) any actual or alleged errors, omissions or representations whatsoever made by any of Our wellness service providers or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

Benefit 20.

Death succeeding a Hospitalization claim: In the event of Your death following a Hospitalisation claim made under Benefit 1, We will provide a 10% discount in premiums on the first subsequent Renewal of the Policy for Your existing family members covered under the Policy as Insured Persons at the time of Your death.

Benefit 21.
Cumulative Bonus

a) If no claim has been made in respect of any Benefits with the exception of any claim under Benefit 13 and the Policy is Renewed with Us without any break, We will apply a bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 50% of the Sum Insured for this Policy Year. The maximum bonus for any Policy Year will not exceed 100% of the Sum Insured of the first Policy Year.

b) If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 50% of the Sum Insured in the following Policy Year. However this reduction will not reduce the Sum Insured below the base Sum Insured of the Policy.

c) In case the Insured Person is porting a similar Policy from Us / another insurance company, portability if requested by the Insured Person, shall be applicable to the previous policy along with enhanced sum insured (base sum insured+ Cumulative Bonus) acquired under the previous policies. The premium applicable would be for the enhanced sum insured (Sum Insured + Cumulative Bonus) and if the same is not available, to the next higher Sum Insured available if requested by the Insured Person. However portability shall be applicable to the previous sum insured and the cumulative bonus.

d) In case You have opted for the 'Family Floater' option as specified in the Schedule, the Cumulative Bonus so applied will only be available to those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

Benefit 22.
Restoration of the Sum Insured

If the Sum Insured and Cumulative Bonus (if any) is exhausted due to claims incurred and paid during the Policy Year or incurred during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Sum Insured) will be automatically available for the particular Policy Year, provided that:

a) The Restore Sum Insured will be enforceable only after the Sum Insured and the Cumulative Bonus have been completely exhausted in that Policy Year;

b) The Restore Sum Insured can only be used for claims made by the Insured Person in respect of Benefits 1-4;

c) The Restore Sum Insured cannot be used for claims based on Maternity Expenses/Treatment;

d) The Restore Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an Illness (including its complications) for which a claim has been paid in the current Policy Year under Benefits 1-4;

e) Only the Sum Insured (excluding Cumulative Bonus) will be considered as Restore Sum Insured;

f) The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year;

g) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

If the Policy is opted by You on a 'Family Floater' basis as specified in the Schedule, then the Restore Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Sum Insured and Cumulative Bonus was exhausted.

Schedule Of Benefits									
		Vital Plan			Superior Plan			Premiere Plan	
Eligibility	Sum Insured (in ₹)	3 lakhs	5 lakhs	10 lakhs	15 lakhs	20 lakhs	25 lakhs	50 lakhs	1 crore
	Minimum age at entry	1 day	1 day	1 day	1 day	1 day	1 day	1 day	1 day
	Maximum age at entry	None	None	None	None	None	None	None	None
	Maximum renewal age	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long
	Individual SI / family floater SI options	Both	Both	Both	Both	Both	Both	Both	Both
	Family definition	S+Sp+2C+2P (1+5)	S+Sp+2C+2P (1+5)	S+Sp+2C+2P (1+5)	Extended family up to 15 members	Extended family up to 15 members	Extended family up to 15 members	Extended family up to 15 members	Extended family up to 15 members
Hospitalisation Benefits	Hospitalisation	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI
	Day care treatment	√	√	√	√	√	√	√	√
	Pre-hospitalisation	60 days	60 days	60 days	60 days	60 days	60 days	60 days	60 days
	Post-hospitalisation	90 days	90 days	90 days	120 days	120 days	120 days	180 days	180 days
	Restoration of SI	√	√	√	√	√	√	√	√
	Cumulative bonus - 50% for every claim-free year to max 100%	√	√	√	√	√	√	√	√
	Maternity benefit - normal delivery (in ₹)	15,000	20,000	25,000	30,000	40,000	40,000	50,000	50,000
	Maternity benefit - LSCS (caesarian) (in ₹)	25,000	35,000	45,000	50,000	60,000	60,000	1,00,000	1,00,000
	Pre-natal hospitalisation (within maternity limits)	×	×	×	90 days	90 days	90 days	90 days	90 days
	Post-natal hospitalisation (within maternity limits)	×	×	×	45 days	45 days	45 days	45 days	45 days
	Organ donor expenses	√	√	√	√	√	√	√	√
	New born baby benefits: Automatic cover within mother's / floater Sum Insured up to expiry date of policy	×	×	×	√	√	√	√	√
	New born baby benefits: Reasonable vaccination benefits up to 1 year of age (in ₹)	×	×	×	Max 3,500	Max 3,500	Max 3,500	Max 5,000	Max 5,000
	Patient care (above 60 years) - per day benefit up to max (in ₹)	350/day	350/day	350/day	500/day	500/day	500/day	1,000/day	1,000/day
	Patient care (above 60 year) - maximum	10 days per Hospitalisation and 30 days per policy year							
	Accidental hospitalisation - 25% increase subject to maximum of ₹10 lakh	√	√	√	√	√	√	√	√
	Accompanying person (up to 12 years) ₹500 /day to maximum of 30 days	√	√	√	√	√	√	√	√
	Domiciliary hospitalisation expenses - maximum up to 10% of SI	√	√	√	√	√	√	√	√
Medical Treatment Abroad	Alternative treatments Ayurveda / Unani / Sidha / Homeopathy - reimbursement	√	√	√	√	√	√	√	√
	Medical treatment abroad	×	×	×	×	×	×	√	√
	Medical treatment abroad - waiting period							4 years	4 years
Road Ambulance	Road ambulance charges - network hospitals (in ₹)	1,500	1,500	1,500	Actuals	Actuals	Actuals	Actuals	Actuals
	Road ambulance charges - non network hospitals (reimbursement up to a maximum) (in ₹)	1,500	1,500	1,500	2,000	2,000	2,000	5,000	5,000

Schedule Of Benefits									
		Vital Plan			Superior Plan			Premiere Plan	
Emergency Medical Evacuation	Emergency medical evacuation - 5% of SI (reimbursement up to a maximum)	×	×	×	√	√	√	√	√
E-Opinion	E-Opinion for illness / injury (maximum 2 per policy year)	√	√	√	√	√	√	√	√
**Out-patient Medical Expenses	Out-patient consultations and diagnostics (reimbursement up to a maximum (in `)	×	×	×	3,000 for Individual option/ 10,000 for floater option	3,000 for Individual option/ 10,000 for floater option	3,000 for Individual option/ 10,000 for floater option	10,000 for Individual option /20,000 for floater option	10,000 for Individual option /20,000 for floater option
	Prescribed medicines (reimbursement up to a maximum)	×	×	×	×	×	×		
Child Vaccination Benefits	Child vaccination benefits (reimbursement up to a maximum)	×	×	×	×	×	×	Up to 12 years of age (`5,000 per annum)	Up to 12 years of age (`5,000 per
Wellness Benefits	Wellness including medical tests at designated centres	√	√	√	√	√	√	√	√
One Time Discount	One time renewal discount-subsequent to death of proposer	10%	10%	10%	10%	10%	10%	10%	10%
Family Discount	Family Discount 10% (Individual SI Policies)	√	√	√	√	√	√	√	√
Voluntary Deductible	Discount in lieu of voluntary deductible	√	√	√	√	√	√	√	√
	Pre-existing disease								
	Compulsory waiting period	2 years	2 years	2 years	2 years	2 years	2 years	2 years	2 years
	Pre-existing disease - max liability 3rd year onwards	50%	50%	50%	50%	50%	50%	50%	50%
	Pre-existing disease - 4th Year onwards	100%	100%	100%	100%	100%	100%	100%	100%
Waiting Periods	General waiting periods								
	30-day - fresh proposals excluding accidental hospitalisation	√	√	√	√	√	√	√	√
	2-year waiting period for listed conditions	√	√	√	√	√	√	√	√
	4-year waiting period - joint replacement and organ transplant	√	√	√	√	√	√	√	√
Compulsory Co-pay	20% co-payment where entry age is from 60 year to 64 years	√	√	√	√	√	√	√	√
	25% co-payment where entry age is from 65 year to 69 years	√	√	√	√	√	√	√	√
	30% co-payment where entry age is from 70 year to 74 years	√	√	√	√	√	√	√	√
	40% co-payment where entry age is 75 years and above	√	√	√	√	√	√	√	√

**Out-patient medical expenses. (Applicable for Superior and Premiere Plan)
In case of bills for any prescribed drugs/medicines, our liability will be restricted to 80% of admissible bills.
In case of dental consultations and diagnostics, our liability will be restricted to 70% of admissible bills.
*All benefits are given within the base Sum Insured except Accidental Hospitalisation.
SI : Sum insured, S: Self, Sp: Spouse, C: Child, P: Parent

D. EXCLUSIONS

1. Exclusions applicable for all Benefits other than Benefit 13

We will not pay for any expenses incurred in respect of any claims arising out of or howsoever related to any of the following (other than for a claim made under Benefit 13):

a) Benefits will not be available for any condition, Illness, or Injury or related condition(s) for which the Insured Person has been diagnosed, received medical treatment, had signs and/or symptoms, prior to inception of the Insured Person's first policy with Us, until 24 consecutive months have elapsed, after the date of inception of the first policy with Us.

This exclusion shall cease to apply if the Insured Person has maintained a health insurance policy with Us for a continuous period of full 24 months, without break from the date of the Insured Person's first health insurance policy with Us.

The period of this exclusion would stand reduced if this Policy is a continuous Renewal of an earlier similar policy of another insurer and has been ported as per the portability regulations of the Insurance Regulatory and Development Authority (IRDA).

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

b) Without derogation from the above Section D 1. a) or (Section III(1) (a) of Policy clause), the Policy will exclude any Medical Expenses incurred during the first consecutive 24 months during which the Insured Person has been covered under a health insurance policy with Us, in connection with Internal Congenital Anomalies, cataracts, Benign Prostatic Hypertrophy, hernia of all types, Deviated Nasal Septum, Hypertrophied Turbinate, Hydrocele, all types of sinuses, Fistulae, hemorrhoids, fissure in ano, dysfunctional uterine bleeding, Fibromyoma Endometriosis, Hysterectomy, all internal or external tumors/cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth, Surgery for prolapsed inter vertebral disc unless arising from Accident, Surgery of varicose veins and varicose ulcers, any types of gastric or duodenal ulcers, stones in the urinary and biliary systems, Surgery on ears and tonsils.

The period of this exclusion would stand reduced if this Policy is a continuous Renewal of an earlier similar policy of another insurer and has been ported as per the portability regulations of the IRDA. The period of exclusion would stand reduced by the period of continuous existence of the earlier policy with another insurer of which this Policy is a Renewal.

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

c) Without derogation from the above Section D 1. a) or Section III(1) (a)of the policy clause , the Policy will exclude any Medical Expenses incurred during the first consecutive 48 months during which the Insured Person has been covered under a health insurance policy with Us in connection with Organ transplant ,Rheumatoid Arthritis, Gout, joint replacement Surgery due to degenerative condition, age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is Medically Necessary due to Injury.

The period of this exclusion would stand reduced if this Policy is a continuous Renewal of an earlier similar policy of another insurer and has been ported as per the portability regulations of the IRDA.

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

d) Medical Expenses incurred for any Illness diagnosed or diagnosable within 30 days, of the commencement of the Policy Period except those incurred as a result of Injury. The exclusion would not apply if this Policy is a continuous Renewal of an earlier similar policy of a different insurer and has been ported as per the portability regulations of the IRDA.

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

e) Outpatient diagnostic, medical and Surgical Procedures or treatments.

f) Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of Injury.

g) Charges incurred at a Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which confi is required at a Hospital.

h) A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges, except to the extent covered under Benefit 7.

2. Exclusions for OPD Treatment claims under Benefit 13

We will not pay for any expenses incurred in respect of any claims made under Benefit 13, arising out of or howsoever related to any of the following:

a) Any expenses in excess of the maximum amount payable under the outpatient medical expenses limit specifi in the Schedule of Benefi

b) Cost of an Annual Health Check-up.

c) Any expenses for OPD Treatment including dental expenses in case of Vital Plan.

d) Any expenses for prescribed medications in case of Superior Plan.

e) Any expenses for consultation, diagnostics, medications which are not duly supported with medical documents from the Medical Practitioner mentioning:

(i) Diagnosis;

(ii) Referral for diagnostic test;

(iii) Prescription for medications.

f) Costs incurred on all methods of treatment except Allopathic.

3. General Exclusions applicable for all Benefits

We will not pay for any expenses incurred in respect of any claims made under the Policy, arising out of or howsoever related to any of the following:

a) Injury or Illness 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).

b) Circumcision, unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an Accident.

c) Vaccination/inoculation (except as post bite treatment) except to the extent covered under Benefits 14 and 15.

d) Cosmetic treatments (for change of life or cosmetic or aesthetic treatment of any description), plastic surgery other than as may be necessitated due to an Accident or as a part of any Illness, refractive error corrective procedures, experimental, investigational or Unproven/Experimental Treatment, devices and pharmacological regimens of any description.

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

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

g) Expenses incurred towards treatment of Illness or Injury arising out of alcohol use/misuse or abuse of alcohol, narcotic substance or drugs (whether prescribed or not).

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

i) In-Vitro Fertilization (IVF), Gamete Intra Fallopian Transfer (GIFT) procedures, and Zygote Intra Fallopian Transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation; voluntary medical termination of pregnancy; any treatment related to infertility, impotence and sterilization.

j) All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymph Tropic Virus Type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or Human Immunodeficiency Virus or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS. This exclusion stands deleted in Premiere Plan except under Section III(2).

k) External Congenital Anomaly and related Illness/ defect.

l) Vitamins, tonics, nutritional supplements unless forming part of the treatment for Injury or Illness as certified by the attending Medical Practitioner.

m) Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.

n) Genetic disorders and stem cell implantation/Surgery/storage.

o) Any treatment required arising from Insured Person's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing unless specifically agreed by Us.

p) Any treatment received in convalescent home, rehabilitation centre, convalescent hospital, health hydro, nature care clinic or similar establishments.

q) Non-prescribed drugs and medical supplies, hormone replacement therapy, sex change or treatment which results from or is in any way related to sex change.

r) Treatment for any mental illness or psychiatric illness.

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

t) Standard list of excluded items attached as Annexure 1 to this Policy.

E. Policy Options: Individual & Family floater

F. Family Definitions:

Vital Plan - Self, spouse, dependent children and dependant parents Children will be covered as dependants upto 25 yrs of age.
Superior and Premiere Plan - Self, spouse, dependant or non-dependant children, dependant or non-dependant parents, Dependent Siblings, daughter in law, son in law, parents in law, grandparents and grandchildren.

Dependent Sum Insured Criteria - In case of individual Sum Insured option, dependents sum insured can be upto two Sums Insured lower than Self /Proposer's sum insured (in applicable plan(s)).
Sums Insured Available in the product are as below:

	Vital Plan		Superior Plan				Premiere Plan	
Sum Insured (in ₹)	3lakhs	5lakhs	10 lakhs	15 lakhs	20 lakhs	25 lakhs	50 lakhs	1 Crore

Example :

Family Member	Self Plan	Self Sum Insured	Dependent Eligible Plan	Dependent Eligible Sum Insured (₹)
Self	Premiere	1crore	Premiere	1crore / 50 lakhs
			Superior	25 lakhs
Self	Superior	25 lakhs	Superior	25 lakhs/ 20 lakhs/ 15 lakhs
Self	Superior	15 lakhs	Superior	15 lakhs
			Vital	10 lakhs /5 lakhs

G. Age Eligibility

Minimum Age At Entry	1 day
Maximum Age At Entry	None
Maximum Renewal Age	Life Long
Minimum policy term	1 year
Maximum Policy term	3 years

Life Long Renewals: The policy if renewed continuously without any break will be renewed lifelong.

Sums Insured – Ranging from ₹ 3 lakhs to ₹ 1crore.
Change in Sum Insured /Plan applicable at renewals only-

a. All proposals wherein change in sum insured or plan is required, need to be referred .

b. Fresh proposal form to be filled.

c. No increase/decrease in Sum Insured/Plan during the currency of the policy.

d. Increase in Sum Insured can be allowed up to two slabs higher, whereas increase in Plan can be allowed up to one plan higher.

e. For age group above 60 years, increase in Plan would not be allowed.

f. For age group up to 50 years increase in sum insured up to ₹ 10Lacs (within Vital Plan) can be allowed without medical examination (in case of no claim / no health declaration).

g. For Superior/Premiere Plan (Sum Insured above 10 lakhs), medical examination is required irrespective of age.

h. For age group above 50 years increase in sum insured can be allowed with medical examination.

i. Decrease in Sum Insured allowed up to one slab lower only, in case of no claim in any preceding Health Total policies.

j. The Dependent Sum insured criteria will apply for enhancement of sum insured for dependent.

k. Sum insured enhancement would be allowed for age group lower than 50 years in case of portable policies.

l. For every Sum insured enhancement the following wording to appear on the face of the policy "For the enhanced Sum Insured ,the waiting periods will apply afresh".

Example – Increase in Sum Insured

Sr. No	Plan	Sum Insured INR	Eligibility	
			Plan	Sum Insured
1.	Vital Plan	3 lakhs	Plan 1	5 lakhs/10 lakhs
2.	Vital Plan	5 lakhs	Plan 1	10 lakhs
			Plan 2	15 lakhs
3.	Superior Plan	15 lakhs	Plan 2	20 lakhs/25 lakhs
4.	Premiere Plan	20 lakhs	Plan 2	25 lakhs
			Plan 3	50 lakhs

In case of SI enhancement for proposals with age falling under pre-acceptance medical grid as mentioned earlier or proposals with positive declarations, they should be referred 1 month prior to the renewal date for test advice, so that the renewal is in time and there is no break. This applies for our company and other company renewals.

Copayment Applicability:

In case an insured enters the policy at the age given in the table, the respective copayments will be applicable on each and every admissible claim

Age	Co-payment
60 yrs to 64 yrs	20%
65 yrs to 69 yrs	25%
70 yrs to 74 yrs	30%
75 yrs and above	40%

Pre-acceptance medical tests:

Pre-acceptance medical tests are not required for all proposers upto the age of 50 yrs for Vital Plan in case of clean proposal form (ie without any health declaration) . For age 51 years and above, medical tests are required.

Compulsory medical tests for Superior and Premiere plan for completed age 18yrs and above.

H. Medical Tests

Plans	Vital		Superior		Premiere	
Age band	Up to 50 years	Above 50 years	From 18 years to 50 years	Above 50 years	From 18 years to 50 years	Above 50 years
Medical tests	Not required	Required	Required	Required	Required	Required
Series details	Not Applicable	Series 3	Series 4	Series 8	Series 7	Series 8

*No tests required for children below 18 years for any plan

** Age in completed years

SERIES 3:

(FMR, ECG, LAB2 (F & PP (BSL) + CBC + S.Cholesterol + S.Creatinine + Urinalysis + Lipid Profile (S.Cholesterol+HDL+LDL+S. Tr ig lys er ide s) +LF T(Tot al Bi li rub in+ SG OT+ SG PT +A. Phosphatase+GGTP+Protiens (total)+RFT (Renal Function Test)-Bl. Urea + S.Electrolytes.)

SERIES 4:

(FMR, ECG + LAB 3 (F & PP (BSL) + CBC + S.Cholesterol + S.Creatinine + Urinalysis + Lipid Profile (S.Cholesterol + HDL + LDL + S.Triglyserides) + LFT (Total Bilirubin + SGOT + SGPT + A.Phosphatase + GGTP + Proteins (total) + RFT + HbsAg + HbA1C +HIV1&2)

SERIES 7:

(FMR, ECG, +CTMT (stress test) + LAB 3((F&PP(BSL) + CBC + S.Cholesterol + S.Creatinine + Urinalysis + Lipid Profile (S.Cholesterol+HDL+LDL+S.Triglyserides) + LFT (Total Bilirubin + SGOT + SGPT + A.Phosphatase + GGTP + Proteins(total) + RFT + HbsAg + HbA1C + HIV1&2)

SERIES 8:

(FMR, ECG, 2DEcho + LAB 3 ((F&PP(BSL) + CBC + S.Cholesterol + S.Creatinine + Urinalysis + Lipid Profile (S.Cholesterol + HDL + LDL + S.Triglyserides) + LFT (Total Bilirubin + SGOT + SGPT + A.Phosphatase + GGTP + Proteins (total) + RFT +HbsAg + HbA1C +HIV1&2)

FMR:

Full Medical Report by an MD Physician

ECG:

Electrocardiogram reported by an MD Physician

Lab 2: includes Fasting Blood Glucose, Post prandial blood sugar, Complete Blood Count (incl Diff), Lipid Profile- Serum Cholesterol, HDL Cholesterol , LDL Cholesterol, Serum Triglycerides ,Urinalysis (chemical & microscopic), Liver Function tests – (Serum Bilirubin , SGOT , SGPT ,Serum Alkaline Phosphatase ,GGTP), Renal Function Tests – (Serum Creatinine, Blood Urea ,Total Proteins and Serum Electrolytes.)

Installment frequency	Loading on standard premiums
Monthly	5%
Quarterly	4%
Half yearly	3%

Relaxation period for the policies with installment option would be as under:

Installment Option	Relaxation for payment of premium
Annual	15 days
Half yearly	15 days
Quarterly	15 days
Monthly	15 days

In case of installment premiums not received within the relaxation period the Policy will get cancelled and a fresh policy with all waiting periods applicable would be issued.

5. Floater discount:

Applicable discount is as per following table:

Age Band	Discount Rates	Age Band	Discount Rates
0-17	60%	51-55	40%
18-25	55%	56-60	35%
26-30	50%	61-65	35%
31-35	45%	66-70	35%
36-40	45%	71-75	35%
41-45	40%	76-80	25%
46-50	40%	81-85	25%
		>85	20%

Premium applicable for the primary insured will be the standard individual premiums from the premium table. For remaining dependant members, floater discounts applicable on their respective premium is as per table above.

6. Direct Sales Discount:

A discount of 15% in lieu of intermediary commissions if policy is taken directly from the insurer and /or Online

Loading on Claim experience:

There will be no loading on premium for adverse claims experience

K. Claims Procedure

If the Insured Person meets with any Injury or suffer an Illness that may result in a claim under the Policy, then as a Condition Precedent to Our liability, the following must be complied with:

a) Cashless Facility is only available at a Network Provider. In order to avail of Cashless Facility, the following procedure must be followed:

(i) For availing cashless at a Network Provider, We must be called at Our call centre and a request for pre-authorisation must be made by way of the written form prescribed by Us.

(ii) After considering the request and obtaining any further information or documentation that We have sought, We may, if satisfied, send the Network Provider an authorisation letter. The authorisation letter, the ID card issued to the Insured Person along with this Policy and any other information or documentation that We have specified must be produced to the Network Provider identified in the pre-authorisation letter at the time of the Insured Person's admission to the Hospital.

(iii) If the above procedure is followed, the Insured Person will not be required to directly pay for those Medical Expenses to the Network Provider that We are liable to indemnify under this Policy. The original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorisation does not guarantee that all costs and expenses that are incurred will be covered. We reserve the right to review each claim for Medical Expenses incurred and accordingly coverage will be determined according to the terms, conditions and exclusions of this Policy. All other costs and expenses that are not covered under this Policy must be settled directly with the Network Provider and We shall have no liability in this regard.

b) If a pre-authorisation request is denied by Us or if treatment is taken in a Hospital other than a Network Provider or if You/Insured Person does not wish to avail of the Cashless Facility, then:

a) We must be given Notification of Claim in writing immediately and in any event within 48 hours of the commencement of the Illness or Injury. The Insured Person must immediately consult a Medical Practitioner and follow the advice and treatment that he/ she recommends.

b) The Insured Person must take reasonable steps or measures in good faith to minimise the quantum of any claim that may be made under this Policy.

c) The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.

d) We must be given promptly, and in any event within 15 days of the Insured Person's discharge from a Hospital, the documentation including written details of the quantum of any claim along with all original supporting documentation, including but not limited to the following, and other information We ask for to investigate the claim for Our obligation to make payment for it:

- The claim form specified by Us duly completed and signed by the claimant or a family member;
- First consultation letter;
- First prescription from the Medical Practitioner;
- original vouchers;
- original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;
- Money receipt duly signed with a revenue stamp;
- Birth/death certificate (as applicable);
- The original Hospital discharge card;
- All original laboratory and diagnostic test Reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc;
- If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist;
- If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.

c) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir 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.

d) If We are not given notice/documentation within the timeframes set out above, then We may accept the claim notice/documentation if it is demonstrated to Us that the delay was for reasons beyond the control of the claimant.

L. Basis of claims payment

1.

a) Claims related to Pre-existing Diseases:

We shall indemnify upto 50% of the admissible claim amount in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule where the claim arises during the third year of continuous Renewal with Us of the Policy for the same Sum Insured and Plan. We shall indemnify upto 100% of the admissible claim amount in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule from the fourth year of continuous Renewal with Us of the Policy for the same Sum Insured and Plan. The above clause is applied subject to portability regulations.

b) Claims related to Surgery for cataracts:

Our obligation to make payment in respect of Surgery for cataracts (after the expiry of the two years period referred to in Section III(1) (b) of policy clause), shall be restricted to 10% of the Sum Insured for each eye, and a maximum of ₹ 1,00,000/- per eye.

c) Claims related to Any One Illness:

All claims relating to Any One Illness shall be deemed to be part of the same original claim.

d) Claims for Day Care Treatment:

The Day Care Treatments listed are subject to the exclusions, terms and conditions of the Policy and will not be treated as independent coverage under the Policy.

e) Claims between 2 Policy Year

If the claim event falls within two Policy Years, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Year, including the Deductibles for each Policy Year. Such eligible claim amount to be payable shall be reduced to the extent of premium to be received for the Renewal/due date of premium of the Health Total Policy, if not received earlier.

2. Co-Payments Applicable under the Policy

The following Co-payments shall be applicable for claims under all Benefits other than Benefit 13:

a) Any Insured Person aged 60 years to 64 years, being covered for the first time in a Health Total Policy shall bear 20% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

b) Any Insured Person aged 65 years to 69 years, being covered for the first time in a Health Total Policy shall bear 25% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

c) Any Insured Person aged 70 years to 74 years, being covered for the first time in Health Total Policy shall bear 30% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

d) Any Insured Person aged 75 years and above, being covered for the first time in Health Total Policy shall bear 40% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

3. Voluntary Deductible Applicable under the Policy for all claims under Benefit 1

a) If a Voluntary Deductible has been opted and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount for each and every claim made under Benefit 1

b) Wherever Co-payments are applicable, as per Section IV(6) above, the same would be applied on the admissible claim amount after the application of Voluntary Deductible, if any.

M. Fraud

If You/Insured Person or Your nominee/legal heir or any person acting on Your/their behalf makes or progresses any claim knowing it to be false or fraudulent in any way, then this Policy will be void and all claims or payments due and the premium paid shall be forfeited

N. Renewal & Cancellation

a) A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the Insured Person.

b) In case of a Renewal a grace period of 30 days is permissible and the Policy will be considered as continuous for the purpose of all waiting periods and health check-up benefits. However, We shall not provide coverage under the Policy to the Insured Persons for any Illness or Injury that occurs during the break period or for any claim which arises during the break period.

c) For Renewal Proposal received after completion of grace period of 30 days, all waiting periods including for health check-up, would apply afresh.

d) This Policy may be renewed at the expiry of the Policy Period on payment of the Renewal premium.

e) Renewals will be lifelong and will not be refused or cancellation will not be invoked by Us except on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured.

f) We may cancel this Policy by giving You at least 15 days written notice on the grounds of fraud, moral hazard or misrepresentation or non-cooperation.

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

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

h) In case the Policy Period exceeds one year, this Policy may be cancelled by the Insured Person at any time by giving at least 15 days written notice to Us. We will refund premium on a pro-rata basis by reference to the time period cover is provided, subject to a minimum retention of premium of 25%.

i) No refund of premium shall be due on cancellation if the Insured Person has made a claim under this Policy.

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

k) The brochure/ prospectus mentions the premiums as per the age slabs/ Sum Insured and the same would be charged as per the completed age at every Renewal. The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the IRDA. However such revised premiums would be applicable only from subsequent Renewals and with due notice whenever implemented.

O. Portability

a) All health insurance policies are portable.

b) Portability if requested by the Insured Person, shall be applicable to the previous sum insured and the Cumulative Bonus acquired under the previous policies. The premium applicable would be for the enhanced sum insured (Sum Insured + Cumulative Bonus) and if the same is not available, to the next higher Sum Insured available if requested by the Insured Person.

c) This clause does not alter the annual character of this insurance policy or Our right to decline to renew or to cancel the Policy.

d) Portability will be granted to policyholders of a similar health indemnity policy of another insurer to Health Total Policy as per portability guidelines of the IRDA.

e) Portability will be granted subject to the policyholder desirous of porting his policy to Health Total Policy applying to Us at least 45 days before the premium renewal date of his/her existing policy.

f) We will not be liable to offer portability if policyholder fails to approach us at least 45 days before the premium renewal date.

g) Where the outcome of acceptance of portability is still awaited from Us on the date of Renewal the existing policyholder should extend his existing policy with the existing insurer on a short period basis as per the portability guidelines of the IRDA.

h) Portability will be allowed for all individual health insurance policies issued by non-life insurance companies including family floater policies.

i) Portability will be applicable for waiting periods under Benefit 1 to 4 except maternity benefit.

j) Policyholders should initiate action to approach another insurer, to take advantage of portability, well before the Renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

P. Dispute Resolution

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

Q. Revision / Modification

There is a possibility of revision/modification of terms, conditions, coverages and/or premiums of this product at any time in future, with the appropriate approval from the IRDA. In such an event of revision/modification of the product, intimation shall given to You at least 3 months prior to the date such revision/modification of the Policy comes into the effect.

R. Withdrawal of Policy

There is a possibility of withdrawal of this product at any time in future with appropriate approval from the IRDA, as We reserve Our right to do so with intimation of 3 months prior to the withdrawal of this product. In such an event of withdrawal of this product, at the time of Your seeking Renewal of this Policy, You can choose, among Our available similar and closely similar health insurance products. Upon Your so choosing Our new product, You will be charged the premium as per Our underwriting policy for such chosen new product, as approved by the IRDA. Provided however, if You do not respond to Our intimation regarding the withdrawal of the product under which this Policy is issued, then this Policy shall be withdrawn and shall not be available to You for Renewal on the Renewal date and accordingly upon Your seeking Renewal of this Policy, You shall have to take a Policy under available new products of Ours subject to Your paying the Premium as per Our Underwriting Policy for such available new product chosen by You and also subject to Portability condition.

S. Territorial Limits and Law

a) Except as provided in Benefit 18, We shall cover only treatment and investigations covered in terms of this Policy that is taken during the Policy Period and takes place anywhere in the territory of 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 between Us and You/Insured Person. 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.

T. Free –look period

1. You will be allowed a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of the Policy and to return the same if not acceptable.

2. If no claim has been made during the free look period, You shall be entitled to-

a) A refund of the premium paid less any expenses incurred by Us on medical examination of the Insured Persons and the stamp duty charges;

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

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

U –Premium rates exclusive of Goods & Services Tax (age in completed years)

(In ₹)

Age / Sum Insured	VITAL			SUPERIOR			PREMIERE	
	3,00,000	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000	50,00,000	1,00,00,000
0-17	4,418	5,061	6,856	8,019	10,400	12,451	37,637	48,628
18-25	4,645	6,213	8,471	10,198	11,923	13,661	39,587	50,572
26-30	4,718	6,718	8,501	10,515	12,034	14,429	40,635	52,037
31-35	4,724	6,739	8,582	10,687	12,523	16,031	45,386	58,388
36-40	4,999	6,752	8,639	10,731	13,942	16,875	48,853	63,237
41-45	5,468	7,227	9,394	12,793	16,858	20,622	56,230	74,117
46-50	8,074	10,033	13,726	17,094	22,453	27,490	69,237	85,353
51-55	11,799	14,866	20,290	25,088	30,870	36,638	85,067	97,038
56-60	15,216	18,311	25,997	31,379	37,228	41,447	99,916	1,13,356
61-65	29,734	34,638	41,816	44,878	48,235	53,934	1,27,456	1,43,324
66-70	37,151	43,613	49,846	53,201	55,518	61,221	1,51,111	1,69,331
71-75	41,096	48,884	56,204	60,241	61,674	67,657	2,13,368	2,37,783
76-80	55,102	64,911	71,342	75,324	78,468	84,246	3,01,946	3,35,176
81-85	65,661	79,968	85,763	89,886	94,353	1,02,736	3,90,351	4,32,376
>85	67,559	81,522	87,236	91,935	1,01,603	1,16,036	4,32,241	4,78,455

Floater Premium rates :

Premium applicable for the primary insured will be the standard individual premiums from the premium table. For remaining dependant members, floater discounts applicable on their respective premium is as per table below .

Applicable discount is as per following table:

Age Band	Discount Rates	Age Band	Discount Rates
0-17	60%	51-55	40%
18-25	55%	56-60	35%
26-30	50%	61-65	35%
31-35	45%	66-70	35%
36-40	45%	71-75	35%
41-45	40%	76-80	25%
46-50	40%	81-85	25%
		>85	20%

For example – In case of a family of Self, spouse and 1 child, the premium for floater for Sum Insured ₹ 10,00,000 would be charged in the following manner –

	Self	Spouse	Child
Age band	36-40	31-35	0-17
Premium as per Individual rate table (in `)	8639	8582	6856
Applicable premium (in `)	8639	4720 (45% discount applied on the respective person's premium)	2742 (60% discount applied on the respective person's premium)
Total Premium to be charged (in `)	16101		
	16101		

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

"I agree to undergo medical tests as advised by the Insurance Company. I agree to a medical underwriting loading as per underwriting guidelines of the Company."

Signature Place

Name Date

In case of any claims please contact:

Claims Department Future Generali Health (FGH) Future Generali India Insurance Co. Ltd. Office No. 3, 3rd Floor, "A" Building, G - O - Square S. No. 249 & 250, Aundh Hinjewadi Link Road, Wakad, Pune - 411 057.

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

FGH/UW/RET/86/02

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PROPOSAL FORM FOR HEALTH TOTAL

IO No : _____

App No : _____

Client Code : _____

Receipt No : _____

Payer ID : _____

Important guidelines:

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

Received date:_____ **Branch code:**_____ **Branch name:**_____

Period of insurance desired: from: DD / MM / YYYY **to** DD / MM / YYYY

1. Proposer details*: Name: ☐ Mr. ☐ Ms. ☐ M/s

2. Address and Other Details*:

State																		**Pin code**									
Tel No												**Mobile no**															
Email id																											
PAN*												**Aadhaar Number***															
PAN Enrolment Form number												**Aadhaar Enrolment Form number**															

Note:

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

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

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

3. Gender*: ☐ Male ☐ Female **4. Date of birth*:**_____/_____/_____ **5. Age*:**_____

6. Nationality*:_____ **7. Annual gross income (`):**_____

8. Marital status*: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorce **9. Occupation*:** ☐ Service ☐ Self Employed ☐ Other

10. Family doctor details: Dr.																									
Address																									
State																		Pin code							
Telephone no.														Fax no.											
Email id																									

11. Are you an existing Future Generali customer*? ☐ Yes / ☐ No. If yes, please provide:

Existing policy no:_____ Customer id no: _____

12. Plan details*: (please refer to the brochure for details of the plan before choosing the plan)

Options: Individual (in case sum insured opted on individual basis kindly fill details in table number 19 below)
Floater (in case sum insured opted on floater basis kindly tick the required plan below)

Plans			
Vital	₹ 300,000	₹ 500,000	₹ 1,000,000
Superior	₹ 1,500,000	₹ 2,000,000	₹ 2,500,000
Premiere	₹ 5,000,000		₹ 10000000

13.Voluntary deductible:

Deductible amount in ₹ Per claim (please tick any one deductible as per the plan opted)

Discount in % in lieu of voluntary deductible

Options		**A**	**B**	**C**
Vital plan	Deductible	☐ ₹ 10,000	☐ ₹ 25,000	☐ ₹ 50,000
	Discount	10.00%	15%	20.00%
Superior plan	Deductible	☐ ₹ 50,000	☐ ₹ 75,000	☐ ₹ 1,00,000
	Discount	15.00%	20.00%	25.00%
Premiere plan	Deductible	☐ ₹ 1,00,000	☐ ₹ 2,50,000	☐ ₹ 5,00,000
	Discount	15.00%	20.00%	25.00%

14.Policy term *(please tick the term opted): ☐ 1 year ☐ 2 years ☐ 3 years

In case policy term more than one year, installment option is available. Please tick any one option in case you want to opt for:

☐ Monthly ☐ Quarterly ☐ Half yearly

Please Note: Under installment option, for policies issued from 1st to 15th of the month, 5th of month shall be the Automated Clearing House (ACH) debit date. For policies issued from 16th to 31st of the month, 25th of the month shall be the ACH debit date.

15. Family definition:

- **Vital plan:** - Family means - self, spouse, dependent children (unmarried and up to the age of 25 years) and dependent parents
- **Superior plan & Premiere plan:** Family means-self, spouse, dependent (unmarried and up to the age of 25 yrs) or non – dependent children, dependent or non – dependent parents, dependent siblings, daughter in law, son in law, parents in law, grandparents and grandchildren

Note - any of the above plans can be opted either on individual basis or on floater basis.

*For Individual and Family Floater cover kindly indicate details of all the members to be covered as per the table below.

*Please note for Family Floater cover do not fill anything in sum insured & premium computation column since sum insured and Voluntary deductible option (if opted) is common for all members.

16. Details of persons to be insured* (in case the nominee is a minor, please provide the name of the appointee)**

Sr. No	Name	Gender	Date of birth	Relationship with proposer	Height	Weight	Occupation	Nominee name**	Relationship of nominee with insured	Plan & sum insured/ Voluntary Deductible opted	Premium computation individual or floater (for office use only)
1	Primary insured			Self							
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

17. Section applicable for females only:

a. Please confirm if any of the persons to be insured is pregnant – ☐ Yes / ☐ No

b. Please indicate obstetric details in below table for all females insured:

Sr. No	Insured name	Number of living children as on date	Any maternity related complications in present or past , For example miscarriage, gestational diabetes, ectopic pregnancy or any other, please provide details

18. Health questions*: please answer „"Yes"" or "No". If „"Yes„" please provide details below.

Sr no	A	B	C	D	E	F	G
	Are you in good health and free from physical and mental disease or infirmity or medical complaints or deformity?	Do you regularly consume tobacco / alcohol or smoke - (please specify – yes/ no. If yes please mention – quantity / day, number of years since consuming/ smoking)	Does any person to be insured suffer or has suffered in the past from any of the following? Disorder of the heart including ischemic heart disease / rheumatic heart disease, or circulatory system, chest pain, high blood pressure, stroke, asthma, any respiratory condition, cancer or tumour / lump of any kind, diabetes, hepatitis, disorder of urinary tract or kidneys, blood disorder, any mental or psychiatric conditions, any disease of brain or nervous system, fits (epilepsy), slipped disc, backache, any congenital / birth defects / disease, AIDS or tested positive for HIV, or any other disease – yes / no. If „yes", indicate in the table given below.	Name of disease / illness / injury suffering from, in the past or at present. Any other diseases or ailments not mentioned? If „yes", give details in the table given below.	Disease / illness / injury / suffering since when / when first treated (applicable to question 21-c and d both). If applicable please mention details. If not applicable please mention "no"" in the table given below	Treatment / medication received / receiving. If applicable please mention details. If not applicable please mention "no"" in the table given below	Are you fully cured? (Yes /No) - applicable only if any of the points„c" to „f" is „Yes"
Insured 1	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 2	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 3	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 4	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 5	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 6	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 7	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 8	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 9	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 10	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 11	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 12	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 13	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 14	Yes/no	Yes/no	Yes/no	Yes/no			
Insured 15	Yes/no	Yes/no	Yes/no	Yes/no			

19. Other concurrent health insurance information*(please provide details of any health insurance cover that you or your family members hold for Future Generali Insurance Company Limited Or any other health insurance)

Description	Policy no	Name & address of insurance company	Sum insured	Period of insurance (first inception date -dd/mm/yy)	From: dd/mm/yy to: dd/mm/yy	Claim details,claim amount received or receivable (in Rs)
Insured 1						
Insured 2						
Insured 3						
Insured 4						
Insured 5						
Insured 6						
Insured 7						
Insured 8						
Insured 9						
Insured 10						
Insured 11						
Insured 12						
Insured 13						
Insured 14						
Insured 15						

20. In case of portability, kindly fill portability request form along with this form.

21. Attach age proof document for each insured. Please tick whichever is applicable: ☐ Passport ☐ PAN Card

☐ Driving license ☐ School/college leaving certificate ☐ Letter from recognized public authority

☐ Others, please specify.

22. Declaration*:

1. "I/We hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that i/we am/are authorized to propose on behalf of these other persons.

2. I/we understand that the information provided by me will form the basis of the insurance policy, is subject to the board approved underwriting policy of the insurance company and that the policy will come into force only after full receipt of the premium chargeable.

3. I/we further declare that i/we will notify in writing any change occurring in the occupation or general health of the life to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the company.

4. I/we declare and consent to the company seeking medical information from any doctor or from a hospital who at any time has attended on the life to be insured/proposer or from any past or present employer concerning anything which affects the physical or mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/proposer has been made for the purpose of underwriting the proposal and/or claim settlement.

5. I/we authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any governmental and/or regulatory authority."

6. I/We hereby acknowledge that I/we have read and understood the contents of the prospectus and have been explained the features, contents and terms of the *Prospectus/Product by the Intermediary/Agent to my/our satisfaction. I agree to undergo medical tests as advised by the Insurance Company. I agree to a medical underwriting loading as per underwriting guidelines of the Company (* To download a copy of the Prospectus and for further details about the product, please visit our website *www.futuregenerali.in*)

7. I agree that this proposal and the declaration shall be the basis of the contract between me and FUTURE GENERALI INDIA INSURANCE CO LTD and I/We agree to accept a policy, subject to the conditions prescribed by FUTURE GENERALI INDIA INSURANCE CO LTD.

8. I hereby authorize the company to authenticate and/or verify my Aadhaar number for e-KYC purpose

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

I/ We hereby declare that the premium is paid from the Bank Account of Mr. /Ms._____, the payment is allowed under the Income Tax Act 1961, and there is insurable interest with the payee. I/we am/are (please tick all that are applicable)

☐ High Net Worth Individual/s ☐ Non Residential Indian/s ☐ Politically Exposed Person/s ☐ Jewelers/s

☐ Non-Governmental Organization ☐ Film Actor/s ☐ Producer/s

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

Date*:_____ **Place*:**_____ **Proposer"s Name***_____

Proposer"s Signature*:_____

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

Intermediary/Agent Name_____ Intermediary/Agent Signature _____

Prospect"s ThumbImpression_____

23.Payment details*:

Premium paid by cash/cheque no (s) _____

Date_____Bank _____

Amount (`) _____

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

Please fill up the request for authorization form attached with this proposal form to receive claim / refund payments if any, directly into your bank account through NEFT if the premium is more than ` 25000/-

24. For office use only

Intermediary"s name:	Intermediary"s code:
Sales manager"s name:	Sales manager"s code:

Section 41. of Insurance act, 1938-prohibition of rebates: No person shall allow or offer either, directly or indirectly as an inducement to any person to take out or renew or continue and insurance in respect of any kind or risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or renewing or continuing a policy accept rebate except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

FGH/UW/RET/84/05