Tata AIA Life Insurance Group Sampoorna Raksha (UIN: 110N154V01)

2. PART B

Tata AIA Life Insurance Group Sampoorna Raksha is a Non-Linked, Non-Participating, Group Protection Oriented Life Insurance Plan.

2.1. Basic definitions

In this Policy, where consistent with the contents, the singular shall include the plural and the plural the singular; words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following meanings:

"Accident" refers to a sudden, unforeseen and involuntary event caused by external, violent and visible means which occurs during the lifetime of the Insured Member, but excludes illness and diseases.

"Accidental Death" means the death of the Insured Member which results directly, solely and independently of any other causes from Bodily Injury and occurs within 180 days of the date of Accident.

"Certificate of Insurance" means the certificate issued by the Company to an Insured Member to confirm his coverage under the Policy. Coverage in respect of an Insured Member shall commence from the Effective Date of Coverage mentioned therein.

"Claimant" means the Insured Member or the Nominee or the Legal heir of the Insured Member as the case may be.

"Company" shall mean the Tata AIA Life Insurance Company Limited.

"Coverage Effective Date" shall mean the commencement date of the insurance coverage in respect of each Insured Member under this Policy or as may be specified in his/her Certificate of Insurance.

"Coverage Term" shall be the period during which the insurance cover of the Insured Member shall continue,

a) Certificate of Insurance - till the expiry of the term as specified in the Certificate of Insurance.
b) Policy Document - till the expiry of the term as specified in the Policy.

"Critical Illness" means illnesses the signs or symptoms of which first commence more than ninety (90) days following the Date of Commencement of Risk or Coverage Effective Date of Insured Member or date of revival whichever is later, and shall include either the first diagnosis of any of the illnesses or first performance of any of the covered surgeries stated in this document.

"Date of Diagnosis" is the date when the diagnosis is first confirmed by test reports or consultation report or note signed by a Registered Medical Practitioners.

"Diagnosis" refers to the act or process of identifying or determining the nature and cause of a disease or injury, by a registered medical practitioner, through evaluation of patient's history, examination, and review of laboratory data. It must be supported by clinical, radiological, histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable.

"Eligible Members" shall mean those members who satisfy and continue to satisfy the eligibility criteria specified in, Section 2.2.1 of this Policy, and are eligible for coverage in the insurance plan under this Policy.

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"First Diagnosis" refers to the first diagnosis of any of the illnesses covered (as listed above) during the Coverage Term.

"**Grace Period**" The time granted by the Company from the due date of payment of Premium, without any penalty/ late fee, during which time the coverage of the Insured Member is considered to be in-force as per the terms of the Policy/Certificate of Insurance.

"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:

(i) Has qualified nursing staff under its employment round the clock
(ii) Has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places
(iii) Has qualified medical practitioner (s) in charge round the clock
(iv) Has fully equipped operation theatre of its own where surgical procedures are carried out.
(v) Maintains daily records of patient and will make these accessible to the Insurance Company's authorized personnel

"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.

"Insured Member/Member" shall mean those members who are and continue to be Eligible Members and who, in accordance with the provisions of this Policy, are covered in the insurance plan under this Policy.

"IRDAI" means the Insurance Regulatory and Development Authority of India.

"Joint Insured Members" shall mean Eligible Members whom, in accordance with the provisions of Part C Section 3.1.1.2are participating for Joint Life Insurance under a single loan, provided there shall be insurable interest between the lives.

"Master Policyholder/Policyholder" means an institution or organization or entity to whom this Policy is issued by Us, as specified in the Schedule. Where the policy is availed under Lender-Borrower Group Schemes, the Master Policyholder/ Policyholder shall be the Scheduled Commercial Bank (including co-operative banks), NBFC, Small Finance Bank regulated by Reserve Bank of India, Housing Finance Company regulated by National Housing Bank, National Minorities Development Finance Corporation and its stake channelizing agency, mutually aided Co-operative Society formed and registered under applicable State Act, Micro Finance Company registered u/s. 8 of the Companies Act, 2013 or any other category as approved by the IRDAI.

"Medical advice" refers to any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council of the Indian Medicine or for Homoeopathy 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 license; but excluding a Physician who is the Insured Member himself or an agent of the Insured Member, an insurance agent, business partner(s) or employer/ employee of the Insured Member or

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a member of the Insured Member's immediate family. Insured Member's immediate family will mean his Spouse, Father (including step father) or Mother (including step mother), Son (including step son), Son's wife, Daughter, Daughter's husband, Brother (including step brother) and Sister (including step sister).

"Nominee" shall mean the person(s) nominated by the Insured Member to receive the insurance benefits payable in the event of the death of the Insured Member.

"Policy" shall mean this agreement, any supplementary contracts or endorsements therein, whenever executed, any amendments thereto signed by the Company, the application attached hereto of the Policyholder and the Policy Schedule.

"Premium" means the amount specified in the Policy Schedule, payable by you, by the due dates to secure the benefits under the Policy, excluding applicable taxes, cesses or levies, if any.

"Regulated Entity" shall mean an entity administering Lender-Borrower Group Scheme and shall be the Reserve Bank of India (RBI) Regulated Scheduled Commercial Banks (including Co-operative Banks), NBFCs having Certificate of Registration from RBI, National Housing Bank (NHB) Regulated Housing Finance Companies, National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies, Small Finance Banks regulated by RBI, Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies, Microfinance companies registered under section 8 of the Companies Act, 2013 or any other category as approved by the Authority.

"**Revival Period**" means the period of five consecutive years from the date of discontinuance of the Policy/Certificate of Insurance, during which period the Policyholder/Insured Member is entitled to revive the Policy/Certificate of Insurance which is discontinued due to the non-payment of Premium.

"Sum Assured" shall mean the amount of benefit payable on the occurrence of an insured event and will be an amount as indicated in his Certificate of Insurance or Policy, as the case may be, and accepted by the Company. Under Reducing Coverage option, if the Sum Assured is being linked to a loan, the Sum Assured will decreases in line with the loan repayment schedule. The reduction in Sum Assured shall be as per the interest rate considered at the time of risk commencement for the Insured Member. The total Sum Insured under this Policy on the life of any Insured Member at any given time for a loan shall not, in any event, exceed an amount of Rs. << *Amount*>>.

"Specialized Medical Practitioner" is a person who holds a Masters' degree in the field of Medicine or Surgery and valid registration from the Medical Council of any state of India and is thereby entitled to practice Medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

"Surgery or Surgical Procedure" means manual and / or operative procedure(s), required for treatment of an illness or injury, correction of deformities or defects, diagnosis and cure of disease, relied of suffering or prolongation of life, performed in a Hospital or Daycare center by a Medical Practitioner.

"Total Premiums Paid" means total of all the Premiums received, excluding any extra premiums, any rider premiums and taxes.

"Waiting Period" - Claim for Critical Illness and Total Permanent Disability due to illness will only be accepted if the illness has occurred after the expiry of ninety (90) days from the date of commencement of risk or Coverage Effective Date of the Insured Member or date of revival, whichever is later. Claim for Terminal Illness will only

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be accepted if the illness has occurred after the expiry of hundred and eighty days (180) days from the date of commencement of risk or Coverage Effective Date of the Insured Member or date of revival, whichever is later. Waiting Period will not be applicable for existing Insured Members of take over and renewal schemes if the coverage is existing. It will be applicable for all new Insured Members of the coverage (take over or renewal) and for all Insured Members if the rider coverage is introduced for the first time.

"**We**", "**Us**", "**Our**" or "**Company**" refers to Tata AIA Life Insurance Company Limited.

"**You**" or "**Your**" means the Policyholder of this Policy as shown in the Policy Schedule.

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2.2. ELIGIBILITY, PARTICIPATION AND TERMINATION

2.2.1. ELIGIBILITY

Each member of the Policyholder shall be eligible to apply for insurance coverage under this Policy subject to fulfilment of the following conditions:

1. The member is a natural person
2. He has attained the Minimum Entry Age but is not over Maximum Entry Age as mentioned in the Policy Schedule attached hereto, at his last birthday.
3. The proposed term of insurance coverage at his Coverage Effective Date shall not be less than the Minimum Coverage Term or more than the Maximum Coverage Term as mentioned in the Policy Schedule attached hereto.
4. The initial Sum Insured at the Coverage Effective Date shall not be less than the Minimum Sum Insured or more than the Maximum Sum Insured as mentioned in the Policy Schedule attached hereto.
5. If the Sum Assured is linked to a loan, the member is a primary borrower or a co-borrower of the loan being covered hereunder. A maximum of five co-borrowers may become eligible for joint life insurance hereunder.

2.2.2. PARTICIPATION

1. If the Premium is borne by the Policyholder, the Eligible Member may be covered under the Policy by the Policyholder. If the Premium is borne by the Insured Member, the Eligible Member may apply through the Policyholder for coverage in this Policy by completing the member enrolment form including the Health Declaration / Health Questionnaire available with the Policyholder and submitting satisfactory evidence of insurability to the Company. The Policyholder shall forward such member enrolment forms to the Company for underwriting the risk.
2. Medical examination as determined by the Company shall be required for all Eligible Members whose total Sum Insured (under this Policy and other policies issued by the Company) and entry age exceeds the non-medical limit of the Policy. Medical examination may also be required for Eligible Members not exceeding the non-medical limit as determined by the Company on a case to case basis for underwriting the risk.
3. Insured Members whose participation has been terminated and who re-apply for participation shall be considered as new Eligible Members. The Company reserves the right to request and review evidence of insurability for any Eligible Member electing to re-apply for the cover. The extent and terms of the cover will be determined by the Company, based on the evidences provided.
4. A minimum of 10InsuredMembers in case of employer-employee group and 50 in case of non employer-employee group are required to avail this Group Insurance Policy. The membership can be compulsory or voluntary in nature.
5. In case of surrender of Group Policy, there is an option provided to the individual member of the Group, to continue the Policy as an individual Policy.

2.2.3. TERMINATION OF THE POLICY

The coverage under the Policy shall automatically cease as below:

1) Upon the date of completion of Policy Term/Coverage Term. Under such cases, if the Coverage Term is beyond the Policy Term, the coverage shall continue till the expiry of the Coverage Term.
2) Upon the date on which the Master Policyholder surrenders the Policy. Under such cases, if the Coverage Term is beyond the Policy Term, the coverage shall continue till the expiry of the Coverage Term.
3) The date on which the Master Policyholder receives the payment for refund of Premium pursuant to free look cancellation request. The coverage of all the Insured Members shall cease immediately.

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2.2.4. TERMINATION OF THE COVER

The coverage of the Insured Member shall automatically cease on the earliest of the following dates:

1. The date of the expiration of the Coverage Term.
2. The date on which the Insured Member attains the Maximum Age for coverage as defined in the Policy Schedule attached hereto.
3. Date of death of the Insured Member.
4. The date on which the Insured Member surrenders the Certificate of Insurance for availing the surrender benefit.
5. In case of joint life –
    a. if more than one member are covered for 100% Sum Assured respectively, then on date of first death of the Insured Members.
    b. if more than one members are covered for Sum Assured proportionately to the loan share, then on date of death of the last Insured Member.

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3. PART C

3.1. Key Benefits

The benefits shall depend on the plan option chosen by You/Insured Member at the inception of the Policy, which cannot be changed once chosen.

- For Critical Illness (Accelerated) / Total Permanent Disability / Accidental Death Benefit, the benefit will be equal to Sum Assured under the plan.
- For Critical Illness (Additional) / Cancer Protect (Additional), the benefit can be up to a maximum of the Sum Assured.
- For Critical Illness and Cancer Protect the cover term is lower of Policy Term/member Coverage Term or 7/10 years, but for Total Permanent Disability and Accidental Death Benefit, the cover term is same as Policy Term/member Coverage Term.

The two types of cover available, under the product, are:

A. **Level Cover:** The Sum Assured will remain unchanged throughout the term. If the Sum Assured is not linked to a loan, only Level coverage shall available.

B. **Reducing Cover:** If the Sum Assured is being linked to a loan, the Sum Assured will decrease in line with the loan repayment schedule. The reduction in Sum Assured shall be as per the interest rate considered at the time of risk commencement for the Insured Member. The loan interest should lie in the range of 0% to 36%.

If the Sum Assured is linked to a loan –

- The Sum Assured shall not exceed the loan amount, except where Moratorium Period without payment of interest has been chosen in which case the Sum Assured at any time during the moratorium period shall be the initial loan amount plus the accrued interest till that time.
- In case of partial repayment of loan covered hereunder before the expiry of the Coverage Term, the cover will continue for the benefit set at the outset and no surrender benefit is available in such case.
  In case of full repayment of the loan before the expiry of the Coverage Term, the cover will continue for the benefit set at the outset unless the Insured Member surrenders the Certificate of Insurance for availing Surrender Benefit as defined in the Policy Schedule attached hereto.

Under each of the above cover type, Master Policyholder/Insured Member can opt for any of the following five (5) benefit options:

1. Critical Illness (Accelerated / Additional);
2. Cancer Protect (Additional) (Minor 25% and Major 100%);
3. Accidental Death Benefit (Additional Benefit);
4. Total and Permanent Disability (Accelerated); and
5. Terminal Illness (Accelerated).

Following are the restriction on benefit options that can be chosen:

a) Critical Illness (Additional) and Cancer covers are allowed for Level Cover only.
b) Member of a scheme can avail only one of Critical Illness (Additional), Critical Illness (Accelerated), Cancer covers.
c) Members can avail only one of Total Permanent Disability benefit and Critical Illness (Additional) benefit.

The Master Policyholder can opt for the Employees Deposit Linked Insurance (EDLI) under this product. To the extent permitted under the Employees Deposit Linked Insurance (EDLI) Scheme, 1976 (as amended from time to time), the applicable terms and conditions including eligibility of this product shall be superseded by those mentioned under EDLI Scheme.

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3.1.1. Death Benefit

3.1.1.1. In case of Single Life:

Upon death of an Insured Member during the Coverage Term provided the coverage is in force, the Sum Assured shall be payable.

If the Sum Assured is linked to loan,

1. Where Policyholder is a Regulated Entity under the Lender-Borrower Group Schemes - The Sum Assured on the life of such Insured Member shall be payable as mentioned below:
   a) Outstanding loan amount as per loan repayment schedule in favor of Master Policyholder of the Policy, provided the authorization for such payment is obtained from the Insured Member;
   b) Balance claim amount, if any, after deduction of the outstanding loan amount as per loan repayment schedule will be paid to the nominee or beneficiary of the deceased Insured Member.
2. Other than Lender-Borrower Group Schemes – The payment of benefits shall be made in the name of the Claimant.

The cover on the life of Insured Member ceases once the death claim is paid on his/her life.

3.1.1.2. In case of Joint Life:

a) When each borrower is insured for entire loan amount:
   Each of the joint borrowers will be insured for 100% of the Sum Assured. In case claim is paid for one joint borrower, the cover ceases for the surviving joint borrower.
   If the insured event is triggered on more than one joint Insured Members at the same time, only one benefit equal to Sum Assured shall be payable in respect of the first Insured Member as stated on the Certificate of Insurance.

b) When each of the joint borrowers is insured up to his / her respective share of Sum Assured:
   If the claim is paid on occurrence of insured event of an Insured Member, then the cover shall cease only for that Insured Member. However, the cover shall continue for the other surviving Insured Member to the extent of his/her share of the Sum Assured. Any due proportionate Premiums shall continue to be collected in case the cover continues for the surviving Insured Member/Members.
   If the insured event is triggered on more than one joint Insured Members at the same time, Sum Assured shall be payable once to each, as per Insured Member’s share of the Sum Assured stated on the Certificate of Insurance.

3.1.2. Accelerated Terminal Illness

Terminal Illness is an advanced or rapidly progressing incurable & un-correctable medical condition, which in the opinion of the treating physician is highly likely to lead to death within the next six months. A Specialized Medical Practitioner also needs to opine that the life expectancy of the Insured Member is less than six months. The Waiting Period for Terminal Illness benefit is 180 days.

3.1.3. Critical Illness

This benefit is payable if the coverage is in force as on date of first diagnosis or occurrence of any of the covered 35 Critical Illnesses listed below, post completion of Waiting Period:

1. Cancer of Specified Severity

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

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The following are excluded –

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

2. Stroke resulting in permanent symptoms

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

The following are excluded:

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

3. Multiple Sclerosis with persisting symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

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

Other causes of neurological damage such as SLE is excluded.

4. Permanent Paralysis of Limbs

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

5. Coma of Specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

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6. Apallic Syndrome
Universal necrosis of the brain cortex with the brainstem remaining intact. Diagnosis must be confirmed by a Neurologist and condition must be documented for at least one month.

7. Benign Brain Tumor
Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

8. Motor Neuron Disease with permanent symptoms
Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

9. Parkinson's Disease
Unequivocal Diagnosis of progressive degenerative Parkinson’s disease by a Registered Medical Practitioner who is a neurologist where the condition:

- cannot be controlled with medication;
- shows signs of progressive impairment; and
- Activities of Daily Living assessment confirms the inability of the Insured to perform at least three (3) of the Activities of Daily Living for a continuous period of at least 6 months, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

The Activities of Daily Living are: -

- Transfer - Getting in & out of a chair without requiring physical assistance.
- Mobility - The ability to move from room to room without requiring any physical assistance
- Continence - The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
- Dressing - Putting on and taking off all necessary items of clothing without requiring assistance of another person.
- Bathing/Washing - The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.
- Eating - All tasks of getting food into the body once it has been prepared.

10. Severe Rheumatoid Arthritis
Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:
(a) Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
(b) Permanent inability to perform at least three (3) of the six (6) Activities of Daily Living;
The Activities of Daily Living are:

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- Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means; ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- Mobility: the ability to move indoors from room to room on level surfaces;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding: the ability to feed oneself once food has been prepared and made available.

(c) Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and

(d) The foregoing conditions have been present for at least six (6) months.

11. Alzheimer's Disease

Alzheimer's disease is a progressive degenerative disease of the brain characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.

Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's Disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured Member. This diagnosis must be supported by the clinical confirmation of an appropriate Registered Medical practitioner who is also a
Neurologist and supported by an independent Specialized Medical Practitioner.

The following are excluded:

- Nonorganic disease such as neurosis and psychiatric illnesses;
- Alcohol related brain damage.
- Any other type of irreversible organic disorder/dementia

12. Poliomyelitis

The occurrence of poliomyelitis where the conditions are met:

- Poliovirus is identified as the cause and is provided by stool analysis
- Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months

13. Muscular Dystrophy

Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:

- Family history of other affected individuals;
- Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
- Characteristic electromyogram; or
- Clinical suspicion confirmed by muscle biopsy.

Activities of Daily Living assessment should confirm the inability of the Insured to perform at least three (3) of the Activities of Daily Living for a continuous period of at least 6 months, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

The Activities of Daily Living are: -

- Transfer - Getting in & out of a chair without requiring physical assistance.
- Mobility - The ability to move from room to room without requiring any physical assistance
- Continence - The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
- Dressing - Putting on and taking off all necessary items of clothing without requiring assistance of another person.

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- Bathing/Washing - The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.
- Eating - All tasks of getting food into the body once it has been prepared.

14. SLE with Lupus Nephritis

Multi-system, autoimmune disorder characterized by the development of autoantibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded. The final diagnosis must be confirmed by a certified doctor specializing in hematology and Immunology.

Abbreviated ISN/RPS classification of lupus nephritis (2003):

Class I - Minimal mesangial lupus nephritis
Class II - Mesangial proliferative lupus nephritis
Class III - Focal lupus nephritis
Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis
Class V - Membranous lupus nephritis
Class VI - Advanced sclerosing lupus nephritis

15. Myocardial Infarction (First Heart Attack of specific severity)

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

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

The following are excluded:

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

16. Open Chest CABG

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

The following are excluded:

Angioplasty and/or any other intra-arterial procedures

17. Open Heart replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

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18. Surgery to aorta
The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra-arterial techniques are excluded

19. Cardiomyopathy
The unequivocal diagnosis by a consultant cardiologist of cardiomyopathy causing impaired ventricular function suspected by ECG abnormalities and confirmed by cardiac echo of variable etiology and resulting in permanent physical impairments to the degree of at least class IV of the New York Heart Association (NYHA) classification of cardiac impairment for at least six (6) months.
NYHA class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echo-graphic findings of compromised ventricular performance.

Cardiomyopathy directly related to alcohol or drug abuse is excluded.

20. Primary (Idiopathic) Pulmonary hypertension
An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization

There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:
- Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV: Unable to engage in any physical activity without discomfort.

Symptoms may be present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart and any secondary cause are specifically excluded.

21. Bacterial Meningitis resulting in permanent neurological deficit
A definite diagnosis of Meningitis confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in permanent neurological deficit documented for at least 90 continuous days from the date of diagnosis.

All other forms of meningitis other than those caused by bacterial infection are excluded.

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

23. Major Organ/Bone Marrow Transplant
The actual undergoing of a transplant of one of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

SAMPLE

The following are excluded:
- Other stem-cell transplants
- Where only islets of Langerhans are transplanted

24. Blindness
Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident

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

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

25. End Stage Lung Failure
End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55$mmHg);
- Dyspnea at rest.

26. End Stage Liver Failure
Permanent and irreversible failure of liver function that has resulted in all three of the following:
- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

27. Loss of Limbs
The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease

This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

28. Third degree burns
There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

29. Major Head Trauma
Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations

SAMPLE

in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

Spinal Cord injuries are excluded.

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30. Aplastic Anemia

Irreversible persistent bone marrow failure which results in anemia, neutropenia and Thrombocytopenia requiring treatment with at least one (1) of the following:

- Regular blood product transfusion;
- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

The Diagnosis of aplastic anemia must be confirmed by a bone marrow biopsy.
Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

31. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident

This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

32. Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords

The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

All psychiatric related causes are excluded.

33. Medullary Cystic Disease

A progressive hereditary disease of the kidneys characterized by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anemia, polyuria and renal loss of sodium, progressing to chronic renal failure

Diagnosis must be supported by renal biopsy.

34. Encephalitis leading to permanent neurological deficit

A definite diagnosis of encephalitis by a Consultant Neurologist supported by investigations like MRI/CT scan, cerebrospinal fluid screening and other tests like EEG

Encephalitis should result in permanent neurological deficit with persisting clinical symptoms documented for at least 90 continuous days from the date of diagnosis.

35. Chronic Pancreatitis

Chronic, progressive inflammatory disease of the pancreas, characterized by irreversible morphologic changes where all of the following criteria are met:
(a) The necessary treatment is surgical clearance of diseased tissue or pancreatectomy; and
(b) The Diagnosis is based on characteristic findings in ERCP/MRCP and other Abdominal Radiography tests (like CT scan of abdomen/Endoscopic or Transabdominal USG, etc.) and is confirmed by a Registered Medical Practitioner who is a gastroenterologist.

SAMPLE

Pancreatitis due to alcohol or drug abuse is excluded.

There will be a survival period of thirty (30) days applicable from the date of Diagnosis of a Critical Illness (not applicable if Accelerated Critical Illness opted for).

Exclusions for Critical Illness benefit:
Apart from the exclusions specified in each of the diseases above, the following exclusions shall apply to the benefits admissible under this policy.

- Pre-existing Disease - Any condition, ailment, injury or disease:
  a) That is/are diagnosed by a physician within 48 months prior to the Date of Commencement of Risk or Coverage Effective Date or its revival.
  b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the Date of Commencement of Risk or Coverage Effective Date or its revival.
- Any covered event or its signs or symptoms having occurred within the waiting period of 90 days from the date of commencement of risk or Coverage Effective Date or revival whichever is later.
- Self-inflicted injuries, attempted suicide, insanity and deliberate participation of the Insured Member in an illegal or criminal act with criminal intent.
- Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner
- War – whether declared or not, civil commotion, breach of law, invasion, hostilities (whether declared or not), rebellion, revolution, military or usurped power or wilful participation in acts of violence with criminal intent.
- Sexually transmitted diseases,
- Radioactive contamination due to nuclear accident.
- Any treatment of a donor for the replacement of an organ.
- Diagnosis and treatment outside India. However, this exclusion shall not be applicable in the following countries: Canada, Dubai, Hong Kong, Japan, Malaysia, New Zealand, Singapore, Switzerland, USA, UK, and countries of the European Union. The company may review the above list of accepted foreign countries from time to time on the basis of Board Approved Underwriting Policy & Board Approved Claims Manual. Claims documents from outside India are only acceptable in English language unless specifically agreed otherwise, and duly authenticated.
- Engaging in hazardous sports / pastimes, i.e. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off pastel skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport, bungee jumping, hand gliding etc. or Any injury, sickness or disease received as a result of aviation (including parachuting or skydiving), gliding or any form of aerial flight other than as a fare-paying passenger on regular routes and on a scheduled timetable unless agreed by special endorsement, however Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.

3.1.4. Accelerated Total Permanent Disability

"Total Permanent Disability" means disablement of the Insured Member. The Insured Member has become totally and irreversibly disabled as a result of accident or illness, in one of the below forms:

1) The total and permanent loss by severance or loss of use of both hands, and both feet, or both eyes, and a combination of any two (i.e. severance or loss of one hand and loss of sight of one eye or loss of one foot and loss of sight of one eye or loss of one hand and one foot), will also result in the Insured Member being regarded as totally and permanently disabled, or
2) The Insured Member must be totally incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit, or

SAMPLE

3) The Insured Member must be unable to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living".

Waiting period is applicable for Total Permanent Disability due to illness. No Waiting Period for any Total Permanent Disability due to Accident.

Activities of Daily Living

- Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- Mobility: the ability to move indoors from room to room on level surfaces;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding: the ability to feed one once food has been prepared and made available.

The above disability must have lasted without interruption for at least six consecutive months (180 days) and must be deemed permanent by a Medical Practitioner appointed by Us.

If the disability is due to amputation/dismemberment, the loss of hand will mean amputation/dismemberment above wrist, the loss of arm will mean amputation/dismemberment above elbow, the loss of feet will mean amputation/dismemberment above ankle and the loss of leg will mean amputation/dismemberment above knee.

If the disability is not due to amputation/dismemberment, the loss will mean loss of usage of limbs and the limbs should have motor power grade 0/5, 1/5 or 2/5 only.

Loss of sight means total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. The Blindness is evidenced by:

- corrected visual acuity being 3/60 or less in both eyes;

- the field of vision being less than 10 degrees in both eyes.

The Diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure. The Diagnosis must be certified by a qualified ophthalmologist.

Exclusions under Total Permanent Disability

- Attempted suicide or self-inflicted injury, whether the Insured Member is sane or insane.
- Pre-existing Disease - Any condition, ailment, injury or disease:
  a) That is/are diagnosed by a physician within 48 months prior to the Date of Commencement of Risk or Coverage Effective Date or its revival.
  b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the Date of Commencement of Risk or Coverage Effective Date or its revival.
- War, terrorism, invasion, act of foreign enemy, hostilities, civil war, martial law, rebellion, revolution, insurrection, military or usurper power or civil commotion.
- Radioactive contamination due to nuclear accident.
- Service in the armed forces, of any country at war or service in any force of an international body.
- Taking part in any naval, military or air force operation during peace time.
- Committing an assault, a criminal offence, an illegal activity or any breach of law with criminal intent.
- Engaging in or taking part in hazardous activities, including but not limited to, diving or riding or any kind of race; martial arts; hunting; mountaineering; parachuting; bungee-jumping; underwater activities involving the use of breathing apparatus or not.

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- Alcohol or Solvent abuse or taking of Drugs, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
- Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable, however Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.

3.1.5. Accidental Death Benefit

If the death is caused by Accident under Level Coverage, provided the coverage is in force, We shall pay an additional amount equal to the Sum Assured payable under 'Death or Accelerated Terminal Illness'. The benefit of additional Accidental Death benefit can be availed only under Level Coverage and is not available under Reducing Coverage.

Where Accident leading to death has occurred during the Coverage Term but Accidental Death has occurred after the expiry of Coverage Term, however within 180 days from the date of Accident, we shall pay the Accidental Death benefit. No Sum Assured shall be payable if the Coverage Term has expired.

In the event of the Accidental Death of the Insured Member after 180 days of the occurrence of the Accident, the Company shall not be liable to pay this benefit. The insurance coverage must be in-force on the date of the Accident.

Exclusions for Accidental Death benefit:

Death due to Accident should not be caused by the following:
- Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Insured Member is under the influence of any narcotic substance or drug or intoxicating liquor unless taken in accordance with the lawful directions and prescription of a registered Medical Practitioner; or
- Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy; or
- The Insured Member with criminal intent, committing any breach of law; or
- Due to war, whether declared or not or civil commotion; or
- Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

3.1.6. Cancer benefit

Carcinoma-in-Situ of any organ:
Carcinoma in Situ (CIS) means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane.
The diagnosis of the Carcinoma in situ must always be supported by a histopathological report and should be certified by an Oncologist. Furthermore, the diagnosis of Carcinoma in Situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.

a. In the case of the cervix uteri, classified as cervical intraepithelial Neoplasia grade SEVERE or as Tis according the TNM staging method or FIGO stage 0. Pap smear alone is not acceptable and should

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be accompanied with cone biopsy or colposcopy with the cervical biopsy report clearly indicating presence of CIS.

b. Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, and CIN II (where there is severe dysplasia without carcinoma in situ) does not meet the required definition and are specifically excluded.
c. Breast, where the tumour is classified as Tis according to the TNM staging method and actual mastectomy is covered, however partial mastectomy / lumpectomy do covered.
d. Corpus, uteri, vagina, or fallopian tubes where the tumour is classified as Tis according to TNM staging method or FIGO stage 0
e. Ovary include borderline ovarian tumours with intact capsule, no tumour on the ovarian surface, classified as T1AN0M0, T1BN0M0 or FIGO 1A, FIGO 1B
f. Colon and rectum
g. Penis
h. Testis / Orchidectomy
i. Lung
j. Liver
k. Stomach and esophagus
l. Urinary tract: Cystectomy for Cis of urinary bladder/T1N0M0, actual undergoing of total radial Cystectomy due to Cis / papillary carcinoma. Segmental Cystectomy is not covered.
m. Nasopharynx

Early stage Cancers:

Early Stage Cancer shall mean first ever diagnosis with the presence of one of the following malignant conditions:

a) Thyroid tumour is defined as papillary carcinoma of the thyroid that is less than 10 mm in diameter and is characterised by the uncontrolled growth and spread of malignant papillary thyroid cancer cells with invasion and destruction of normal thyroid tissue, which is histologically classified as T1N0M0 according to the TNM classification system, or another equivalent classification. The cancer is confined to the thyroid gland and has not spread to nearby lymph nodes or elsewhere in the body.
b) Prostate tumour should be histologically described as TNM (T1N0M0) Classification T1a or T1b or T1c are of another equivalent classification, where the tumour is localized in the prostate but not palpable or detectable with imaging. This condition is characterised by uncontrolled growth and spread of malignant prostate cancer cells with invasion and destruction of normal prostate tissue. The cancer is still within the prostate and has not spread to nearby lymph nodes [N0] or elsewhere in the body [M0]. The diagnosis must always be on the basis of a microscopic examination of fixed tissue showing a Gleason Score of two to six. All grades of Prostate Intraepithelial Neoplasia (PIN) are not covered under this definition.
c) Chronic Lymphocytic Leukaemia is categorized as the uncontrolled growth and spread of malignant lymphocyte white blood cells within the bone marrow and the blood. The Chronic Lymphocytic Leukaemia must be diagnosed and classified as Rai stage 0, 1, or 2. These early Rai stages of leukaemia imply that there is an elevated malignant monoclonal lymphocyte count with or without enlarged lymph nodes or spleen, but there is no anaemia and no thrombocytopenia.
d) Basal cell and Squamous skin cancer that has spread to distant organs beyond the skin
e) Hodgkin's lymphoma Stage I by the Cotswold's classification staging system.
f) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM Classification)

The Diagnosis must be based on histopathological features and confirmed by a Pathologist. Pre-malignant lesions and conditions, unless listed above, are excluded.

Exclusions will be same as for Critical Illness benefit.

Additional Exclusions under Cancer benefit:

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- A waiting period of 180 days shall be applicable from the date of issue of the Effective Coverage Date or date of revival of the coverage, whichever is later:
- For any claim to be valid under this policy, the incidence of the condition must be thefirst occurrence in the lifetime of the insured.
- Any claim made against one of the covered conditions will reduce the opted sum assured under the policy and the balance amount will be available for subsequent claims.
- 4 minor claims can be made under this benefit subject to the below mentioned cooling off period.
  For multiple minor conditions claims of an Insured Member to be admissible, there needs to be a period of at least 180 days between the date of diagnosis of a minor condition claim and date of diagnosis of subsequent minor condition claim. However, this requirement of 180 days is not applicable in case of diagnosis of a major condition claim following a minor condition claim.
- In no case, the total claims payout shall exceed 100% of the chosen Sum Assured as mentioned in the Policy Schedule.

Any covered condition will be covered only once during Coverage Term. For example, once a minor stage cancer claim is paid, no payment for any future claims under the minor stage of the same cancer would be admissible. Same cancer means cancer of the same organ and histological type. Where the organs are in a pair such as breasts, lungs, kidneys, testes, ovaries etc., the entire pair is considered as one organ.

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3.1.7. Moratorium Period

The moratorium period benefit is available with the Reducing Coverage option only wherein the Insured Member may take mortgage or retail loan. Master Policyholder/Insured Member may choose a moratorium period of 1 month to 84 months. After moratorium period the Sum Assured follows the outstanding loan amount as per the loan repayment schedule.

Moratorium cover options:

a) With payment of interest during the moratorium period - where interest is paid by the Insured Member during the moratorium period, the Sum Assured during the moratorium period is level, equal to the initial loan amount.
b) With no payment of interest during the moratorium period - where no interest is paid by the Insured Member during the moratorium period, the Sum Assured at any time during the moratorium period is the initial loan amount plus the accrued interest till that time.

For both the above options the Sum Assured after the moratorium period will be the amount of loan outstanding as per the loan repayment schedule.

3.1.8. Maturity Benefit

If the Insured Member has opted for return of premium, We shall pay the Total Premiums Paid for Insured Member's coverage, after deduction of the applicable taxes, cesses and levies, at Maturity. The return of premium option is available as below:

a) Policy Term 10 years with return of premium option for base Death Benefit; or
b) Policy Term greater than or equal to 15 years with return of premium option for Benefit Option/s as per Clause 3.1 of Part C.

3.1.9. Survival Benefit

There is no Survival Benefit payable in this plan.

3.1.10. Premium details

3.1.10.1. Payment

a. A Single/ Limited/ Regular premium is payable in respect of each Insured Member at the time of his enrolment, to the Company at either the issuing office or at its Head Office, based on the premium rates as determined by the Company and specified in the Policy Schedule. The Company reserves the right to impose additional Premium in respect of Insured Members that represent a substandard risk, as determined by the Company based on its underwriting guidelines and practices.
b. In the case of Joint Life insurance coverage, Premiums will be calculated separately for each Joint Insured Member as per their respective entry age with applicable Joint Life insurance coverage discount specified in the Policy Schedule attached hereto.
c. Collection of advance Premium shall be allowed within the same Financial Year for the Premium due in that financial year. However, where the Premium due in one financial year is being collected in advance in earlier financial year, the Company may collect the same for a maximum period of three months in advance of the due date of the Premium.
d. The Premium so collected in advance shall only be adjusted on the due date of the premium.

3.1.10.2. Change of frequency of premium payment

You may change the frequency of Premium payments by written request. Subject to our minimum Premium requirements, Premiums may be paid on Annual, Half- yearly, Quarterly or Monthly mode at the premium rates applicable on the Coverage Effective Date.

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3.1.10.3. Grace period

A Grace Period of fifteen (15) days for monthly mode and thirty (30) days for all other modes, from the due date will be allowed for payment of each subsequent premium. The coverage will remain in force during this period. In case Premium in respect of Insured Member is collected by Master Policyholder within grace period but is not remitted to the Company for some reason, then on expiry of grace period risk cover will continue in respect of those Members. If the full Premium for the first 2 years of coverage remains unpaid at the end of the grace period for limited / regular pay 5 years with Return of Premium option, the coverage shall lapse from the due date of the first unpaid premium. If any claim occurs during the grace period, any due premium (without interest) under the coverage of the Insured Member will be deducted from the claim pay-out.

3.2. Other benefits and features

3.2.1. Flexible Payout

If You/Insured Member have chosen Flexible Payout option, this benefit shall be given on the basis of following aspects chosen by You at the proposal stage:

a) Amount of lump sum benefit, (if any)
b) Income period - the period for which income is expected (Minimum income term of 1 month and up to a maximum of 480 months). The income period shall commence immediately on death and continue for the chosen income period. In the event of a claim, the applicable monthly income would continue throughout the income term even if the Coverage Term has ended.
c) Amount of annual income during the income period. This income will be payable monthly in arrears, in 12 equal instalments.
d) A simple rate of increase of the annual income, if any. These increases will apply to the annual income from the 2nd year of the income period.

If the Sum Assured is linked to a loan,

a) Where Master Policyholder is a Regulated Entity under the Lender-Borrower Group Schemes - The payment of benefits to the extent of loan outstanding shall be made to the Master Policyholder, provided the authorization for such payment is obtained from the Insured Member. Any balance Sum Assured shall be paid via income instalments during the income period, if chosen.
b) Other than Lender-Borrower Group Schemes – The payment of benefits shall be made to the claimant via income instalments during the income period.

Under this option, the Sum Assured shall be payable monthly in arrears during income period and shall commence from the 1st day of the month following the month of Insured Member's death. The Sum Assured for the income option shall be derived by discounting the income payments at 4% p.a. At the time of claim intimation, all future income payments can be commuted for a lump sum. This lump sum shall be the discounted value of the future income payments at 6.90% per annum. This discounting rate is not guaranteed and is subject to change based on prevailing bond yields (aligned to 10 year G-sec). However, any change in the methodology/formula shall be subject to IRDAI approval.

3.2.2. Payment of benefits

2. If the Sum Assured is linked to a loan,

a) Where Policyholder is a Regulated Entity under the Lender-Borrower Group Schemes - The payment of benefits shall be made to the Master Policyholder to offset the outstanding on Insured Member's loan account with the Master Policyholder, provided the authorization for such payment is obtained from the Insured Member. Any balance Sum Assured remaining subsequent

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to this payment, shall be paid via the Policyholder or directly to the Insured Member's nominee, legal representative, executor or administrator in case of death.

b) Other than Lender-Borrower Group Schemes – The payment of benefits shall be made in the name of the Claimant.

3. If the Sum Assured is not linked to a loan, the payment of benefits shall be payable to the Claimant.
4. Payment to the Policyholder and / or to the Insured Member's nominee, legal representative, executor or administrator, as provided by this Section, shall release the Company from all liabilities under this Policy with respect to the Policyholder and the Insured Member for whom the claim has been settled.

3.2.3. Modal Loading

The Premium can be paid either Annually, Half-yearly, Quarterly or Monthly mode. Modal loading on premiums is as mentioned below:

Annual Premium Rate	: Multiply Annual Premium Rate by 1 (i.e. No loading).
Half-Yearly Premium Rate	: Multiply Annual Premium Rate by 0.51(i.e. loading of 2%)
Quarterly Premium Rate	: Multiply Annual Premium Rate by 0.2575(i.e. loading of 4%)
Monthly Premium Rate	: Multiply Monthly Premium Rate by 1

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4. PART D

4.1. Free look period

Where free look cancellation is exercised by You

The Policy shall terminate forthwith and all rights, benefits and interests under the Policy shall cease immediately. We will only refund the premiums received by Us, after deducting the proportionate risk premium for the period of cover, charges of stamp duty paid and the expenses incurred on medical examination of the Insured Member(s), if any. No new Insured Members will be enrolled under the Policy.

Where free look cancellation is exercised by Insured Member, Certificate of Insurance shall terminate forthwith and all rights, benefits and interests shall cease immediately. We will only refund the premiums received by Us, after deducting the proportionate risk premium for the period of cover, charges of stamp duty paid and the expenses incurred on medical examination of the Insured Member(s), if any.

4.2. Revival

If a premium is in default beyond the Grace Period and subject to the Policy/Certificate of Insurance not having been surrendered, it may be revived, in accordance with Board approved Underwriting Guidelines within five years after the due date of the first unpaid premium and before the end of the Coverage Term subject to:

(i) Insurance cover has not been surrendered;
(ii) A written application for revival is received from the Insured Member by the Company, together with revival fee (including applicable interest), evidence of insurability of the Insured Member;
(iii) Payment of all overdue premiums with applicable interest charged by the Company to reinstate this cover;

The cost incurred by the Company for the medical examination of the Insured Member to revive the Insurance cover shall also be borne and paid by the Insured Member to the Company.

Interest on premiums will be at a simple annual rate which we shall determine. The applicable interest rate for revival is determined using the State Bank of India(SBI) [or any other public sector undertaking bank] domestic term deposit rate for tenure '1 year to 455 days', plus 2%. Any alteration in the formula will be subject to prior approval of IRDAI. The current interest rate on revival from 1st October 2019 is 8.50% simple p.a. (i.e. SBI interest rate of 6.50% + 2%).

Any evidence of insurability requested at the time of revival will be based on the prevailing Underwriting Guidelines duly approved by the Board.

The cover which is not revived by the end of the revival period shall be terminated. There is no revival option for Single Premium.

4.3. Loan

Loan facility is not allowed under this Plan.

4.4. Non-Forfeiture Benefit

If the Insured Member prepays his loan with the Master Policyholder in full, he will be entitled for surrender value if applicable. In such case the surrender value will be calculated by using the formula specified in the section 4.4.2. Surrender Benefit.

4.4.1. Reduced Paid-Up

At any time during the Coverage Term, if the Premiums are not paid within the Grace Period, the coverage of the Insured Member will lapse. This will only be true in case of those Regular Premium with Return of Premium option/Limited Pay 5 policies for which premiums have been paid for less than 2 years. Such coverage of the Insured Member may be revived, within five years from the due date of the first unpaid premium, as per Section

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4.2. However, if the coverage of the Insured Member is not revived, no further benefit will be payable and the coverage of the Insured Member will terminate.

The coverage of the Insured Member will be converted into a Reduced Paid-up by default, provided it has acquired Surrender Value and subsequent premiums remain unpaid.

Reduced Paid-up is a default non-forfeiture benefit. Such Reduced Paid-up coverage can be revived within five by payment of all due premiums together with interest as mentioned in section 4.2. Once coverage of the Insured Member becomes Reduced Paid-up and is not revived till the end of the revival period, as per section4.2 it will continue to be in Reduced Paid-up status.

The benefits to be paid in case of Reduced Paid up coverage are as follows:

For the purpose of the benefit descriptions below, the "Reduced Paid-up (RPU) Factor" at any point during the term of the policy shall be defined as: RPU Factor = (No of Premiums paid) *divided by*(No of Premiums Payable during the entire premium payment term)

a) *Death/ Accidental death /Accelerated Terminal Illness/Accelerated Critical Illness/Accelerated Total Permanent Disability Benefit/ Additional Critical Illness/ Additional Cancer Benefit (as the case may be)= Benefit payable as per the option chosen (as given under section 3.1 above) x RPU Factor*

b) *Return on Premium Benefit = Total Premiums Paid.*

4.4.2. Surrender Benefit

By Insured Member - In case of Regular Premium with Return of Premium option or Limited Premium option with or without Return of Premium Option, the surrender benefit will be available if at least two full years' premiums are paid.

By Master Policyholder - In case of Regular Premium with Return of Premium option or Limited Premium option, the Policy can be surrendered by the Master Policy holder by giving a written intimation to the Company. In such cases, post surrender new enrolments will cease and the existing insured members shall continue to be covered under the Policy as an individual coverage on same terms and condition as those of the group Policy or avail surrender benefit and terminate the insurance cover.

Surrender Value (without Return of Premium benefit)**:**

Premium Payment Term	Surrender Value
Single Pay	*Surrender value = (50% of the Total Premiums Paid) x (unexpired Coverage Term/ total Coverage Term) x (Coverage at the time of surrender / Sum Assured at inception)*
Yearly Renewable	*No surrender value payable*
Regular Pay	*No surrender value payable*
Limited Pay	*Surrender value = (50% of Total Premiums Paid) x (unexpired Coverage Term/ total Coverage Term) x (Coverage at the time of surrender / Sum Assured at inception)*

Surrender Value (with Return of Premium benefit)**:**

Surrender value = Special Surrender Value Factor (As per Annexure I) x Total Premiums Paid

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The exits would be alike in the product whereby the coverage ends in case of a claim, cancellations, coverage ending on attaining the maximum coverage age or expiry of Coverage Term.

Surrender Value for Single Premium coverage is payable at any point during the Coverage Term.

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PART E

Not Applicable for this Product

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5. PART F

5.1. Enrolment Forms

Unless otherwise specified in the Policy Schedule, the Policyholder shall furnish member enrolment forms for each Insured Member where the Premium is borne by the Insured Member. The format of the enrolment form will be provided by the Company. The Policyholder shall retain a copy of the enrolment forms for records.

5.2. The Policy Contract

All statements relating to material facts made by the Policyholder, or by the Insured Members, shall, in the absence of fraud, be deemed representations and not warranties.

The rights of the Policyholder or of any Insured Member under the Policy shall not be affected by any provision other than those contained in this Policy.

No person except the person designated by the Company is authorized to waive, alter or amend this Policy or to extend the due date of any Premium, to amend these terms, conditions and exclusions or to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced by the endorsement hereon, or by amendment hereto signed by the Company.

5.3. Certificate of Insurance

In non-Employer-Employee group, the Company shall issue to the Policyholder for delivery to each Insured Member accepted for coverage under this Policy, a Certificate of Insurance certifying that the person so named therein has become an Insured Member under the Policy and coverage shall commence in respect of such Insured Member from the Coverage Effective Date.

5.4. Data Required

The Policyholder shall maintain a record with respect to each Insured Member under this Policy, showing the Insured Member's name, sex, age or date of birth, Sum Assured under each Certificate of Insurance, the Coverage Effective Date, the date when the coverage terminates or terminated, changes, with dates noted, of classification, nominee details and other pertinent information as may be necessary to carry out the terms of this Policy.

Clerical error in keeping the records shall not invalidate the Policy or the insurance coverage of an Insured Member otherwise validly in force, but upon the discovery of such error, it shall be rectified at the earliest.

The Policyholder shall furnish the Company with all information and proof which the Company may reasonably require with regard to any matters pertaining to the Policy/Certificate of Insurance. All documents furnished to the Policyholder by any Insured Member in connection with the Policy/Certificate of Insurance, and other records as may have a bearing on the insurance under this Policy, shall be open for inspection by the Company at all reasonable times.

Any personal information collected or held by the Company with respect to each Insured Member under this Policy may be held, used and disclosed by the Company to individuals or organizations associated with the Company with regard to matters pertaining to the Insured Member's coverage.

It shall be the responsibility of the Policyholder to ensure that the personal information provided to the Company is accurate. The Policyholder shall indemnify and keep indemnified the Company against any and all losses, costs, expenses, actions, proceedings suffered by the Company as a result of the Policyholder's failure to carry out the aforesaid.

In case of a loan from a Policyholder which is a Regulated Entity under the Lender-Borrower Group Schemes, the Policyholder shall furnish the Company with authorization from the Insured Members under the Policy

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authorising the Company to make claim payments in favour of the Policyholder to the extent of outstanding loan balance as per loan repayment schedule and the balance amount shall be paid to the Nominee or the Legal heir. This authorization may be retained by you along with the enrolment form which will be retrieved during claim processing. For policies where Insured authorization was part of the enrolment form, this section is not required. In case no authorization is received from the Insured Members, entire claim amount shall be paid to the Nominee or the Legal heir of the Insured Member. In case of a loan from a Policyholder which is not a Regulated Entity under the Lender-Borrower Group Schemes, the payment of claim amount shall be made in the name of the Claimant.

The Policyholder agrees that, they will furnish the required documents to the Company and Company shall audit or cause an audit into accuracy of Credit Account Statements of the Insured members / deceased Insured Member in respect of claims settled on completion of every Financial Year.

However, notwithstanding the above clause the Company may also delegate the responsibility of the audit and require the Policyholders to audit or to cause an audit into the accuracy of the Credit Account Statements of the Insured Members in respect of which claims were settled on the completion of every financial year and shall obtain a certification from their respective Internal / Statutory Auditors that the Outstanding Loan Balance being shown in the 'Credit Account Statement' / 'Claim Discharge Form' is correct and reflecting the balance as per the conditions governing the Credit Account / Loan Account.

5.5. Fraud, Misrepresentation and Forfeiture

Fraud, Misrepresentation and forfeiture would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938 as amended from time to time.
The simplified version of the provisions of Section 45 is enclosed in Annexure 3 for reference.

5.6. Exclusions:

5.6.1. Suicide

For all schemes other than those covering Employer-Employee groups on a compulsory basis, if the Insured Member commits suicide, whether sane or insane, within 12 months from the Effective Coverage Date or from the date of revival of the Insured Member’s coverage, as applicable, the nominee or beneficiary of the Insured Member shall be entitled to at least 80% of the Total Premiums Paid (for the coverage of the respective Insured Member) till the date of death or the surrender value available as on the date of death whichever is higher, provided the coverage is in force. The period of 12 months will be from the later of (i) Date of inception of Insured Member’s coverage, or (ii) Date of revival of Insured Member’s coverage (in case of revival).

5.6.2. Active at Work:

This exclusion applies to Employer-Employee groups coming into effect for the first time or after a period of discontinuance.

An employee of the Master Policyholder is said to be “Actively at Work“ if he/she meets both the conditions listed below:

i) he/she is not absent on the grounds of ill health or maternity leave at the time of joining the coverage, and

ii) he/she has not have availed any leave on the grounds of ill-health for a continuous period of fifteen (15) days or more in the previous coverage year and/or year preceding his/her admission into the coverage as applicable.

The above exclusions may be waived by the Company based on Claims Underwriting.

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5.7. Misstatement of age and gender

Subject to Section 45 of the Insurance Act, 1938 as amended from time to time.

The coverage is issued at the age and gender as disclosed by Master Policyholder/Insured Member. If the age and/or gender is misstated and on the basis of actual age and/or gender the coverage of the Insured Member would have been issued but with a higher premium, the benefit payable shall be paid after deduction of such difference of premium along with interest thereon. In such cases, the coverage of the Insured Member shall be subject to re-underwriting and the Sum Assured shall be subject to eligibility of the member as per Our Board Approved Underwriting Guidelines and if the coverage of the Insured Member would have been issued, the premium to be deducted shall be calculated proportionately on such Sum Assured payable. Similarly, if the Insured's age/gender is misstated and on the basis of actual age and/or gender the coverage of the Insured Member would have been issued but with a lower premium, the Company will refund any excess premiums paid without interest. If at the correct age/gender it is found that the Insured Member was not eligible to be covered under this Policy/Certificate of Insurance pursuant to our Underwriting rules, the coverage of the Insured Members hall be terminate and the Company will refund the all the Premiums paid without interest after deducting all applicable charges like medical, Stamp duty, Proportionate Risk Premium along with applicable taxes, cesses or levies, if any incurred by the Company.

5.8. Nomination

Nomination allowed as per provisions of Section 39 of the Insurance Act 1938 as amended from time to time. The simplified version of the provisions of Section 39 is enclosed in Annexure 2 for reference.

5.9. Assignment

Assignment shall be treated in accordance with the provisions of Section 38 of the Insurance Act, 1938 as amended from time to time.

5.10. Currency and place of payment

All amounts payable either to or by Us will be paid in the Indian currency. Such amounts will be paid by a negotiable bank draft or cheque drawn on a bank or NEFT (National Electronic Funds Transfer) or electronic clearing systems. All amounts due from Us will be payable from Our office.

5.11. Freedom from restrictions

Unless otherwise specified, this Policy is free from any restrictions upon the Insured Member as to travel, residence or occupation.

5.12. Taxes

All Premiums and interest payable under the Policy/Certificate of Insurance are exclusive of applicable taxes, duties, surcharge, cesses or levies which will be entirely borne by the Policyholder/Insured Member, in addition to the payment of such Premium or interest. Tata AIA Life shall have the right to claim, deduct, adjust and recover the amount of any applicable tax or imposition, levied by any statutory or administrative body, from the benefits payable under the Policy/Certificate of Insurance.

5.13. Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and shall be enforced in accordance with the laws of India.

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5.14. Claims

All cases of claim must be notified to us in writing within 90 days of occurrence of Insured event. However, we may condone delay on merit for delayed claims where the reason for delay is proved to be for reasons beyond the control of the claimant. In case of any delay on the part of the Company to process the claim within extant regulatory timeline, We shall pay interest as may be prescribed by the IRDAI from time to time.

Please note that all claims will be payable to the rightful Claimant.

Filing Proof of Claim – Unless otherwise specified, duly filled in requisite forms along with proof of loss shall be furnished to us, at the claimant's expenses, within 90 days from the date the Insured event happens. A list of documents required in general, is attached to the Policy. However, submission of such documents, forms or other proof shall not be construed as an admission of liabilities by the Company and we reserve right to request additional proof and/or documents in support.

For processing the claim request under this policy, we will require the following documents:

5.14.1. Death claims requirements

Type of Claim	Requirement
Death (all causes of death other than the Accidental Death)	a) Claim Forms ▪ Application Form for Death Claim (Claimant's Statement) along with NEFT form ▪ Part II: Physician's Statement - to be filled by last attending physician
	b) Death Certificate
	c) Medical Records (Admission Notes, Discharge/Death Summary, Indoor Case Papers, Test Reports etc)
	d) Original Policy document
	e) Claimant's Photo ID with age proof & relationship with the Insured Member along with Address proof of the claimant and Cancelled cheque with name and account number printed or cancelled cheque with copy of Bank Passbook / Bank Statement If no nomination - Proof of legal title to the claim proceeds (e.g. legal succession paper)
	f) Outstanding Loan Statement as per loan repayment schedule as on the date of event
	g) Credit Account Statement from Master Policyholder
If Death due to Accident (to be submitted in addition to the above)	h) Postmortem report (Autopsy report) & Chemical Viscera report – if performed
	i) All Police Papers – Panchnama, Inquest, First Information Report (FIR) and Final Investigation Report
	h) Newspaper cutting / Photographs of the accident – if available

5.14.2. Critical Illness claims requirements

Type of Claim	Requirements for Critical Illness Claim
Critical Illness	A. Claim Forms

	• Part I: Application Form for Critical Illness Claim (Claimant's Statement) along with NEFT form • Part II: Confidential Medical Report –to be filled by Attending Physician
	B. Hospital Bills for the confinement.
	C. Attested True Copy of Indoor Case Papers of the Hospital
	D. Discharge Summary of Present and Past Hospitalizations
	E. Photo Identity of Insured Member with age and address proof
	F. Bank Details of the claimant – Cancelled cheque (with printed name and account number)/bank passbook and NEFT Form
	G. Certificate of Diagnosis
	H. Medical Examination Certificate (First Consultation Notes).
	I. All related clinical Reports pertaining to the claim event – • Laboratory test reports, X-Ray / CT Scan / MRI Reports & Plates, Ultrasonography Report • Histopathology Report • Clinical / Hospital Reports • Angiography Reports & Plates • Others (please specify)
	J. All follow-up Consultation Notes in relation to the hospitalized condition.
	K. Outstanding Loan Statement as per loan repayment schedule as on the date of event
	L. Credit Account Statement from Master Policyholder
If Claims is due to accidental causes (submit in addition to the above)	M. All police reports - First Information Report, Final Investigation Report

5.14.3. Total Permanent Disability claims requirements

Type of Claim	**Requirement**
Disability Claim (all causes of disability)	a) Claim Forms • Part I: Application Form for Disability Claim (Claimant's Statement) along with NEFT form • Part II: Confidential Medical Report -to be filled by Attending Physician
	b) Attested True Copy of Indoor Case Papers of the Hospital
	c) Discharge Summary of Present and Past Hospitalizations
	d) Photo Identity of Insured with age and address proof
	e) Bank Details of the claimant – Cancelled cheque (with printed name and account number)/bank passbook and NEFT Form
	f) Disability Certificate by attending Physician / Institute for disabled
	g) Rehabilitation Certificate - if applicable
	h) Employer's written confirmation / statement - for Disability claim
	i) All related Medical Examination Reports, e.g. - Laboratory test reports, X-Ray / CT Scan / MRI Reports & Plates Ultrasonography Report, Clinical / Hospital Reports
	j) Clinical Photographs showing the injured areas - if available

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	k) Outstanding Loan Statement as per loan repayment schedule as on the date of event
	l) Credit Account Statement from Master Policyholder
If Disability due to Accident (to be submitted in addition to the above)	m) All police reports- First Information Report Final Investigation Report

Medical Examination – We reserve the right to request medical examination of the Insured Member. In the event of the Company requesting for a medical examination, the cost of such medical examination shall be borne by Us.

NOTE:

- In case the claim warrants any additional requirement, the Company reserves the right to call for the same.
- Notification of claim & submission of the claim requirements does not mean admission of the claim liability by the Company.

Proof of Occurrence of an Insured Event - Proof of occurrence of any Insured event covered by this Policy must be supported by:

1. Appropriate Specialist Medical Practitioners registered in India (or other country approved by Tata AIA Life), not being the Policy owner, Insured Member or the respective partner or spouse or relatives.
2. Confirmatory investigations including, but not Limited to, clinical, radiological, histological and laboratory evidence, and,
3. If the Insured event requires a surgical procedure to be performed, the procedure must be the usual treatment for the condition and be medically necessary.

5.14.4. Claims Intimation Process

A claim can be made through any of the following avenues:

a. Online at www.tataaia.com
b. Email - credit.life@tataaia.com or customercare@tataaia.com
c. Call our helpline number 1-860-266-9966 (local charges apply)
d. Walk into any of the Company branch office
e. Write directly to us on following address:

Tata AIA Life Insurance Company Limited
B - Wing, 9th Floor, I-Think Techno Campus,
Behind TCS, Pokhran Road No.2,
Close to Eastern Express Highway,
Thane (West) – 400 607, Maharashtra.

5.15. Change in address of Policyholder

In order to provide You better services, We request You to intimate us in the event of any change in the address of the Policyholder.

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6. PART G

CONSUMER INFORMATION

POLICYHOLDER'S SERVICING

With regards to any query or issue related to the Policy, the Policyholder can contact the Company through the following service avenues:

- Contact your Tata AIA Life Agent / Distributor
- Call our helpline number 1-860-266-9966 (local charges apply)
- E-mail us atcustomercare@tataaia.com or credit.life@tataaia.com
- Visit the nearest the Tata AIA Life branch or CAMS Service Center
- Log on to Online Customer Portal by visitingwww.tataaia.com
- Write to Us at: B- Wing, 9th Floor, I-Think Techno Campus, Behind TCS, Pokhran Road No.2, Close to Eastern Express Highway, Thane (West) – 400 607, Maharashtra.

GRIEVANCE REDRESSAL PROCEDURE

1) Resolution of Grievances

Customers can register their grievances through Multiple Service Avenues:

- Call our helpline number 1-860-266-9966 (local charges apply)
- Email us atlife.complaints@tataaia.com
- Login to online Policy account onwww.tataaia.com
- SMS SERVICE to 58888 to receive a call back from our Customer Service Representative
- Visit any of the nearest Tata AIA Life branches or CAMS Service Centers
- Contact your Tata AIA Life Agent / Distributor
- Write to us on the following address:
  Grievance Redressal Department
  Tata AIA Life Insurance Company Limited
  B- Wing, 9th Floor, I-Think Techno Campus,
  Behind TCS, Pokhran Road No.2,
  Close to Eastern Express Highway,
  Thane (West) – 400 607, Maharashtra.

- We shall acknowledge a customer's grievance within 3 business days by providing the customer with the name of the Grievance Redressal Executive who is responsible to handle the grievance.
- We shall provide the customer with an equitable resolution within 2 weeks of receipt of the grievance.
- In case customers wishes to contact us during the course of the assessment, they can contact us at any of the above mentioned touch points.
- All Tata AIA Life branches have a Grievance Redressal Officer who can be contacted for any support during the grievance redressal process.

2) Escalation Mechanism

In case customers are not satisfied with the decision of the above offices, or has not received any response within the stipulated timelines, they may contact the following officials for resolution:

- 1st level of Escalation: Head - Customer Service
- 2nd level of Escalation: Grievance Redressal Officer (GRO)

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For escalations, customers can email to **head.customerservice@tataaia.com** or write to –

Tata AIA Life Insurance Company Limited,
B-Wing, 9th Floor, I-Think Techno Campus,
Behind TCS, Pokhran Road No.2,
Close to Eastern Express Highway,
Thane (West) – 400 607, Maharashtra

We request our customers to follow the escalation mechanism in case of non-receipt of response or unsatisfactory response from the concerned persons mentioned above.

If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:
IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255or 18004254732 (Toll free).
Email ID: complaints@irda.gov.in

You can also register your complaint online athttp://www.igms.irda.gov.in /
Address for communication for complaints by fax/paper:
Consumer Affairs Department

Consumer Affairs Department - Grievance Redressal Cell.
Insurance Regulatory and Development Authority of India
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

3) Insurance Ombudsman:

In case the Insured Member is not satisfied with the redressal or there is no response within a period of 1 (One) month, the complainant or his legal heirs may approach Insurance Ombudsman at the address mentioned in Annexure A or on the IRDAI website www.policyholder.gov.in, if the grievance pertains to:

3.1 delay in settlement of claims;
3.2 any partial or total repudiation of a claim by Us;
3.3 disputes over premium paid or payable in terms of insurance policy;
3.4 misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
3.5 legal construction of the Policy in so far as such dispute relates to claim;
3.6 policy servicing related grievances against insurers and their agents and intermediaries;
3.7 issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with the proposal form submitted by the proposer;
3.8 non issuance of any insurance document after receipt of the Premium
3.9 any other matter resulting from the violation of provisions of the Insurance Act, 1938 or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned hereinabove.

The complaint should be made in writing duly signed by the complainant or through his legal heirs, nominee or assignee, and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman. As per provision 14(3) of the Insurance Ombudsman Rules, 2017; the complaint to the Ombudsman can be made:

- Only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer; or
- the complainant had not received any reply within a period of one month after the Insurer received his representation; or

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- the complainant is not satisfied with the reply given to him by the Insurer.

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Annexure I

1a. Surrender Value factors (% of premiums paid) - For Level Cover | Limited Pay

PPT	PT	Duration (years)-->																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
5	6	0%	33%	25%	17%	8%	0%												
5	7	0%	36%	29%	21%	14%	7%	0%											
5	8	0%	38%	31%	25%	19%	13%	6%	0%										
5	9	0%	39%	33%	28%	22%	17%	11%	6%	0%									
5	10	0%	40%	35%	30%	25%	20%	15%	10%	5%	0%								
5	11	0%	41%	36%	32%	27%	23%	18%	14%	9%	5%	0%							
5	12	0%	42%	38%	33%	29%	25%	21%	17%	13%	8%	4%	0%						
5	13	0%	42%	38%	35%	31%	27%	23%	19%	15%	12%	8%	4%	0%					
5	14	0%	43%	39%	36%	32%	29%	25%	21%	18%	14%	11%	7%	4%	0%				
5	15	0%	43%	40%	37%	33%	30%	27%	23%	20%	17%	13%	10%	7%	3%	0%			
5	16	0%	44%	41%	38%	34%	31%	28%	25%	22%	19%	16%	13%	9%	6%	3%	0%		
5	17	0%	44%	41%	38%	35%	32%	29%	26%	24%	21%	18%	15%	12%	9%	6%	3%	0%	
5	18	0%	44%	42%	39%	36%	33%	31%	28%	25%	22%	19%	17%	14%	11%	8%	6%	3%	0%
5	19	0%	45%	42%	39%	37%	34%	32%	29%	26%	24%	21%	18%	16%	13%	11%	8%	5%	3%
5	20	0%	45%	43%	40%	38%	35%	33%	30%	28%	25%	23%	20%	18%	15%	13%	10%	8%	5%
5	21	0%	45%	43%	40%	38%	36%	33%	31%	29%	26%	24%	21%	19%	17%	14%	12%	10%	7%
5	22	0%	45%	43%	41%	39%	36%	34%	32%	30%	27%	25%	23%	20%	18%	16%	14%	11%	9%
5	23	0%	46%	43%	41%	39%	37%	35%	33%	30%	28%	26%	24%	22%	20%	17%	15%	13%	11%
5	24	0%	46%	44%	42%	40%	38%	35%	33%	31%	29%	27%	25%	23%	21%	19%	17%	15%	13%
5	25	0%	46%	44%	42%	40%	38%	36%	34%	32%	30%	28%	26%	24%	22%	20%	18%	16%	14%
5	26	0%	46%	44%	42%	40%	38%	37%	35%	33%	31%	29%	27%	25%	23%	21%	19%	17%	15%
5	27	0%	46%	44%	43%	41%	39%	37%	35%	33%	31%	30%	28%	26%	24%	22%	20%	19%	17%
5	28	0%	46%	45%	43%	41%	39%	38%	36%	34%	32%	30%	29%	27%	25%	23%	21%	20%	18%
5	29	0%	47%	45%	43%	41%	40%	38%	36%	34%	33%	31%	29%	28%	26%	24%	22%	21%	19%
5	30	0%	47%	45%	43%	42%	40%	38%	37%	35%	33%	32%	30%	28%	27%	25%	23%	22%	20%
5	31	0%	47%	45%	44%	42%	40%	39%	37%	35%	34%	32%	31%	29%	27%	26%	24%	23%	21%
5	32	0%	47%	45%	44%	42%	41%	39%	38%	36%	34%	33%	31%	30%	28%	27%	25%	23%	22%
5	33	0%	47%	45%	44%	42%	41%	39%	38%	36%	35%	33%	32%	30%	29%	27%	26%	24%	23%
5	34	0%	47%	46%	44%	43%	41%	40%	38%	37%	35%	34%	32%	31%	29%	28%	26%	25%	24%
5	35	0%	47%	46%	44%	43%	41%	40%	39%	37%	36%	34%	33%	31%	30%	29%	27%	26%	24%

PPT	PT	Duration (years)-->																
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
5	6																	
5	7																	
5	8																	
5	9																	
5	10																	
5	11																	
5	12																	

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PPT	PT	Duration (years)-->																
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
5	13																	
5	14																	
5	15																	
5	16																	
5	17																	
5	18																	
5	19																	
5	20																	
5	21																	
5	22																	
5	23																	
5	24																	
5	25																	
5	26																	
5	27	0%																
5	28	3%	0%															
5	29	5%	2%	0%														
5	30	7%	5%	2%	0%													
5	31	9%	7%	4%	2%	0%												
5	32	10%	8%	6%	4%	2%	0%											
5	33	12%	10%	8%	6%	4%	2%	0%										
5	34	13%	12%	10%	8%	6%	4%	2%	0%									
5	35	15%	13%	11%	9%	7%	6%	4%	2%	0%								

1b. Surrender Value factors (% of premiums paid) - For Level Cover | Single Pay

PPT	PT	Duration (years)-->																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1	2	25%	0%																
1	3	33%	17%	0%															
1	4	38%	25%	13%	0%														
1	5	40%	30%	20%	10%	0%													
1	6	42%	33%	25%	17%	8%	0%												
1	7	43%	36%	29%	21%	14%	7%	0%											
1	8	44%	38%	31%	25%	19%	13%	6%	0%										
1	9	44%	39%	33%	28%	22%	17%	11%	6%	0%									
1	10	45%	40%	35%	30%	25%	20%	15%	10%	5%	0%								
1	11	45%	41%	36%	32%	27%	23%	18%	14%	9%	5%	0%							
1	12	46%	42%	38%	33%	29%	25%	21%	17%	13%	8%	4%	0%						
1	13	46%	42%	38%	35%	31%	27%	23%	19%	15%	12%	8%	4%	0%					
1	14	46%	43%	39%	36%	32%	29%	25%	21%	18%	14%	11%	7%	4%	0%				

SAMPLE

PPT	PT	Duration (years)-->																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1	15	47%	43%	40%	37%	33%	30%	27%	23%	20%	17%	13%	10%	7%	3%	0%			
1	16	47%	44%	41%	38%	34%	31%	28%	25%	22%	19%	16%	13%	9%	6%	3%	0%		
1	17	47%	44%	41%	38%	35%	32%	29%	26%	24%	21%	18%	15%	12%	9%	6%	3%	0%	
1	18	47%	44%	42%	39%	36%	33%	31%	28%	25%	22%	19%	17%	14%	11%	8%	6%	3%	0%
1	19	47%	45%	42%	39%	37%	34%	32%	29%	26%	24%	21%	18%	16%	13%	11%	8%	5%	3%
1	20	48%	45%	43%	40%	38%	35%	33%	30%	28%	25%	23%	20%	18%	15%	13%	10%	8%	5%
1	21	48%	45%	43%	40%	38%	36%	33%	31%	29%	26%	24%	21%	19%	17%	14%	12%	10%	7%
1	22	48%	45%	43%	41%	39%	36%	34%	32%	30%	27%	25%	23%	20%	18%	16%	14%	11%	9%
1	23	48%	46%	43%	41%	39%	37%	35%	33%	30%	28%	26%	24%	22%	20%	17%	15%	13%	11%
1	24	48%	46%	44%	42%	40%	38%	35%	33%	31%	29%	27%	25%	23%	21%	19%	17%	15%	13%
1	25	48%	46%	44%	42%	40%	38%	36%	34%	32%	30%	28%	26%	24%	22%	20%	18%	16%	14%
1	26	48%	46%	44%	42%	40%	38%	37%	35%	33%	31%	29%	27%	25%	23%	21%	19%	17%	15%
1	27	48%	46%	44%	43%	41%	39%	37%	35%	33%	31%	30%	28%	26%	24%	22%	20%	19%	17%
1	28	48%	46%	45%	43%	41%	39%	38%	36%	34%	32%	30%	29%	27%	25%	23%	21%	20%	18%
1	29	48%	47%	45%	43%	41%	40%	38%	36%	34%	33%	31%	29%	28%	26%	24%	22%	21%	19%
1	30	48%	47%	45%	43%	42%	40%	38%	37%	35%	33%	32%	30%	28%	27%	25%	23%	22%	20%
1	31	48%	47%	45%	44%	42%	40%	39%	37%	35%	34%	32%	31%	29%	27%	26%	24%	23%	21%
1	32	48%	47%	45%	44%	42%	41%	39%	38%	36%	34%	33%	31%	30%	28%	27%	25%	23%	22%
1	33	48%	47%	45%	44%	42%	41%	39%	38%	36%	35%	33%	32%	30%	29%	27%	26%	24%	23%
1	34	49%	47%	46%	44%	43%	41%	40%	38%	37%	35%	34%	32%	31%	29%	28%	26%	25%	24%
1	35	49%	47%	46%	44%	43%	41%	40%	39%	37%	36%	34%	33%	31%	30%	29%	27%	26%	24%

PPT	PT	Duration (years)-->																
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
1	2																	
1	3																	
1	4																	
1	5																	
1	6																	
1	7																	
1	8																	
1	9																	
1	10																	
1	11																	
1	12																	
1	13																	
1	14																	
1	15																	
1	16																	

SAMPLE

PPT	PT	Duration (years)-->																
		19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
1	17																	
1	18																	
1	19	0%																
1	20	3%	0%															
1	21	5%	2%	0%														
1	22	7%	5%	2%	0%													
1	23	9%	7%	4%	2%	0%												
1	24	10%	8%	6%	4%	2%	0%											
1	25	12%	10%	8%	6%	4%	2%	0%										
1	26	13%	12%	10%	8%	6%	4%	2%	0%									
1	27	15%	13%	11%	9%	7%	6%	4%	2%	0%								
1	28	16%	14%	13%	11%	9%	7%	5%	4%	2%	0%							
1	29	17%	16%	14%	12%	10%	9%	7%	5%	3%	2%	0%						
1	30	18%	17%	15%	13%	12%	10%	8%	7%	5%	3%	2%	0%					
1	31	19%	18%	16%	15%	13%	11%	10%	8%	6%	5%	3%	2%	0%				
1	32	20%	19%	17%	16%	14%	13%	11%	9%	8%	6%	5%	3%	2%	0%			
1	33	21%	20%	18%	17%	15%	14%	12%	11%	9%	8%	6%	5%	3%	2%	0%		
1	34	22%	21%	19%	18%	16%	15%	13%	12%	10%	9%	7%	6%	4%	3%	1%	0%	
1	35	23%	21%	20%	19%	17%	16%	14%	13%	11%	10%	9%	7%	6%	4%	3%	1%	0%

2. Surrender Value factors (% of premiums paid) - For Reducing Cover

Surrender Value Factors mentioned in Table 1a/Table 1b above multiplied by (Coverage at the time of surrender / Sum Assured at inception)

With Return of Premium

PT	Duration (years)-->																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
10	47%	51%	55%	60%	65%	71%	77%	84%	92%	100%								
11	43%	47%	51%	55%	60%	65%	71%	78%	84%	92%	100%							
12	40%	43%	47%	51%	55%	60%	65%	71%	78%	84%	92%	100%						
13	37%	40%	43%	47%	51%	55%	60%	66%	71%	78%	84%	92%	100%					
14	34%	37%	40%	43%	47%	51%	55%	60%	66%	71%	78%	84%	92%	100%				
15	31%	34%	37%	40%	43%	47%	51%	56%	60%	66%	71%	78%	84%	92%	100%			
16	29%	31%	34%	37%	40%	43%	47%	51%	56%	60%	66%	71%	78%	84%	92%	100%		
17	27%	29%	31%	34%	37%	40%	43%	47%	51%	56%	60%	66%	71%	78%	84%	92%	100%	
18	25%	27%	29%	31%	34%	37%	40%	44%	47%	51%	56%	60%	66%	71%	78%	84%	92%	100%
19	23%	25%	27%	29%	32%	34%	37%	40%	44%	47%	51%	56%	61%	66%	71%	78%	84%	92%
20	21%	23%	25%	27%	29%	32%	34%	37%	40%	44%	47%	51%	56%	61%	66%	71%	78%	84%
21	20%	21%	23%	25%	27%	29%	32%	35%	37%	41%	44%	48%	52%	56%	61%	66%	71%	78%
22	18%	20%	22%	23%	25%	27%	30%	32%	35%	38%	41%	44%	48%	52%	56%	61%	66%	71%
23	17%	19%	20%	22%	24%	25%	28%	30%	32%	35%	38%	41%	44%	48%	52%	56%	61%	66%

Tata AIA Life Insurance Group Sampoorna Raksha (UIN: 110N154V01)

PT	Duration (years)-->																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
24	16%	17%	19%	20%	22%	24%	26%	28%	30%	32%	35%	38%	41%	44%	48%	52%	56%	61%
25	15%	16%	18%	19%	21%	22%	24%	26%	28%	30%	33%	35%	38%	41%	44%	48%	52%	56%
26	14%	15%	17%	18%	19%	21%	22%	24%	26%	28%	30%	33%	35%	38%	41%	45%	48%	52%
27	13%	14%	16%	17%	18%	19%	21%	23%	24%	26%	28%	31%	33%	36%	38%	41%	45%	48%
28	13%	14%	15%	16%	17%	18%	20%	21%	23%	25%	27%	29%	31%	33%	36%	39%	42%	45%
29	12%	13%	14%	15%	16%	17%	19%	20%	22%	23%	25%	27%	29%	31%	33%	36%	39%	42%
30	11%	12%	13%	14%	15%	16%	18%	19%	20%	22%	24%	25%	27%	29%	31%	34%	36%	39%
31	11%	12%	12%	13%	14%	16%	17%	18%	19%	21%	22%	24%	26%	27%	29%	32%	34%	37%
32	10%	11%	12%	13%	14%	15%	16%	17%	18%	20%	21%	23%	24%	26%	28%	30%	32%	34%
33	10%	11%	11%	12%	13%	14%	15%	16%	17%	19%	20%	21%	23%	25%	26%	28%	30%	32%
34	9%	10%	11%	12%	13%	13%	14%	15%	17%	18%	19%	20%	22%	23%	25%	27%	28%	30%
35	9%	10%	10%	11%	12%	13%	14%	15%	16%	17%	18%	19%	21%	22%	24%	25%	27%	29%

PT	Duration (years)-->																
	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
10																	
11																	
12																	
13																	
14																	
15																	
16																	
17																	
18																	
19	100%																
20	92%	100%															
21	84%	92%	100%														
22	78%	84%	92%	100%													
23	71%	78%	84%	92%	100%												
24	66%	72%	78%	84%	92%	100%											
25	61%	66%	72%	78%	84%	92%	100%										
26	56%	61%	66%	72%	78%	84%	92%	100%									
27	52%	56%	61%	66%	72%	78%	84%	92%	100%								
28	48%	52%	56%	61%	66%	72%	78%	84%	92%	100%							
29	45%	49%	52%	57%	61%	66%	72%	78%	84%	92%	100%						
30	42%	45%	49%	53%	57%	61%	66%	72%	78%	84%	92%	100%					
31	39%	42%	45%	49%	53%	57%	61%	66%	72%	78%	84%	92%	100%				
32	37%	39%	42%	46%	49%	53%	57%	61%	66%	72%	78%	84%	92%	100%			
33	35%	37%	40%	43%	46%	49%	53%	57%	62%	67%	72%	78%	85%	92%	100%		
34	33%	35%	37%	40%	43%	46%	49%	53%	57%	62%	67%	72%	78%	85%	92%	100%	
35	31%	33%	35%	38%	40%	43%	46%	50%	53%	57%	62%	67%	72%	78%	85%	92%	100%

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The above factors are applicable at the end of the year and shall be interpolated, on a daily basis, to arrive at the factors applicable at the time of surrender. Any change in SSV factors shall be filed with the Authority and shall be intimated to You/Member from time to time.

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Annexure 1

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	**Details**	**Jurisdiction of Office Union Territory,District)**
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

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NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	**Details**	**Jurisdiction of Office Union Territory,District)**
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

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NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Office of the Ombudsman	**Details**	**Jurisdiction of Office Union Territory,District)**
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

For further information or latest updated list of Ombudsman Office addresses, kindly visit the IRDAI websitehttp://www.Policyholder.gov.in/ - Ombudsman / List of Insurance Ombudsmen OR our website www.tataaia.com

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Annexure 2

Section 39 - Nomination by Insured Member

Nomination of a life Insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

01. The Insured Member of a life Insurance on his own life may nominate a person or persons to whom money secured by the Policy shall be paid in the event of his death.

02. Where the nominee is a minor, the Insured Member may appoint any person to receive the money secured by the Policy in the event of Insured Member's death during the minority of the nominee. The manner of appointment to be laid down by the Insurer.

03. Nomination can be made at any time before the maturity of the Policy.

04. Nomination may be incorporated in the text of the Policy itself or may be endorsed on the Policy communicated to the Insurer and can be registered by the Insurer in the records relating to the Policy.

05. Nomination can be cancelled or changed at any time before Policy matures, by an endorsement or a further endorsement or a will as the case may be.

06. A notice in writing of Change or Cancellation of nomination must be delivered to the Insurer for the Insurer to be liable to such nominee. Otherwise, Insurer will not be liable if a bona fide payment is made to the person named in the text of the Policy or in the registered records of the Insurer.

07. Fee to be paid to the Insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.

08. On receipt of notice with fee, the Insurer should grant a written acknowledgement to the Insured Member of having registered a nomination or cancellation or change thereof.

09. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the Insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of Insurer's or transferee's or assignee's interest in the Policy. The nomination will get revived on repayment of the loan.

10. The right of any creditor to be paid out of the proceeds of any Policy of life Insurance shall not be affected by the nomination.

11. In case of nomination by Insured Member whose life is Insured, if the nominees die before the Insured Member, the proceeds are payable to Insured Member or his heirs or legal representatives or holder of succession certificate.

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12. In case nominee(s) survive the person whose life is Insured, the amount secured by the Policy shall be paid to such survivor(s).

13. Where the Insured Member whose life is Life Assured nominates his

a. parents or

b. spouse or

c. children or

d. spouse and children

e. or any of them

the nominees are beneficially entitled to the amount payable by the Insurer to the Insured Member unless it is proved that Insured Member could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14. If nominee(s) die after the Insured Member but before his share of the amount secured under the Policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).

15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life Insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act, 2015.

16. If Insured Member dies after maturity but the proceeds and benefit of the Policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the Policy.

17. The provisions of Section 39 are not applicable to any life Insurance Policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act, 2015., a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the Policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the Policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policyholder and Insured Members are advised to refer to Insurance Laws (Amendment) Act, 2015 for complete and accurate details.]

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Tata AIA Life Insurance Group Sampoorna Raksha (UIN: 110N154V01)

Annexure 3

Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding Policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended by Insurance Laws (Amendment) Act, 2015 are as follows:

01. No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 yrs from

a. the date of issuance of Policy or

b. the date of commencement of risk or

c. the date of revival of Policy or

d. the date of rider to the Policy

whichever is later.

02. On the ground of fraud, a Policy of Life Insurance may be called in question within 3 years from

a. the date of issuance of Policy or

b. the date of commencement of risk or

c. the date of revival of Policy or

d. the date of rider to the Policy

whichever is later.
For this, the Insurer should communicate in writing to the Life Assured or legal representative or nominee or assignees of Insured, as applicable, mentioning the ground and materials on which such decision is based.

03. Fraud means any of the following acts committed by Life Assured or by his agent, with the intent to deceive the Insurer or to induce the Insurer to issue a life Insurance Policy:

a. The suggestion, as a fact of that which is not true and which the Life Assured does not believe to be true;

b. The active concealment of a fact by the Life Assured having knowledge or belief of the fact;

c. Any other act fitted to deceive; and

d. Any such act or omission as the law specifically declares to be fraudulent.

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04. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the Life Assured or his agent keeping silence to speak or silence is in itself equivalent to speak.

05. No Insurer shall repudiate a life Insurance Policy on the ground of Fraud, if the Life Assured/ beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the Insurer. Onus of disproving is upon the Insured Member, if alive, or beneficiaries.

06. Life Insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the Life Assured was incorrectly made in the proposal or other document basis which Policy was issued or revived or rider issued. For this, the Insurer should communicate in writing to the Life Assured or legal representative or nominee or assignees of Insured, as applicable, mentioning the ground and materials on which decision to repudiate the Policy of life Insurance is based.

07. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on Policy till the date of repudiation shall be paid to the Life Assured or legal representative or nominee or assignees of Insured, within a period of 90 days from the date of repudiation.

08. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the Insurer. The onus is on Insurer to show that if the Insurer had been aware of the said fact, no life Insurance Policy would have been issued to the Insured.

09. The Insurer can call for proof of age at any time if he is entitled to do so and no Policy shall be deemed to be called in question merely because the terms of the Policy are adjusted on subsequent proof of age of Life Insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015. and only a simplified version prepared for general information. Policyholders and Insured Members are advised to refer to Insurance Laws (Amendment) Act, 2015 for complete and accurate details.]

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