FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

POLICY WORDINGS

Group Health Insurance (Small and Mid-size Groups)

I. Whereas the Insured Person designated in the Schedule hereto has by a proposal and declaration dated as stated in the schedule which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to Future Generali India Insurance Company Ltd. (herein after called the Company) for the insurance herein after set forth in respect of Employees/ Members (including their eligible Family Members) named in the schedule hereto (herein after called the Insured Person) and has paid premium as consideration for such insurance.

The Insured Person is eligible to be covered under this policy from birth/90 days (as a dependent child) upto the age of 80 years with lifelong renewability subject to continuous renewal of the Group Health policy for Small and Mid-size groups. This Policy records the agreement between the Company and the Insured Person and sets out the terms of insurance and the obligations of each party.

II. SCOPE OF COVER

Now this policy witnesseth that subject to the terms, Conditions, exclusions and definitions contained herein or endorsed or otherwise expressed here on the Company undertakes that if during the period stated in the schedule or during the continuance of this policy by renewal any Insured Person shall contract any disease or suffer from any illness (herein after called DISEASE) or sustain any bodily injury through accident (herein after called INJURY) and if such disease or injury shall require any such Insured Person, upon the medical advice of a duly qualified Physician/ Medical Specialist/ Medical Practitioner (herein after called Medical Practitioner) or of a duly qualified surgeon (herein after called SURGEON) to incur Inpatient care/ Emergency care/ Domiciliary Hospitalisation expenses for medical/ surgical treatment at any Nursing Home/ Hospital in India as herein defined (herein after called Hospital) as an inpatient, the Company will pay to the Insured Person the amount of such expenses as would fall under different heads mentioned below, and as are medically necessary and reasonable & customary charges incurred therefore by or on behalf of such Insured Person, but not exceeding the sum insured for the person in any one period of such insurance as mentioned in the schedule hereto.

1. In Patient Expenses

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

2. Day Care Treatment expenses

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

3. Pre-hospitalisation Medical Expenses

We will pay the Reasonable and Customary Charges for Medical Expenses incurred up to 30 days prior to hospitalization on disease/ injury/ illness, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

4. Post-hospitalisation Medical Expenses

We will pay the Reasonable and Customary Charges for Medical Expenses incurred up to 60 days after discharge from the hospital, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

5. Domiciliary Hospitalisation Expenses

In this policy Domiciliary Hospitalisation expenses are limited to 15% of the sum insured. However that domiciliary hospitalisation benefits shall not cover:-

1 Expenses incurred for pre and post hospital treatment and
2 Expenses incurred for treatment for any of the following diseases
i. Asthma
ii. Bronchitis
iii. Chronic Nephritis and Nephritic Syndrome
iv. Diarrhea and all type of Dysenteries including Gastro-enteritis

v. Diabetes Mellitus and Insipidus
vi. Epilepsy
vii. Hypertension
viii. Influenza, Cough and Cold
ix. All Psychiatric or Psychosomatic Disorders
x. Pyrexia of unknown Origin for less than 10 days
xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis
xii. Arthritis, Gout and Rheumatism
xiii. Dental Treatment or Surgery

Note: The Company's Liability in respect of all claims admitted including Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses during the period of insurance shall not exceed the Sum Insured for the person as mentioned in the schedule.

6. Optional Covers
Optional Covers are available on payment of additional premium, the details of optional covers are mentioned in Annexure I.

III. DEFINITIONS:

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

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

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

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

4. **Bank Rate** means Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

5. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

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

7. **Claim**: means a demand made in accordance with the terms and conditions of the Policy for payment of Medical Expenses or Optional EXTENSION in respect of the Insured Member as covered under the Policy.

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

9. **Congenital Anomaly:** Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a) **Internal Congenital Anomaly**- Congenital anomaly which is not in the visible and accessible parts of the body.
   b) **External Congenital Anomaly**- Congenital anomaly which is in the visible and accessible parts of the body.

10. **Co-Payment**: A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum insured.

11. **Day care centre:** A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

- has qualified nursing staff under its employment
- has qualified medical practitioner/s in charge
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

12. **Day Care Treatment:** refers to medical treatment, and/ or surgical procedure which is:
    a) undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hrs because of technological advancement, and
    b) which would have otherwise required a hospitalization of more than 24 hours.
    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

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

15. **Dependent** means a person who is a member of the Primary Insured Member's family who is legally wedded spouse, natural or legally adopted child, parents and parents in law and whose name is mentioned in the Policy schedule as an Insured Member.

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

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

18. **Domiciliary Hospitalisation:** Domiciliary hospitalization means medical treatment for an illness/ disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    - the condition of the patient is such that he/ she is not in a condition to be removed to a hospital, or
    - the patient takes treatment at home on account of non-availability of room in a hospital.

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

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

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

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

23. **Illness:** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

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

B. **Chronic condition**: is defined as a disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it recurs or is likely to recur.

24. **Injury:** 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.

25. **Inpatient Care:** Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

26. **Intensive Care Unit:** Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

27. **ICU Charges: ICU (Intensive Care Unit)** Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

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

30. **Medical expenses:** Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

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

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

33. **Network Provider:** Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by cashless facility.

34. **New Born Baby:** Newborn baby means baby born during the Policy Period and is aged upto 90 days.

35. **Non- Network:** Any hospital, day care centre or other provider that is not part of the network.

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

37. **OPD treatment:** OPD treatment one in which the Insured visits a clinic/ hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

38. **Policy Period** The period commencing with the start date mentioned in the **Schedule** till the end date mentioned in the **Schedule**

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

40. **Policyholder**: means the entity or person named as such in the Schedule.

41. **Portability:** Portability means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

42. **Pre-Existing Disease:** Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/ or were diagnosed, and/ or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer and renewed continuously thereafter.

43. **Pre-hospitalization Medical Expenses**: Medical Expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

44. **Post-hospitalization Medical Expenses:** Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required, and
    ii. The in-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

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

46. **Qualified Nurse:** Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

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

49. **Room rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

50. **Spouse** means an insured person's husband or wife who is recognized as such by the laws of the jurisdiction in which they reside.

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

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

53. **We/Our/Us**: means Future Generali India Insurance Company limited.

54. **You/Your**: means the Policyholder.

IV. EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of the following:-

1. Benefits will not be available for any Pre-existing disease(s)/ condition(s) as defined in the policy, until 48 months of continuous coverage have elapsed, since inception of the first policy.
2. Any disease other than those stated in clause IV. A. 3, contracted by the Insured Person during the first 30 days from the commencement date of the policy except accidental bodily injury requiring hospitalisation.
3. During the first year of the operation of insurance cover, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus, Hernia, Hydrocele, Fistula in anus, piles, Sinusitis and related disorders, Surgery for prolapsed inter vertebral disc unless arising from accident, Surgery of varicose veins and varicose ulcers, Joint Replacement due to Degenerative condition, Age related osteoarthritis and Osteoporosis are not payable.
4. Injury or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not).
5. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident.
6. Vaccination/ inoculation (except as post bite treatment), cosmetic treatments (for change of life or cosmetic or aesthetic treatment of any description), plastic surgery other than as may be necessitated due to an accident or as a part of any illness, refractive error corrective procedures, Unproven/ Experimental treatment, investigational or treatments, devices and pharmacological regimens of any description.
7. Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to wheel chair ,crutches, artificial limbs, belts, braces, stocking, Glucometer and the like), namely that equipment used externally from the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose ;is generally not useful in absence of an Illness or Injury and is usable outside of a Hospital) unless required for the treatment of Illness or Accidental Bodily Injury.
8. Any dental treatment or surgery which is a corrective in nature, unless it requires Hospitalisation and is carried out under general anesthesia and is necessitated by Illness or Accidental Bodily Injury.
9. Personal comfort and convenience items or services such as television, telephone, barber or beauty service guest service and similar incidental services and supplies.
10. The treatment of obesity (including morbid obesity) and other weight control programs, services and supplies.
11. Expenses incurred towards treatment of illness/ disease/ condition arising out of alcohol use/ misuse or abuse of alcohol, substance or drugs (whether prescribed or not).
12. Convalescence, general debility, ''Run-down'' condition or rest cure, venereal disease, intentional self-injury.
13. Invitro fertilization (IVF), Gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation; voluntary medical termination of pregnancy; any treatment related to infertility and sterilization.
14. Treatment arising from or traceable to pregnancy childbirth, miscarriage, abortion or complications of any of this, including caesarian section. However, this exclusion will not apply to abdominal operation for extra uterine pregnancy (Ectopic Pregnancy).
15. All expenses arising out of any condition directly or indirectly caused to or associated with Human T - Cell Lymphotropic Virus type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.
16. Any External Congenital illness/ disease/ defect/ anomaly. Any Internal Congenital Anomaly until 48 months of continuous coverage has elapsed for the insured, since the inception of the first policy with us.
17. Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home.
18. Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending medical practitioner.
19. Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.
20. Costs incurred on all methods of treatment including Alternative treatments except Allopathic.
21. Stem cell implantation/ surgery/ storage.
22. Any treatment required arising from Insured Person's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Company.
23. Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
24. Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.

25. Outpatient Diagnostic, Medical and Surgical procedures or treatments (OPD treatment), non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
26. Any kind of Service charges, Surcharges, Admission fees/ Registration charges etc levied by the hospital.
27. Medical Practitioner's home visit charges, Attendant/ Nursing charges during pre and post hospitalization period.
28. Expenses related to donor screening, treatment, including surgery to remove organs from the donor in case of a transplant surgery.
29. Standard list of excluded items as mentioned in our website https://general.futuregenerali.in
30. Treatment taken in any hospital or by any Provider that We have blacklisted, as mentioned in our website https://general.futuregenerali.in/general-insurance/network-hospitals

V. CONDITIONS

1. **Condition Precedent to the contract**

i. The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company

2. **Conditions applicable during the contract**

i. **Addition and Deletion of members**

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

ii. **Cancellation**

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

Period on risk	Rate of premium retained
Up to one month	1/4th of the annual rate
Up to three months	1/2nd of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

iii. **Policy Period**

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

iv. **Portability**

Individual members, including the family members covered under Group Health Insurance policy of a non-life insurance company shall have the right to migrate from such a similar group policy to an individual health policy or a family floater policy with the same insurer. For Group Health Insurance policies, the individual member's shall be given credit based on the number of years of continuous insurance coverage as per the Portability guidelines.

v. **Dispute Resolution**

a. Any dispute regarding the claim amount, liability otherwise being admitted, are to be referred to arbitration under the Arbitration & Conciliation Act 1996. The law of the arbitration shall be Indian law and the seat of the arbitration and venue for all the hearings shall be within India.
b. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian courts.

vi. **Territorial limit**
All medical/ surgical treatments/ expenses under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency (Indian Rupees).

vii. **Communication**
Every notice of communication to be given or made under this policy shall be delivered in writing at the address as shown in the schedule.

viii. **Fraud**
The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

ix. **Contribution (In case of Multiple Policies)**
a) If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.
b) In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
c) The policyholder having multiple policies shall also have the right to prefer claims from other policy/ policies for the amounts disallowed under the earlier chosen policy/ policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.
d) If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
e) Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

x. **Denial of liability**
If the Company shall disclaim liability to the Insured Person for any claim hereunder and if the Insured Person shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

3. **Conditions when a claim arises**

i. **Claims Procedure**: Claims procedure for policies serviced by in-house service administrator (Future Generali Health (FGH))
   a. The Company's in-house service administrator will provide the user guide & identity card to Insured Person within 15 days from the date of issue of policy. User guide will have following details:
      i. Contact details of in-house service administrator
      ii. Website address of in-house service administrator
      iii. Updated Network list of hospitals with their contact details.
      iv. Claim submission guidelines.
   b. Notification of the Claim intimation should be given within 48 hrs of Admission or before Discharge from Hospital/ Nursing Home.
   c. The Insured Person shall without any delay consult a medical practitioner and follow the advice and treatment recommended, take reasonable step to minimize the quantum of any claim that might be made under this Policy.
   d. The Insured Person shall immediately file the claim and in any case within 30 days of discharge from the Hospital provide the Company with written details of the quantum of any claim along with all the original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.
   e. The Insured Person shall submit himself for examination by the Company's medical advisors as often as may be considered necessary by the Company.

ii. **Claims Administration**: If Insured Person meets with any accidental Bodily Injury or suffers an Illness that may result in a claim, then as a condition precedent to the Company's liability, Insured Person must comply with the following:
   i. Cashless treatment is only available at a Network Provider. In order to avail of cashless treatment, the following procedure must be followed by Insured Person:
      a) Prior to taking treatment and/ or incurring Medical Expenses at a Network Hospital, Insured Person must call us at our call centre and request pre-authorisation by way of the written form.

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

c) If the procedure above is followed, Insured Person will not be required to directly pay for the Medical Expenses in the Network Hospital that the Company is liable to indemnify under this Policy and the original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorisation does not guarantee that all costs and expenses will be covered. The Company reserves the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. Insured Person shall, in any event, be required to settle all other expenses directly.

iii. If pre-authorisation as above is denied by the Company or if treatment is taken in a Hospital which is Non-Network or if Insured Person does not wish to avail cashless facility, then:

a) Insured Person must give Notification of Claim, in writing, immediately, and in any event within 48 hours of the aforesaid Illness or Bodily Injury. Insured Person must immediately consult a Doctor and follow the advice and treatment that he recommends.

b) Insured Person must promptly and in any event within 30 days of discharge from a Hospital give the Company the documentation (written details of the quantum of any claim along with all original supporting documentation, including but not limited to first consultation letter, original vouchers, bills and receipts, birth/death certificate (as applicable)) and other information the Company asks for to investigate the claim or the Company's obligation to make payment for it.

c) In the event of the death of the insured person, someone claiming on his behalf must inform the Company in writing immediately and send the Company a copy of the post mortem report (if any) within 14 days.

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

iv. Claims Processing

a) Claims submission

i. Insured Person will submit the claim papers to in-house service administrator

ii. Following is the 'necessary' document list for claim submission:

- Claim form
- Original discharge summary
- Original set of investigation reports
- Original bills and receipts
- Pharmacy bills in original with prescriptions

b) Claims Processing

i. The Company's In-house service administrator doctors will scrutinize the claims and flag the claim as settled/ Rejected/ Pending within the period of 30 days of the receipt of the last 'necessary' documents.

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

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

iv. In cashless claims, hospital will submit the claims to the Company's In-house service administrator for payment.

c) Claims Payment

i. The Company's In-house service administrator will send the discharge voucher with details of allowed and disallowed amount

ii. Insured Person will send the signed discharge voucher to the Company's in-house service administrator, on which the administrator will send the cheque in name of Insured Person.

iii. We will make payment of the amount due within 30 days from the date of receipt of last 'necessary' document. However, in the circumstances where a claim warrant an investigation in our opinion, we shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last 'necessary' document. In such cases, we shall settle the claim within 45 days from the date of receipt of last 'necessary' document.

iv. In case of delay in the payment, we shall be liable to pay interest at a rate 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by us.

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

a) This Policy may be renewed by mutual consent and in such event; the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof.
b) The Policyholder, shall throughout the period of insurance keep and maintain a record containing the names of all the insured persons. The Policyholder shall declare to the company any additions in the number of insured persons as and when arising during the period of insurance and shall pay the additional premium as agreed
c) It is hereby agreed and understood that, this insurance being a group policy availed by the Insured covering members, the benefit thereof would not be available to members who cease to be part of the group for any reason whatsoever.

   Such members may obtain further individual insurance directly from the Company and any claims shall be governed by the terms thereof.
d) The premium rates or loadings for the product would not be changed without approval from Authority. However the performance of the product will be reviewed annually and further pricing will be done on experience basis.

VI. DAY CARE LIST

In addition to Day Care list – We would also cover any other surgeries/ procedures agreed by Us which require less than 24 hours hospitalization as an inpatient due to subsequent advancement in technology.

1. Suturing - CLW -under LA or GA
2. Surgical debridement of wound
3. Therapeutic Ascitic Tapping
4. Therapeutic Pleural Tapping
5. Therapeutic Joint Aspiration
6. Aspiration of an internal abscess under ultrasound guidance
7. Aspiration of hematoma
8. Incision and Drainage
9. Endoscopic Foreign Body Removal - Trachea /- pharynx-larynx/ bronchus
10. Endoscopic Foreign Body Removal - Oesophagus/stomach /rectum.
11. True Cut Biopsy – Breast/ liver/ Kidney- Lymph Node/ Pleura/ Lung/ Muscle biopsy/ Nerve biopsy/ synovial biopsy/ Bone trephine biopsy/ Pericardial biopsy
12. Endoscopic ligation/banding
13. Sclerotherapy
14. Dilatation of digestive tract strictures
15. Endoscopic ultrasonography and biopsy
16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease
17. Endoscopic placement/removal of stents
18. Endoscopic Gastrostomy
19. Replacement of Gastrostomy tube
20. Endoscopic polypectomy
21. Endoscopic decompression of colon
22. Therapeutic ERCP
23. Brochoscopic treatment of bleeding lesion
24. Brochoscopic treatment of fistula /stenting
25. Bronchoalveolar lavage & biopsy
26. Tonsillectomy without Adenoidectomy
27. Tonsillectomy with Adenoidectomy
28. Excision and destruction of lingual tonsil
29. Foreign body removal from nose
30. Myringotomy
31. Myringotomy with Grommet insertion
32. Myringoplasty /Tympanoplasty
33. Antral wash under LA
34. Quinsy drainage
35. Direct Laryngoscopy with or w/o biopsy
36. Reduction of nasal fracture
37. Mastoidectomy
38. Removal of tympanic drain
39. Reconstruction of middle ear
40. Incision of mastoid process & middle ear
41. Excision of nose granuloma
42. Blood transfusion for recipient
43. Therapeutic Phlebotomy
44. Haemodialysis/Peritoneal Dialysis
45. Parenteral Chemotherapy
46. Radiotherapy
47. Coronary Angioplasty (PTCA)
48. Pericardiocentesis
49. Insertion of filter in inferior vena cava
50. Insertion of gel foam in artery or vein
51. Carotid angioplasty
52. Renal angioplasty
53. Tumor embolisation
54. TIPS procedure for portal hypertension
55. Endoscopic Drainage of Pseudopancreatic cyst
56. Lithotripsy
57. PCNS (Percutaneous nephrostomy)
58. PCNL (percutaneous nephrolithotomy)
59. Suprapubiccytostomy
60. Trans urethral resection of bladder tumor
61. Hydrocele surgery
62. Epididymectomy
63. Orchidectomy
64. Herniorrhaphy
65. Hernioplasty
66. Incision and excision of tissue in the perianal region
67. Surgical treatment of anal fistula
68. Surgical treatment of hemorrhoids
69. Sphincterotomy/Fissurectomy
70. Laparoscopic appendicectomy
71. Laparoscopic cholecystectomy
72. TURP (Resection prostate)
73. Varicose vein stripping or ligation
74. Excision of dupuytren's contracture
75. Carpal tunnel decompression
76. Excision of granuloma
77. Arthroscopic therapy
78. Surgery for ligament tear
79. Surgery for meniscus tear
80. Surgery for hemoarthrosis/pyoarthrosis

81. Removal of fracture pins/nails
82. Removal of metal wire
83. Incision of bone, septic and aseptic
84. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis
85. Suture and other operations on tendons and tendon sheath
86. Reduction of dislocation under GA
87. Cataract surgery
88. Excision of lachrymal cyst
89. Excision of pterigium
90. Glaucoma Surgery
91. Surgery for retinal detachment
92. Chalazion removal (Eye)
93. Incision of lachrymal glands
94. Incision of diseased eye lids
95. Excision of eye lid granuloma
96. Operation on canthus & epicanthus
97. Corrective surgery for entropion & ectropion
98. Corrective surgery for blepharoptosis
99. Foreign body removal from conjunctiva
100. Foreign body removal from cornea
101. Incision of cornea
102. Foreign body removal from lens of the eye
103. Foreign body removal from posterior chamber of eye
104. Foreign body removal from orbit and eye ball
105. Excision of breast lump /Fibro adenoma
106. Operations on the nipple
107. Incision/Drainage of breast abscess
108. Incision of pilonidal sinus
109. Local excision of diseased tissue of skin and subcutaneous tissue
110. Simple restoration of surface continuity of the skin and subcutaneous tissue
111. Free skin transportation, donor site
112. Free skin transportation recipient site
113. Revision of skin plasty
114. Destruction of the diseases tissue of the skin and subcutaneous tissue
115. Incision, excision, destruction of the diseased tissue of the tongue
116. Glossectomy
117. Reconstruction of the tongue
118. Incision and lancing of the salivary gland and a salivary duct
119. Resection of a salivary duct
120. Reconstruction of a salivary gland and a salivary duct
121. External incision and drainage in the region of the mouth, jaw and face
122. Incision of hard and soft palate
123. Excision and destruction of the diseased hard and soft palate
124. Incision, excision and destruction in the mouth
125. Surgery to the floor of mouth
126. Palatoplasty
127. Transoral incision and drainage of pharyngeal abscess
128. Dilatation and curettage
129. Myomectomies
130. Simple Oophorectomies

Note: The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/ disease under treatment. Only 24 hours Hospitalisation is not mandatory.

In case of any claims contact
Claims Department
Future Generali Health (FGH)
Future Generali India Insurance Co. Ltd.
Office No. 3, 3rd Floor, "A" Building, G - O – Square
S. No. 249 & 250, Aundh Hinjewadi Link Road, Wakad, Pune - 411 057.
Toll Free Number: 1800 103 8889
Toll Free Fax: 1800 103 9998
Email: fgh@futuregenerali.in

ISO No.: FGH/UW/GRP/80/01
Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287. Regd. and Corp. Office: Indiabulls Finance Centre, Tower 3, 6th Floor, Senapati Bapat Marg, Elphinstone, Mumbai – 400013. Call us at: 1800-220-233 | Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in | Email: fgcare@futuregenerali.in. Trade Logo displayed above belongs to M/S Assicurazioni Generali - Societa Per Azioni and used by Future Generali India Insurance Co Ltd. under license.

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

GRIEVANCE REDRESSAL PROCEDURES

Dear Customer,

At **Future Generali** we are committed to provide **"Exceptional Customer-Experience"** that you remember and return to fondly. We encourage you to read Your policy & schedule carefully. We want to make sure the plan is working for you and welcome your feedback.

What Constitutes a Grievance?
A "Grievance/Complaint" is defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard service/ deficiency of service from Future Generali or its intermediary or asks for remedial action.

If you have a complaint or grievance you may reach us through the following avenues:

	**Help - Lines**	**1800-220-233/ 1860-500-3333 / 022-67837800**		**Email**	**Fgcare@futuregenerali.in**
				**Website**	**www.futuregenerali.in**
	**GRO at each Branch**	Walk-in to any of our branches and request to meet the **Grievance Redressal Officer (GRO).**			

What can I expect after logging a Grievance?
- We will acknowledge receipt of your concern within 3 - business days.
- Within 2 - weeks of receiving your grievance, we shall revert to you the final resolution.
- We shall regard the complaint as closed if We do not receive a reply within 8 weeks from the date of receipt of response

What do I do, if I am unhappy with the Resolution?
- You can write directly to our **Customer Service Cell at our Head office**:

	**Customer Service Cell**	**Customer Service Cell, Future Generali India Insurance Company Ltd.** Corporate & Registered Office:- 6th Floor, Tower 3, Indiabulls Finance Center, Senapati Bapat Marg, Elphinstone Road, Mumbai – 400013 Please send your complaint in writing. You can use the complaint form, annexed with your policy. Kindly quote your policy number in all communication with us. This will help us to deal with the matter faster.

How do I Escalate?
While we constantly endeavor to promptly register, acknowledge & resolve your grievance, if you feel that you are experiencing difficulty in registering your complaint, you may register your complaint through the **IRDAI** (**Insurance Regulatory and Development Authority of India**).
- **CALL CENTER: TOLL FREE NUMBER (155255). REGISTER YOUR COMPLAINT ONLINE AT: HTTP://WWW.IGMS.IRDA.GOV.IN/**

Insurance Ombudsman:

If you are still not satisfied with the resolution to the complaint as provided by our **GRO**, you may approach the Insurance Ombudsman for a review.

The Insurance Ombudsman is an organization that addresses grievances that are not settled to your satisfaction. You may reach the nearest insurance ombudsman office. The list of Insurance Ombudsmen offices is as mentioned below.

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Insurance Ombudsman Office of the Insurance Ombudsman 2nd Floor, Ambica House, Nr. C. U. Shah College, 5, Navyug Colony, Ashram Road, AHMEDABAD-380014 Tel: 079-27545441/ 27546139 Fax: 079-27546142 E-mail: bimalokpal.ahmedabad@gbic.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Mangal Bldg., 2nd Floor, Behind Canara Mutual Bldgs., No.4,	Karnataka

	Residency Road, Bengaluru–560 025 Tel.: 080 - 22222049 E-mail: bimalokpal.bengaluru@gbic.co.in	
BHOPAL	Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL-462023 Tel:0755-2569201/9202Fax:0755-2769203 E-mail:bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Insurance Ombudsman Office of the Insurance Ombudsman 62, Forest Park, BHUBANESHWAR - 751009 Tel: 0674-2596455/2596003 Fax: 0674-2596429 E-mail: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH	Insurance Ombudsman Office of the Insurance Ombudsman S.C.O.No. 101-103, 2nd Floor, Batra Building, Sector 17-D, CHANDIGARH-160 017 Tel: 0172-2706468/2705861 Fax: 0172-2708274 E-mail: bimalokpal.chandigarh@gbic.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Insurance Ombudsman Office of the Insurance Ombudsman Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600018 Tel:044-24333668 /5284 Fax: 044-24333664 E-mail: bimalokpal.chennai@gbic.co.in	Tamil Nadu, UT -Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
DELHI	Insurance Ombudsman Office of the Insurance Ombudsman 2/2 A, Universal Insurance Bldg. Asaf Ali Road, NEW DELHI - 110002 Tel: 011-23237539/23232481 Fax: 011-23230858 E-mail: bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Nivesh, 5th floor, Nr. Pan bazar Overbridge, S.S. Road, GUWAHATI-781 001 Tel:0361-2132204/5 Fax: 0361-2732937 E-mail: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Insurance Ombudsman Office of the Insurance Ombudsman 6-2-46,1st Floor, Moin Court Lane, Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD - 500004 Tel:040-65504123/23312122Fax:040-23376599E-mail:bimalokpal.hyderabad@gbic.co.in	Andhra Pradesh, Telangana and UT of Yanam - a part of UT of Pondicherry
JAIPUR	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Nidhi–II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur-302005 Tel : 0141-2740363 E-mail: bimalokpal.jaipur@gbic.co.in	Rajasthan
ERNAKULAM	Insurance Ombudsman Office of the Insurance Ombudsman 2nd Floor,CC27/2603, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682015 Tel: 0484-2358759/ 2359338 Fax: 0484-2359336 E-mail: bimalokpal.ernakulam@gbic.co.in	Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry
KOLKATA	Insurance Ombudsman Office of the Insurance Ombudsman 4th Floor, Hindusthan Bldg., Annexe, 4, C.R. Avenue, KOLKATA - 700072 Tel: 033-22124346 / (40) Fax: 033-22124341 E-mail :bimalokpal.kolkata@gbic.co.in	West Bengal, Sikkim and UT of Andaman & Nicobar Islands
LUCKNOW	Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Road, Hazratgaj, LUCKNOW-226001 Tel: 0522-2231331/30 Fax: 0522-2231310 E-mail: bimalokpal.lucknow@gbic.co.in	Districts of U.P:- 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	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Seva Annexe, 3rd Floor, S.V. Road, Santacruz (W), MUMBAI - 400054 Tel:022-26106928/ 26106552 Fax:022-26106052 E-mail:bimalokpal.mumbai@gbic.co.in	Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai &Thane
NOIDA	Office of the Insurance Ombudsman 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, NOIDA – 201301 Tel: 0120-2514250/51/53 E-mail: bimalokpal.noida@gbic.co.in	Uttaranchal and the following Districts of U.P:- Agra, Aligarh, Bagpet, Bareilly, Bijnor, Budaun, Bulandshehar, Etah , Kanooj, Mainpuri, Mathura ,Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozabad, 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 – 800006 Tel: 0612-2680952, E-mail: bimalokpal.patna@gbic.co.in	Bihar and 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 E-mail: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane but excluding Mumbai Metropolitan Region

The updated details of Insurance Ombudsman are available on IRDAI website: www.irdai.gov.in, on the website of General Insurance Council: www.generalinsurancecouncil.org.in, our website www.futuregenerali.in or from any of our offices.

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

FORM FOR
REQUEST / COMPLAINT / FEEDBACK / APPRECIATION

I want to submit a ☐ REQUEST ☐ COMPLAINT ☐ SUGGESTION/ FEEDBACK ☐ APPRECIATION

POLICY TYPE ☐ MOTOR ☐ HEALTH ☐ PERSONAL ACCIDENT ☐ OTHER _____

POLICY DETAILS ☐ POLICY NO ☐ CLAIM NO ☐ COVER NOTE ☐ HEALTH CARD

EXISTING SERVICE REQUEST

☐☐☐☐☐☐☐☐☐☐☐☐

CUSTOMER NAME _____ FIRST MIDDLE LAST

ADDRESS _____

_____

CITY _____ PIN CODE _____

TEL NO. _____ MOBILE NO. _____

Detailed description

_____

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D D M M Y Y Y Y

Customer's Date

You may submit the form to the Nearest Branch Office or mail it to our Customer Service Cell at:

Customer Service Cell
Future Generali India Insurance Company Ltd.
Corporate & Registered Office:- 6th Floor, Tower 3, India bulls Finance Centre, Senapati Bapat Marg, Elphinstone Road, Mumbai – 400013
Care Lines: 1800-220-233/ 1860-500-3333/ 022-6783 7800. Email: fgcare@futuregenerali.in, Website: www.futuregenerali.in

Office Use Only: Service / Case # ☐☐☐☐☐☐☐☐☐☐

Comments:

_____

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_____

Annexure I: OPTIONAL COVERS

1. EXTENSION FOR ROOM RENT

This is an optional cover which can be obtained by the insured under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, if the Insured Member is admitted in a Hospital Room where the Room Rent incurred is higher than the eligible limit, then the Insured Member shall bear the ratable proportion of the Medical Expenses (including surcharge or taxes thereon) as specified in the Policy Schedule in the proportion of the Room Rent actually incurred, subject to co-payment as applicable and mentioned in the policy schedule, provided that We have admitted a Claim under In patient benefit.

2. EXTENSION FOR MATERNITY AND CHILD COVER

This is an optional cover which can be obtained on payment of additional premium for all the Insured Persons under the Policy.

When Maternity Expenses Benefit is opted for in the policy, Exclusion IV.14 of the policy stands deleted. Option for Maternity Benefits has to be exercised at the inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during currency of the policy.

Special conditions applicable to Maternity Expenses Benefit Extension

This benefit covers treatment taken in Hospital/ Nursing Home arising from or traceable to pregnancy, child birth including Normal/ Caesarean section.

1. These Benefits are admissible only if the expenses are incurred in Hospital/ Nursing Home as in-patient in India.
2. A waiting period of 9 months is applicable for payment of any claim related to normal delivery, caesarean section and complications of maternity (including and not limited to medical complications). The waiting period stands waived if additional premium is paid for the same.
3. Claim in respect of delivery for only first two children and/ or operations associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit. In case the first delivery is a twin (more than 1 child) delivery, then the second delivery will not be covered.
4. Pre-natal and post natal expenses including expenses for the new born baby are not covered. Pre-natal and Post-natal treatment is covered within the maternity limits as inpatient only. Here Prenatal would mean complete antenatal period, and Post natal would mean up to six weeks after date of delivery.
5. No Individual (Employee or Dependent) can be covered more than once in a policy. If Self and Spouse are both covered under the GMC policy, maternity benefit will be available only once.
6. Corporate buffer is not applicable for maternity claims.

3. EXTENSION FOR VACCINATION COVER

This is an optional cover which can be obtained on payment of additional premium under the Policy, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will cover the Reasonable and Customary Charges for vaccination of the Insured. This benefit shall be limited to maximum amount as mentioned in schedule.

4. EXTENSION FOR WAIVER OF WAITING PERIODS

This is an optional cover which can be obtained on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, the waiting periods under the Policy will be waived.

a) **Waiver of Pre-Existing Diseases waiting period** (including 30 days and 1 year waiting period)

In consideration of additional premium received by the Company from the Policyholder, notwithstanding anything to the contrary contained in any term, condition or exclusion of the policy or endorsement(s) here to, the scope of cover under the policy is widened so as to pay claims arising out of a Pre-Existing Condition.

When Waiver of Pre-Existing periods is opted for in the policy, Exclusion IV.1) of the policy stands deleted

All other terms and conditions of the policy remain unchanged.

b) **Waiver of 1 year waiting period**

In consideration of additional premium received by the Company from the Policyholder, Exclusion IV.3) of the policy stands deleted

All other terms and conditions of the policy remain unchanged.

c) **Waiver of 30 days waiting period**

In consideration of additional premium received by the Company from the Policyholder, Exclusion IV.2) of the policy stands deleted

All other terms and conditions of the policy remain unchanged.

5. EXTENSION FOR EMERGENCY AMBULANCE

This is an optional cover which can be obtained on payment of additional premium under the Policy, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will reimburse up to a maximum amount as mentioned in the schedule per Hospitalization, for the reasonable expenses incurred by the Insured on availing ambulance services offered by a Hospital or by an ambulance service provider for Your necessary transportation to the nearest Hospital in case of a life threatening emergency condition, provided however that, a Claim under this extension shall be payable by Us only when:

1. Such life threatening emergency condition is certified by the Medical Practitioner, and
2. We have accepted Your Claim under "In-patient Treatment" or "Day Care Procedures" section of the Policy, if applicable.

6. EXTENSION FOR EMERGENCY AIR AMBULANCE

This is an optional cover which can be obtained on payment of additional premium under the Policy, it is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay the expenses incurred for ambulance transportation in an airplane or helicopter for rapid ambulance transportation as set out in the Schedule if the Insured Person suffers an Injury which causes emergency life threatening conditions during the Policy Year and it is necessary to immediately transfer such person from the site of Accident to the nearest Hospital/ Day Care Centre/ Nursing Home.

Specific Conditions

a. Expenses for air ambulance transportation are restricted within India.
b. Return transportation to the **Insured Person's** home by ambulance is excluded.
c. Insured needs to take an intimation before availing the benefit under Air Ambulance Cover.

7. EXTENSION FOR DEDUCTIBLE OR CO-PAYMENT

This is an optional cover which can be obtained by the Insured under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, that Our liability to pay each and every claim under any Benefit will be in excess of any Deductible applicable to that Benefit (if any) as specified in the Schedule.

Deductible will be charged for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once **subject to the terms and conditions of the Policy.**

Or,

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, that Our liability to pay each and every claim under any Benefit will be in excess of any Co-payment applicable to that Benefit (if any) as specified in the Schedule.

Co-payment will be charged for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once **subject to the terms and conditions of the Policy.**

8. EXTENSION FOR AYUSH COVER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will reimburse Reasonable and Customary Charges for Medical Expenses incurred with respect to the Insured Person for Hospitalization under Ayurveda, Unani, Siddha or Homeopathy provided that the Treatment has been undergone in

(i) A government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health for that Alternative Treatment
(ii) Teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
(iii) AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:
(a) has at least fifteen in-patient beds;
(b) has minimum five qualified and registered AYUSH doctors;
(c) has qualified paramedical staff under its employment round the clock;
(d) has dedicated AYUSH therapy sections;
(e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

Specific Exclusions applicable to this Benefit:
a) All preventive and rejuvenation treatments (non-curative in nature) including without limitation, treatments that are not Medically Necessary are excluded.
b) Pre-hospitalisation Medical Expenses, Post-hospitalisation Medical Expenses, Day Care Treatment and outpatient Medical Expenses are excluded.
c) Any Alternative Treatment other than Ayurveda, Unani, Siddha or Homeopathy are excluded.

9. EXTENSION FOR SUM INSURED GETS DOUBLED IN CASE OF NAMED ILLNESS

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay you the sum insured in case you are diagnosed with one or more of the named Illnesses as mentioned in the Policy Schedule.

10. EXTENSION FOR COVERAGE FOR NON-MEDICAL EXPENSES/ DEVICES

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will reimburse Insured for the charges incurred by Insured during the Policy Period on account of procuring medically necessary prosthetic or artificial devices, Prescribed Diabetes monitoring kits including Strips, Hearing Aids or any medical equipment including spectacles, contact lenses etc.

11. EXTENSION FOR ORGAN DONOR EXPENSES COVER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will indemnify the Insured for the medical expenses incurred in respect of donor for any of the organ transplant surgery during the Policy Period, provided the organ donated is for Insured's use and the claim is considered admissible by the Company. This benefit shall be limited to maximum amount as mentioned in schedule.

We shall not cover:
a) Pre-hospitalisation or Post-hospitalisation Medical Expenses or screening expenses of the donor or any other Medical Expenses as a result of the harvesting from the donor
(b) Costs directly or indirectly associated with the acquisition of the donor organ.
(c) Treatment for an Insured Person unless, these expenses for the Insured Person are covered under Hospitalisation.
(d) We do not cover organ donor treatment for the harvesting of the organ.

12. EXTENSION FOR HOSPITAL DAILY CASH ALLOWANCE

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay the Insured a fixed amount for each day of his hospitalization to compensate against the loss of wage/salary incurred by Insured on account of hospitalization.

We will pay daily cash amount, for each and every completed day of Hospitalization up to a maximum number of days subject to any deductible, as applicable and stated in the schedule, and it falls within the Policy Period. The Claim under this extension will be payable only if we have admitted Our liability under "In-patient Treatment" section of the Policy.

If an Insured Person is Hospitalised then We will pay the daily allowance specified in the Schedule of Insurance Certificate for each continuous and completed period of 24 hours of Hospitalisation provided that:
(a) The Insured Person is Hospitalised for a minimum period of atleast 2 days with continuous and completed period of at least 24 hours following which it will be payable from the first day of Hospitalisation;
(b) In any Policy Period, We shall not be liable to make payment of the Daily Allowance under this benefit for more than the number of days as specified in the Schedule of Insurance Certificate, including all days of admission to the Intensive Care Unit.

13. EXTENSION FOR ATTENDENTS/ AYAH/ NURSING CHARGES FOR POST HOSPITALISATION PERIOD

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay for the Reasonable and Customary Charges for a Qualified Nurse for the Insured Person for a period of up to maximum days as mentioned in the schedule subject to immediately following the Insured Person's discharge from Hospital provided that:

a) The Insured Person's Hospitalisation was due to Illness or Injury sustained during the Policy Period.
b) The treating Medical Practitioner has recommended that the nursing charges are Medically Necessary.
c) We will not be liable to make payment under this Benefit in excess of the per day limits specified in the Schedule of Benefits.
d) We will not be liable to make payment under this Benefit for any Insured Person in excess of number of days as specified in the policy schedule during a Policy Year.

14. EXTENSION FOR DENTAL COVER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will reimburse the medical expenses related to dental treatment incurred by the Insured during the Policy Period. This benefit shall be limited to maximum amount as mentioned in schedule.

15. EXTENSION FOR VISION COVER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will reimburse the medical expenses related to Vision incurred by the Insured during the Policy Period. This benefit shall be limited to maximum amount as mentioned in schedule.

16. EXTENSION FOR HEALTH CHECK-UP

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will cover the cost of health checkup incurred by the Insured for medical examination undergone being a requirement from employer. Such medical examination is generally conducted to understand health status of the employee. This benefit shall be limited to maximum amount as mentioned in schedule.

17. EXTENSION FOR OPD TREATMENT COVER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will reimburse medical expenses incurred by the Insured as an Outpatient. Outpatient means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient. However, any Insured person undergoing any named day care procedure/ treatment will not be considered as an Outpatient. This benefit shall be limited to maximum amount as mentioned in schedule.

When OPD treatment cover is opted for in the policy, Exclusion mentioned in Section, IV.25 related to outpatient treatment of the policy stands deleted.

18. EXTENSION FOR SPECIAL COVERS

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will indemnify the medical expenses incurred by the Insured Person for the special covers (as opted from the listed conditions/ diseases/ surgeries) as mentioned in the Policy Schedule. This benefit shall be limited to the maximum amount as mentioned in schedule.

19. EXTENSION FOR WELLNESS CARE

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. The additional premium will be as per the negotiated rates with the network providers for the specific wellness care program.

Under Wellness Care, any program intended to maintain, improve, promote health and fitness are included.

The health specific services offered would include outpatient consultations or treatments, pharmaceuticals, health talks or sessions, health check-ups provided by network providers at negotiated rates.

The Insured can avail the wellness care benefits as specified in the Policy Schedule.

20. EXTENSION FOR CORPORATE BUFFER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, that in case the Sum Insured is exhausted, then additional sum insured would be available to the Insured Persons as specified in the Policy Schedule as per the terms and conditions of the Policy. The individual or floater Sum Insured would be first exhausted followed by the corporate buffer amount which would be availed as per the floater/ individual Sum Insured.

21. EXTENSION FOR CRITICAL ILLNESS COVER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay the Insured Person the Sum Insured as a lump sum amount mentioned in the Policy Schedule, in case the Insured Person is diagnosed as suffering from the listed Critical Illness, provided it occurs or manifests itself during the policy period as a first incidence.

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

1. Cancer of specified severity

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

II. The following are excluded –

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

2. Kidney failure requiring regular dialysis

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

3. Primary (Idiopathic) pulmonary hypertension

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

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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

4. End Stage Liver failure

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded

5. Multiple sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded

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

II. The following are excluded:
i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

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

II. The following are excluded:
i. Angioplasty and/or any other intra-arterial procedures

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

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

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

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

10. Myocardial Infarction (First heart attack of specified severity)
I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

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

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

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

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

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

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

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

For other terms and conditions, please refer to the standard filed and approved Future Criticare product

22. EXTENSION FOR TOP-UP COVER

This is an optional cover which can be obtained by the Insured on payment of additional premium under the Policy. It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy that the additional Sum Insured will be available for the insured person, which can be utilized once the basic Sum Insured is exhausted. Top up policy will be offered only to those members who are covered under the base GMC policy. This benefit shall be limited to the maximum amount as mentioned in schedule.