WOMEN'S CANCER SHIELD

SECTION I: DEFINITIONS

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in this Policy and, where , the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same:

Appointee	means the person named by you and registered with us in accordance with the Nomination Schedule, who is authorized to receive the benefits under this Policy on the death of the Life Assured while the Nominee is a minor;
Assignee	means the person to whom the rights and benefits under this Policy are transferred by virtue of assignment under section 38 of the Insurance Act, 1938; as amended from time to time;
Assignment	means a provision wherein the Policyholder can assign or transfer a Policy in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time.
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.
Cancellation	means the terms on which the policy contract can be terminated either by the insurer or the insured while giving sufficient notice to the other which is not lower than a period of fifteen days. The terms of cancellation may differ from insurer to insurer
Condition Precedent	means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
Congenital Anomaly	means a condition 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.
Disclosure to information Norm	The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact
Free look period	means the period specified under Section VI clause 13 from the receipt of the Policy during which Policyholder can review the terms and conditions of this Policy and where if the Policyholder is not agreeable

	to any of the provisions stated in the Policy, he/ she has the option to return this Policy
Grace Period	means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity Benefits such as waiting periods and coverage of pre- existing diseases. Coverage is not available for the period for which no premium is received.
Health service provider	means any person or entity providing healthcare and medical services in individual capacity, or through aggregation under "Health Service Provider Agreement", and shall include but not be limited to any clinic, diagnostic centre, pharmacy, associated facility for diagnosis, treatment or wellness services, and health care providers empanelled with Us to provide services specified under the Benefits (including Extensions) to the Insured Person on cashless /reimbursement basis for OPD Treatment or otherwise. The list of the Health Service Providers is available at our website (https://www.icicilombard.com) and is subject to amendment from time to time.
Insured Person(s)	means the individual(s) covered under the Policy whose name(s) is/are specifically appearing as such in the Policy Schedule.
Nominee	means the person(s) nominated by The Insured person to receive the benefits under this Policy payable on The Insured person's death. For the purpose of avoidance of doubt it is clarified that if The Insured person are a minor, The Insured person's legal guardian shall appoint the Nominee
Notification of Claim	means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
Policy	means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.
Policy Holder	means the person(s) or the entity named in the Policy Schedule who executed the Policy Schedule and is responsible for payment of premium(s).
Policy Period	means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy as specified in the Policy Schedule.
Policy Schedule	means the Policy Schedule attached to and forming part of the Policy.

Policy Year	means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.
Portability	means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, if the Policy holder 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.
Pre-Existing Disease	means any condition, ailment, injury or disease: a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
Renewal	means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time bound exclusions and for all waiting periods.
Sum Insured	means the pre-defined limit specified in the Policy Schedule against a Benefit or set of Benefits that represents either the fixed amount of allowance payable by Us in case of a claim made, or Our maximum, total and cumulative liability for any and all claims made under that Benefit, in respect of that Insured Person during the Policy Period .
Unproven/Experimental treatment	means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
You/ Yourself	means the insured and/or Policyholder named in the Policy Schedule as applicable.
We/ Our/ Us	means the ICICI Lombard General Insurance Company Limited.

SECTION II: Benefits under the cover

The customer may opt for any one or more base benefits. Extensions may be opted only if a base benefit has been opted. The Policy Schedule will specify which of the following Basic Benefits and Extensions are applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Benefit applicable to the Insured Person shall be subject to the availability of the Sum Insured, applicable sub-limits for the Benefit claimed as specified in the Policy Schedule and the terms, conditions and exclusions of this Policy.

Basic benefits:

1. **Breast cancer cover**

If an Insured Person is First Diagnosed with Breast cancer during the Policy Period, then We will pay the Sum Insured specified in the Policy schedule against this Benefit as a lumpsum amount, in the manner specified in the Policy Schedule, provided that the signs or symptoms of such Cancer first commence after the completion of mandatory waiting period as specified in the policy schedule.

On the acceptance of a claim under this Benefit, the cover under this Benefit will terminate in relation to the Insured Person, and further no subsequent Renewals of the Policy will be allowed.

Breast cancer can be defined as a cancer that develops in the breast tissue. This cover will be eligible for both Minor stages of breast cancer and also Major stages of breast cancer.

Minor stages of breast cancer can be defined as carcinoma in situ of the breast

Carcinoma-in-situ of the breast shall mean a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma of the breast. The Diagnosis must be based on histopathological features and confirmed by a Pathologist. Pre-malignant lesions and conditions, are excluded.

Major cancer means invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The following are excluded: Breast cancer

i. Where the symptoms indicative of such cancer have first manifested or first occurred prior to the Risk Inception Date
ii. Where the symptoms indicative of such cancer have first manifested within the mandatory waiting period as specified in the policy schedule
iii. Arising on account of or in connection with any Pre-Existing Disease(s).
iv. Arising out of any Congenital Anomaly of the Insured Person.
v. Any cancer/ tumor in the presence of HIV infection
vi. Where any claim made without a medical certificate or records from the treating Medical Practitioner evidencing the diagnosis of such Cancer

Claim documents:

i. Claim form duly filled and signed
ii. Certificate by treating medical practitioner duly attested
iii. Current and past consultation papers
iv. All histology/cytology/FNAC/Biopsy/Immuno-chemistry reports, X-ray, CT Scan, MRI, PET Scan, Bone Marrow Test, Cancer Markers, all other pathological tests
v. Discharge summary and indoor case papers where applicable (in case of hospitalisation)
vi. Bills and receipts from hospitals, doctor consultations and diagnostic procedures, where applicable

2. **Cervical cancer cover**

If an Insured Person is First Diagnosed with Cervical cancer during the Policy Period, then We will pay the Sum Insured specified in the Policy schedule against this Benefit as a lumpsum amount, in the manner specified in the Policy schedule, provided that the signs or symptoms of such Cancer first commence after the completion of mandatory waiting period as specified in the policy schedule.

On the acceptance of a claim under this Benefit, the cover under this Benefit will terminate in relation to the Insured Person, and further no subsequent Renewals of the Policy will be allowed.

Cervical cancer can be defined as a malignant cancer that develops in the cervix. This cover will be eligible for both Pre-cancerous lesions of the cervix and Malignant cancer of the cervix

Pre-cancerous lesions of the cervix shall include cervical intraepithelial lesion (CIN) and Saquamous intraepithelial lesion. The Diagnosis must be based on histopathological features and confirmed by a Pathologist.

Major cancer means invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist.

The following are excluded: Cervical cancer

1. Where the symptoms indicative of such cancer have first manifested or first occurred prior to the Risk Inception Date
2. Where the symptoms indicative of such cancer have first manifested or first occurred within the mandatory waiting period as specified in the policy schedule
3. Arising on account of or in connection with any Pre-Existing Disease(s).
4. Arising out of any Congenital Anomaly of the Insured Person.
5. Any cancer/ tumor in the presence of HIV infection
6. Where any claim made without a medical certificate or records from the treating Medical Practitioner evidencing the diagnosis of such Cancer

Claim documents:

i. Claim form duly filled and signed
ii. Certificate by treating medical practitioner duly attested
iii. Current and past consultation papers
iv. All histology/cytology/FNAC/Biopsy/Immuno-chemistry reports, X-ray, CT Scan, MRI, PET Scan, Bone Marrow Test, Cancer Markers, all other pathological tests
v. Discharge summary and indoor case papers where applicable (in case of hospitalisation)
vi. Bills and receipts from hospitals, doctor consultations and diagnostic procedures, where applicable

3. Other women specific cancer cover:

a. Ovarian cancer cover
b. Fallopian cancer cover
c. Vaginal cancer cover
d. Cancer of vulva
e. Uterine/ endometrial cancer
f. Thyroid cancer

If an Insured Person is First Diagnosed with any of the aforementioned cancers during the policy Period, then We will pay the Sum Insured specified in the Policy schedule against this Benefit as a lumpsum amount, in the manner specified in the Policy schedule, provided that the signs or symptoms of such Cancer first commence after the completion of mandatory waiting period as specified in the policy schedule.

On the acceptance of a claim under this Benefit, the cover under this Benefit will terminate in relation to the Insured Person, and further no subsequent Renewals of the Policy will be allowed.

The following are excluded:

1. Where the symptoms indicative of such cancer have first manifested or first occurred prior to the Risk Inception Date
2. Where the symptoms indicative of such cancer have first manifested or first occurred within the mandatory waiting period as specified in the policy schedule
3. Arising on account of or in connection with any Pre-Existing Disease(s).
4. Arising out of any Congenital Anomaly of the Insured Person.
5. Any cancer/ tumor in the presence of HIV infection
6. Where any claim made without a medical certificate or records from the treating Medical Practitioner evidencing the diagnosis of such Cancer

Claim documents:

vii. Claim form duly filled and signed
viii. Certificate by treating medical practitioner duly attested
ix. Current and past consultation papers
x. All histology/cytology/FNAC/Biopsy/Immuno-chemistry reports, X-ray, CT Scan, MRI, PET Scan, Bone Marrow Test, Cancer Markers, all other pathological tests
xi. Discharge summary and indoor case papers where applicable (in case of hospitalisation)
xii. Bills and receipts from hospitals, doctor consultations and diagnostic procedures, where applicable

Extension cover:

This cover can be availed only as an add-on cover subject to payment of additional premium, if any one of the base covers are opted for under the policy.

1. Tele-Consultation:

We will arrange consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional up to the limit as specified in the policy schedule. For the purpose of this benefit Telephonic/Virtual consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile app. The services provided under this Benefit will be made available subject to the terms and conditions, and in the manner prescribed below:

i. The Medical Practitioner may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*.
ii. This service will be available 24 hours a day, and 365 days in a year.
iii. We/Medical Practitioner/Healthcare professional may refer the Insured Person to a specialist or a general physician, if required**, and the charges for such specialist or a general physician will have to be borne by the Insured Person.
iv. We shall not be liable for any discrepancy in the information provided under this Benefit.
v. Choosing the services under this Benefit is purely upon the customer's own discretion and at own risk.

**The insured should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured person has any concerns about His/ her health, He/ She may consult His/ her general practitioner. Kindly note that any charges incurred on consultations/medications/diagnostic tests/therapy shall not be paid under this benefit*
***Consultations charges would be applicable.*

2. Preventive screening and assessment:

We shall arrange for Preventive Examinations specified in the Policy schedule once during the Policy Period through our empaneled Health service providers. This service shall be provided on cashless basis only and subject to availability of empaneled Health services providers. For the purpose of this Benefit, 'Preventive Examinations' shall mean diagnostic tests including any consultations from relevant Medical Practitioners/Healthcare Professionals. Examples of some preventive screenings that may be included in your coverage are Mammograms, PAP smear, Ultrasounds, CA-125 cancer marker and clinical examination.

The insured should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances.

SECTION III: EXCLUSIONS (WHAT WE WILL NOT PAY)

We shall not be liable to make any payment under this Policy in connection with or in respect of any expenses whatsoever incurred by You in connection with or in respect of:

i. **Code- Excl11:** Excluded Providers

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders/proposers are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

iii. Any physical, medical or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions

iv. Any expenses arising out of Domiciliary Hospitalisation treatment

v. Treatment taken outside the country

vi. Any Illness or Injury caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel

SECTION IV: CLAIM PROCEDURE

- The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the procedures and requirements in relation to claims, shall be Conditions Precedent to Our liability under this Policy.
- We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full and on time in respect of the Insured Person's cover under the Policy and all payments have been realised.
- On occurrence of an any event that may give rise to a Claim under this Policy, You shall-
    - Notify Us immediately on toll free number 1800 2666 or on our website www.icicilombard.com or also in writing at Our address specified in the Policy schedule.

- Along with the completed and signed Claim form, provide all the relevant documents, specified within the relevant Section of the Policy for the Benefit being claimed, must be submitted in full within 30 days.
- Wherever details pertaining to happening of Claim are conveyed by you to Us after reasonable period, You shall provide the reasons of such delay to Us.

- If any Claim is not made within 30 days of the Insured Event, then We will condone such delay on merits only where the delay has been proved to be for reasons beyond the claimant's control.
- We shall make the payment of claim that has been admitted as payable by Us under the Policy within 30 days of receipt of the last necessary documents and information required for the settlement of the claim, and any rejections if done, would be provided with proper reasons by Us.
- If the circumstances of 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 documents. In such cases, We shall settle the claim within 45 days from such date of receipt of last necessary documents.
- All claims will be investigated (as required) and settled in accordance with the applicable regulatory guidelines, including the IRDAI (Protection of Policyholders Interests) Regulations, 2017.
- The admissible Claim amount will be calculated post applicability of Deductible, Co-pay, Sub-limits, if any, and as specifically defined in Policy schedule.
- The role of the TPA (if any) would be limited to facilitate the flow of information between Us and the Insured Person.

SUPPORTING CLAIM DOCUMENTATION

1. The Insured person shall be required to furnish/courier the necessary and requisite claim documents at his/ her own expense for or in support of a claim to the below mentioned address:

   ICICI Lombard Healthcare,
   ICICI Bank Towers,
   Plot No. 12, Financial district,
   Nanakramguda, Gachibowli,
   Hyderabad- 500032

2. You may also intimate a claim on our website and upload your documents digitally. We may seek original documents on case to case basis as per our discretion in which case you will be required to furnish/ courier the same at aforementioned address.

3. The following shall include necessary and requisite claims documentation to be provided to Us in the event of any claim under the Policy:

   - Duly completed Claim Form signed by the Insured Person. The Claim Form can be downloaded from our website www.icicilombard.com.
   - Copy of original policy
   - All reports and records, including but not limited to first diagnosis of cancer
   - Discharge summary, Indoor case papers/ Operation theatre notes, Original Investigation test reports with prescriptions and Medical Practitioner's referral letter
   - All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which Claim is being made.
   - All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection.

- Regulatory requirements as amended from time to time: NEFT details (to enable direct credit of Claim amount in bank account), KYC (recent ID/ Aadhaar card/Address proof and photograph), and PAN card
- Legal heir certificate (if applicable)
- Any other document as required by Us to investigate the claim or Our obligation to make payment for it.

SECTION V: GENERAL POLICY TERMS AND CONDITIONS

1. AGE LIMIT: The minimum and maximum age of entry into the Policy is 18 years and 65 years respectively.

2. PAYMENTS: We shall make payment of an admissible claim to the Insured person, Insured person's nominee/ assignee/partial assignee/conditional assignee, as the case may be. If there is no assignee or Nominee and the Insured Person is incapacitated or deceased, We will pay to the Insured Person's heir, executor or validly appointed legal representative. Any payment We make in this manner will be a complete and final discharge of Our obligations under this Policy and Our liability towards the claim.

3. TERMS OF RENEWAL:
   - The Policy may be renewed by mutual consent under the then prevailing Women's cancer shield product or its nearest substitute product (in case of product withdrawal) approved by the IRDAI, and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any Claim arising out of an Insured Event that occurs during the Grace Period.
   - The Policy provides for life-long Renewals
   - Notwithstanding anything to the contrary contained in the Policy, no subsequent Renewals will be allowed, in the event of any claim made and admitted by Us under the Policy
   - You shall on tendering any premium for the Renewal of this Policy give notice in writing to Us of any Illness, physical defect or infirmity with which any of the Insured Person(s) have become affected since the payment of the expiring Policy start date.
   - Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts. We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved in accordance with the IRDAI rules and regulations as applicable from time to time. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.
   - We shall not be bound to give any notice to You/Insured Person that the premium for the Renewal is due.
   - The above conditions for Renewal are to be read in unison, and not standalone.

4. PORTABILITY BENEFITS:

As per the applicable IRDAI regulations on Portability, Insured Persons, in a group insurance shall, on leaving the group as per group rules, have an option to migrate to another policy, with all benefits of Portability. Consequently, the Insured Person shall have the right to migrate from this group insurance to a similar individual health insurance policy, if available with Us.

Subject to Our underwriting, at the time of Renewal any Insured Person has the option to migrate to a similar health insurance policy available with Us, or any other non-life insurer with all the accrued continuity benefits such as waiver of Waiting Period served under this Policy, provided the Policy has been maintained without a break.

Portability benefits is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, Waiting Periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority of India (IRDAI).

In accordance with the applicable IRDAI regulations on Portability, Waiting Period credits would be extended to Pre-Existing Diseases and time bound exclusions/Waiting Periods.

5. OTHER RELATED TERMS AND CONDITIONS

- Please inform Us immediately of any change in the address, occupation, state of health, or of any other changes affecting the Insured Person (or his Nominee/ legal heir, as the case may be).
- Any change in the policy terms and conditions including but not limited to Sum Insured and/or coverage shall not be permitted within the Policy Period.
- In case You choose to pay the premium in instalments, then You shall not be able to change the frequency of payments within the Policy Period.
- In case You have opted for auto renewal, the Policy shall be Renewed with the same terms & conditions including but not limited to the Sum Insured, coverage, premium paying terms and claim payment terms.
- The scope of cover shall be within the geographical boundaries on India unless specified otherwise.

Section VI: STANDARD POLICY TERMS AND CONDITIONS

1. Incontestability and Duty of Disclosure: The Policy shall be null and void and no Benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis description or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or devices being used by the Insured Person or any one acting on his/her behalf to obtain any benefit under this Policy.

2. Observance of terms and conditions: The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured Person, shall be a condition precedent to Our liability to make any payment under this Policy.

3. Records to be maintained: The Insured Person shall keep an accurate record containing all relevant particulars and shall allow Us to inspect such record.

4. No constructive Notice: Any knowledge or information of any circumstances or condition in relation to the Insured Person, or in connection with which a claim may be made under this Policy coming to the knowledge or possession of any of Our officials shall not be construed as notice to or be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium

5. Notice of Charge: We shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by Us to the Insured Person, Nominee, assignee or his legal heirs of any amount under the Policy shall in all cases be an effectual discharge to Us.

6. Special Provisions: Any special provisions subject to which this Policy has been entered into and endorsed in the Policy, Policy schedule or in any separate instrument or Endorsement shall be deemed to be part of this Policy and shall have effect accordingly.

7. Overriding effect of the policy schedule: The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read as if they are

specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in the Policy Schedule, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in the Policy Schedule to this Policy, and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

8. Electronic transaction: The Insured Person agrees to adhere to and comply with all such terms and conditions as We may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, the world wide web, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on Our behalf, for and in respect of the Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time. The Insured Person agrees that We may exchange, share or part with any information with any government institution or statutory body, as may be determined by Us and shall not hold Us liable for such use/application.

9. Right to Inspect: In case of any loss or occurrence to the Insured Person that has given or may give rise to a claim under the Policy, If required by Us, Our agent/representative, including any loss assessor or surveyor/investigator or any individual or entity appointed on Our behalf shall be permitted at all reasonable times to examine the circumstances of such loss or occurrence. The Insured Person shall on being required to do so by Us, produce all books of accounts, receipts, documents relating to or containing entries relating to the loss or such circumstance in his/her possession and furnish copies of or extracts from such of them as may be required by Us so far as they relate to such claim(s), or may in any way assist Us to ascertain the correctness thereof or Our liability under the Policy.

10. Fraudulent claims: If any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person, or anyone acting on his/her behalf to obtain any Benefit under this Policy, or if a claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the arbitrator(s) have made their award, all Benefits under this Policy shall be forfeited.

11. Policy disputes: Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured Person and Us to be subject to Indian Law. Each party agrees to submit to the exclusive jurisdiction of the High Court of Mumbai and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

12. Arbitration clause: If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if We have disputed or not accepted liability under or in respect of this Policy. It is hereby expressly

stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

13. Free Look Period: The Insured person would be given a period of 15 days, or 30 days if the Policy is sold through distance marketing, from the date of receipt of the Policy to review its terms and conditions ("Free Look Period"). Where the Policyholder disagrees to any of the terms or conditions of the Policy, he has the option to return the Policy stating the reasons for his objection. If Insured Person has not made any Claim during free look period, Insured Person will be entitled to:
    i. A refund of premium paid less any expenses incurred by Us on medical examination of the Insured Person(s) and the stamp duty charges, or;
    ii. Where the risk has already commenced and the option of return of policy is exercised by the Insured person, a deduction towards the proportionate risk premium for period on cover or;
    iii. Where only a part of risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

14. Cancellation/ Termination
    a) Disclosure to information norm- The Policy shall be void and all premium paid hereon shall be forfeited to Us, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
    b) You/the Insured Person may also cancel this policy by giving 15 days notice in writing to Us, for the cancellation of this Policy, in which case We shall from the date of receipt of the notice cancel the Policy, retain the premium for the period this Policy has been in force, and refund at Our short period scales as per the Refund Grid provided below, provided that no refund of premium shall be made if any claim has been made under the Policy by or on behalf of the Insured Person.
    c) Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured Person where any Claim has been admitted by Us or has been lodged with Us or any Benefit has been availed by the Insured Person under the Policy.

Policy tenure/ Cancellation month	1 year	2 years	3 years	4 years	5 years
0-1 month	75%	80%	82.5%	82.5%	83%
2-3 months	62.5%	72.5%	77.5%	77.5%	80.0
4-6 months	40.0%	62.5%	70.0%	72.5%	75.0%
7-12 months	0.0%	42.5%	55.0%	62.5%	65.0%
13-18 months		20.0%	42.5%	52.5%	57.5%
19-24 months		0.0%	27.5%	42.5%	50.0%
25-30 months			12.5%	30.0%	42.5%
31-36 months			0.0%	20.0%	32..5%
37-42 months				10.0%	25.0%
43-48 months				0.0%	15.0%
49-54 months					7.5%
55-60 months					0.0%

There will no refund on cancelling the policy after the free look period for policies with premium amount up to Rs. 500/-

15. Multiple Policies

In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.

16. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address.

In Our case:
ICICI Lombard General Insurance Company Limited
ICICI Lombard House
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

17. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified, during normal business hours.

18. Grievances

In case You are aggrieved in any way, the Insured should do the following:

1. For resolution of any query or grievance, Insured(including senior citizens) may contact the respective branch office the Company or may call us at at toll free number: 1800 2666 or email us at customersupport@icicilombard.com or write to Us at
ICICI Lombard General Insurance Company Ltd.
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai- 400025.

2. If You are not satisfied with the resolution provided, you may approach us at the sub-section "Grievance Redressal" on our website www.icicilombard.com (Customer Support section).

3. In case Your complaint is not fully addressed by the insurer, You may use the Integrated Grievance Management System (IGMS) for escalating the complaint to IRDA. Through IGMS, You can register your complain online and track its status. For registration please visit IRDA website www.irda.gov.in.If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance through below mentioned link http://ecoi.co.in/ombudsman.html

CONTACT DETAILS	JURISDICTION

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**	State of Gujarat and Union Territories of Dadra & Nagar Haveli and 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, 1st 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:- **bimalokpalbhopal@ecoi.co.in**	States of Madhya Pradesh and 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**	State of 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**	States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.

CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668 / 24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@ecoi.co.in	State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 2323481/23213504 Email:- bimalokpal.delhi@ecoi.co.in	State of Delhi
ERNAKULAM Office of the Insurance Ombudsman, 2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulum - 682 015. Tel.:- 0484-2358759/2359338 Fax:- 0484-2359336 Email:- **bimalokpal.ernakulum@ecoi.co.in**	Kerala, Lakshadweep, Mahe-a part of Pondicherry
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**	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
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.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- **bimalokpal.hyderabad@ecoi.co.in**	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of the Union Territory of Pondicherry.
JAIPUR	State of Rajasthan.

Office of the Insurance Ombudsman, Jeevan Nidhi-II Bldg., Ground Floor, Bhawani Singh Marg, Jaipur - 302005. Tel.:- 0141-2740363 Email:- bimalokpal.jaipur@ecoi.co.in	
KOLKATA Office of the Insurance Ombudsman, Hindustan Building Annexe, 4th floor, 4, CR Avenue, Kolkata - 700 072. Tel.:- 033-22124339 / 22124340 Fax:- 033-22124341 Email:- **bimalokpal.kolkata@ecoi.co.in**	States of West Bengal, Bihar, Sikkim and Union Territories of Andaman and 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**	District of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, 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**	States of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Gautam Budh Nagar, Noida U.P-201301.	States 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, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj,

Tel.: 0120-2514250 / 2514252 / 2514253 Email:- **bimalokpal.noida@ecoi.co.in**	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	States of Bihar and Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Building, 3rd Floor, CTS Nos. 195 to 198, NC Kelkar Road, Narayan Peth, Pune - 411 030 Tel: 020 -41312555 Email:- bimalokpal.pune@ecoi.co.in	States of Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

ADDITIONAL FEATURES AVAILABLE UNDER THIS POLICY

Feature 1: Premium Installment Clause

a) We will accept payment of the premium applicable taxes, charges, cess etc. in monthly/quarterly/semiannual/annual installments as specified in the Policy schedule provided that the Policyholder continues to perform and observe all their obligations hereunder.
b) Notwithstanding the above Clause, upon non-payment of any premium installments for up to 7 days from the due date of such installment thereof, this Policy shall cease to operate from the time and date of the default in payment of such premium installment and We shall not be liable under this Policy for any loss occurring thereafter, nor shall any refund of premium become due under the Policy. We shall not be bound to give any notice that such Premium Installment is due.
c) However if the Policyholder makes the payment of the due installment before the payment of next installment due date or the Policy End Date as specified in the Policy schedule, whichever is earlier, and further provided that all the other installments payable under the Policy are realized by the Company by the respective due dates, the Company may at its sole option revive the Policy, subject to the balance Sum Insured(s) if any, of the respective Section(s)/Benefits(s) at the time of such revival.
d) Notwithstanding anything to the contrary contained above, in the event of a claim becoming payable under the Policy all the subsequent premium installments shall immediately become due and payable. We shall not be obligated to give any notice to the Policyholder for payment of premium installment, and may recover and deduct any or all the pending premium installments from the claim amount falling due under the Policy.

Feature 2: Assignment clause

It is hereby declared and agreed that upon due written consent granted by the Insured as stated under the Schedule to the Policy:

a. Any amount becoming payable to the Insured Person in accordance with policy terms and conditions) including all rights, title, benefits and interest of the Insured Person under this Policy stand assigned in favour of the Assignee specified in the Schedule of the Policy with respect to only that Loan Account Number, as specified in the Schedule.

b. The receipt of such amount in the manner aforesaid by the Assignee specified in the Schedule of this Policy, shall completely discharge Us from all Our liability under the Policy in respect of such payable amount, and this shall be binding on the Insured Persons and their legal heirs, executors, administrators, and successors.

c. This is to clarify that such assignment shall be subject to the condition that in the event of the Insured Person's death during the Policy Period, the amounts payable as per the Policy terms and conditions will be paid to the said Assignee only as the case may be, to the extent of the Loan amount outstanding, if any, and any amount in excess after such payment shall be paid to the Insured Person's Nominee/Appointee as the case may be.