GROUP SAFEGUARD INSURANCE

PART II OF THE POLICY SCHEDULE

I. PREAMBLE

ICICI Lombard General Insurance Company Limited ("the Company"), having received a Proposal and the premium from the Proposer named in the Schedule referred to herein, and the said Proposal and Declaration together with any statement, report or other document leading to the issue of this Policy and referred to therein having been accepted and agreed to by the Company and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Schedule with all its Parts, and further, subject to the terms and conditions contained in this Policy, as set out in the Schedule with all its Parts that on proof to the satisfaction of the Company of the compensation having become payable as set out in Part I of the Schedule to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy, the Sum Insured/ appropriate Benefit will be paid by the Company.

II. DEFINITIONS

Certain words are used in the policy and this Policy Schedule, which have a specific meaning and are shown below. They have this meaning wherever they appear in the Policy. Where the context so permits, references to the singular shall also include references to the plural and references to the male gender shall also include references to the female gender, and vice versa in both cases.

A. STANDARD DEFINITIONS

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital; or
   b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i. Having at least 5 in-patient beds;
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
3. **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.

4. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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

   Deductible shall be applicable per year, per life or per event as stated in the policy certificate and specific benefit based deductible shall be applied if specified in the policy certificate.

6. **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 t*o prevent death or serious long term impairment of the insured person's health
7. **Grace Period m**eans 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.
8. **Hospital** means any institution established for *in-patient care* and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulations) 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:
   a. Has qualified nursing staff under its employment round the clock;
   b. Has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
   c. Has qualified medical practitioner(s) in charge round the clock;
   d. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
   e. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
9. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive *'In-patient Care'* hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
10. **Illness** means a sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **Acute condition** - is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b. **Chronic condition** - A chronic condition is defined as a disease, illness, or Injury that has one or more of the following characteristics
       i. It needs ongoing or long-term monitoring through consultations, examinations, checkups, and / or tests
       ii. it needs ongoing or long-term control or relief of symptoms
       iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
       iv. it continues indefinitely
       v. It recurs or is likely to recur.

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11. **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.
12. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

13. **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.
14. **Medical Practitioner** is a person who holds a valid registration from 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 its scope and jurisdiction of license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude the Insured Person and his/her Family Members.
15. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:
    a. is required for the medical management of the illness or injury suffered by the insured
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a *medical practitioner*;
    d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
16. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer
17. **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 a Cashless Facility.
18. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
19. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
20. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    a. Such Medical Expenses are incurred for the same condition for which the insured person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
21. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
22. **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 or its reinstatement.

23. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / Injury involved .
24. **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.

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B. SPECIFIC DEFINITIONS

1. **Adventure Sport** means sports/activities including but not limited to Sky Diving, Bungee Jumping, Bungee swoop, Bungee slingshot, Dune sliding, Hot air ballooning, Bridge Swinging, Zip Lining, Zip Trekking, Rock Climbing, Bicycle Polo, Bamboo rafting, Rock Scrambling, Rappelling, Via Ferrata, Fell Running, Fell Walking, Gorge Walking, Indoor Rock Climbing, Mountain Biking, Mountaineering, Body Boarding, Sailing, Ski boarding, Scuba Diving, Snorkeling, Shark Diving, Sky Diving, Swimming with Dolphins, Banana boating/donuts/inflatable's behind power boat Diving with Whales, Wakeboarding, Surfing, Auto (car) racing, Motor rallying, Motorcycle racing, Air racing, Kart racing, Boat racing, Hovercraft racing, Lawn mower racing, Snowmobile racing, Zorbing, and Truck racing Bodies or organizations conducting any such adventure sports must be recognized and licensed by Government authorities.
2. **Age** means the completed years on last birthday as per the English calendar calculated on the day of inception of cover under the Policy.
3. **Air Ambulance** means a specially equipped aircraft, typically a helicopter, which is equipped with life saving medications, CPR equipments, cardiac monitoring unit and qualified EMS personnel, used to transport injured people to Hospital in an emergency.
4. **Ambulance Charges** means transportation costs incurred by the insured person towards availing ambulance services from the site of Accident to the nearest Hospital or from the site of first treatment to the nearest higher center of care in case of life threatening emergency conditions.
5. **Ambulance Services** means procedures that are used to provide immediate care and support to transfer the patient from the pick-up point/location to the nearest Hospital where necessary treatment/care can be initiated depending on the nature of Illness or disorder, presence, severity and cause of disease.
6. **ALS Ambulance** means an ambulance in which Advanced Life Support (ALS) is provided in situations where the patient being transported is in a more critical condition and a paramedic is required to assist in the treatment of the patient before and/or during transport to the emergency facility.
7. **Assault** means any unlawful use of force inflicted by an individual(s) upon an Insured Person that is a criminal offence in the jurisdiction in which it occurs and which results in Injury to the Insured Person.
8. **BLS Ambulance** means an ambulance in which Basic Life Support (BLS) is provided in an emergency by certified Emergency Medical Technicians (EMTs).
9. **Child** means dependent child/children including adopted and step child/children of the Insured Person up to the age of twenty five (25) years and dependent on the insured person for maintenance and financial support.
10. **Coma** means 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:
    a. no response to external stimuli continuously for at least 96 hours;
    b. life support measures are necessary to sustain life; and
    c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

    The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.
11. **Common Carrier** shall mean any commercial public airline, railway, bus transport, or water borne vessel (which shall include ocean going and / or coastal vessels and / or vessels engaged for official or personal purposes), taxi services or any other mode of transport operating under license issued by the appropriate authority for transportation of passengers and / or cargo and / or any other vehicle licensed to carry fare paying passengers.
12. **EMI or EMI Amount** means and includes the amount of monthly payment required to repay the principal amount of Loan and interest by the Insured Person as set forth in the amortization chart. For the purpose of claim settlement against any coverage under this Policy the amortization schedule prepared by the

financier as on the loan disbursal date or risk inception date (whichever is later) shall be considered wherever applicable.

13. **Family Member** means an Insured Person's legally wedded spouse, children, ward, step or adopted children, parents, stepparents , mother in law, father in law, children in law, legal guardian, siblings, and siblings in law
14. **Franchise** means a per Insured event provision in the policy whereby the insurer will not pay unless damage (or loss) exceeds the specified number of days/hours/months as defined in the Policy Certificate. Once a franchise is met, the Sum Insured subject to the Benefit is payable as per terms and conditions. Illustration: If the customer opts for a Franchise of two days and he is admitted in a hospital for one day the benefit shall not be triggered. However, if the customer is hospitalized for more than two days the customer shall be entitled for a benefit for all days of hospitalization (up to the sum insured).
15. **Healthcare Service Provider Agreement** means an agreement prescribing the terms and conditions of services which may be rendered to the holders of health insurance policies of Insurance company and may be entered into between:
    a. Service provider and an insurer; or
    b. Service provider, a TPA and the insurer
16. **Immediate Family Member** means spouse, children, step or adopted children, brother(s), sister(s) and parent(s) or stepparents of the Insured Person.
17. **Insured Event** means any event specifically mentioned in the Policy Certificate as covered under this Policy for which premium is received by the Company.
18. **Insured Person(s)** means the persons named as insured persons in the Policy Schedule who are insured for the applicable Benefits under this Policy.
19. **Loan** means the sum of money lent at an interest or otherwise to the Insured Person by any bank/financial institution as identified by the Loan Account Number specified in the Policy Certificate or certified in writing by the bank/financial institution.
20. **Nominee** means the person(s) nominated by the Insured Person to receive the Benefits payable under this Policy on death.
21. **Permanent Total Disablement** means any of the following:
    a. Total and irrevocable loss of sight in both eyes, or
    b. Total and irrevocable physical separation of two entire hands or two entire feet, or
    c. Total and irrevocable loss of one entire hand and one entire foot, or
    d. Total and irrevocable loss of sight of one eye and physical separation of one entire hand or physical separation of one entire foot, or Total and irrevocable loss of use of two hands or two feet, or
    e. Total and irrevocable loss of use of one hand and one foot, or
    f. Total and irrevocable loss of sight of one eye and loss of use of one hand or one foot.

    For the purpose of this definition:
    a. Physical separation of a hand or foot means separation of the hand at or above the wrist, and of the foot at or above the ankle.
    b. Loss of use or Loss of sight means total paralysis of one or more limb, or loss of vision respectively, which is certified in writing by a Medical Practitioner to be permanent, complete and irreversible and substantiated by physical examination and investigation to be permanent, complete and irreversible.
22. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or Benefits 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.
23. **Policy Period** means the period commencing from the Policy Start Date, Time and ending at the Policy End Date, Time of the Policy and as specifically appearing in the Policy Schedule during which the policy is valid and Insured Person is liable to get a claim subject to waiting periods and policy terms and conditions
24. **Period of Cover** means the period specified in the Policy Certificate during which the Insured Person is covered under the Policy.

25. **Policy Schedule** means the Policy Schedule attached to and forming part of the Policy.
26. **Professional Sports** means a sport which would remunerate a player in excess of 50% of his or her annual income as a means of their livelihood.
27. **Proposal and Declaration Form** means any initial or subsequent declaration made by the policyholder and is deemed to be attached and which forms a part of this Policy.
    a. While filling the proposal form, you are expected to provide all information pertaining to your health and to the cover you would be opting/buying in this policy
    b. Any non-declaration of information which insurance Company should have known for underwriting this policy can lead to cancellation of policy and Company will have a right to forfeit the premium.
28. **Service Provider** means any person, organization, institution, company providing services in individual capacity or through aggregation that has been empanelled with the Insurance Company to provide services specified under the benefits (including add-ons) to the Insured Person on cashless or reimbursement basis. These shall also include providers empanelled to form a part of network other than hospitals
29. **Specific Vector-Borne Disease** means Dengue, Chickungunya, Kala azar, Japanese encephalitis and Filariasis.
30. **Sum Insured** means the amount specified in the Policy Certificate against a Benefit **or set of Benefits** that represents Our maximum, total and cumulative liability for any and all claims made in respect of that Insured Person during the Period of Cover under that Benefit/set of Benefits.
31. **You / Your** means person or the entity named as the policyholder in the Policy Schedule and who is responsible for payment of premium.
32. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Certificate which shall be served before a claim related to such condition becomes admissible.
33. **We/ Our / Us** means the ICICI Lombard General Insurance Company Limited.

II. BENEFITS COVERED UNDER THE POLICY

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit in full (first installment in case the customer has opted for Periodic Premium Payment option) in respect of the Insured Persons and the terms, conditions and exclusions of this Policy.

The customer may opt for any one or more base benefits under one or more sections. Extensions may be opted only if a base benefit under the respective section has been opted. The Policy Certificate 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 Certificate and the terms, conditions and exclusions of this Policy.

All claims shall be made in accordance with the procedures set out in this Policy. Admitted claims will be payable to the Insured Person or the Nominee (as applicable).

SECTION A – ACCIDENTAL INJURY BENEFITS

Our maximum, total and cumulative liability for claims arising in respect of the Insured Person during the Period of Cover under Benefits A.1.1, A.1.2, and A.1.3 shall be the Sum Insured as specified against this set of Benefits in the Policy Certificate.

Section A.1 – Death and Disability Related Benefits

A.1.1 Basic Benefit: Death Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident.

On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person.

A.1.2 Basic Benefit: Permanent Total Disablement (PTD) Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Benefit A.1.1, if in force for the Insured Person.
ii. If the Insured Person suffers Injuries resulting in more than one of the Permanent Total Disablements, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.

iii. If We have admitted a claim for Permanent Total Disablement in accordance with this Benefit, then We shall not be liable to make any payment under the Policy under Benefit A.1.1 on the death of the Insured Person, if the Insured Person subsequently dies. However, any other applicable Benefits which may get triggered will be considered in accordance with the terms and conditions of the applicable Benefits.

iv. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit and Benefit B.2 in respect of the Insured Person shall immediately and automatically cease.

v. On the acceptance of a claim under this Benefit, insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.3 Basic Benefit: Permanent Partial Disablement (PPD) Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) in the manner which is specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person (which is of the nature specified in the table below) within 365 days from the date of the Accident.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irrecoverable loss of use or the actual loss by physical separation of the body parts as specified in the table below:

SR No.	LOSSES COVERED	% OF SUM INSURED payable
1	Loss of one entire hand	70
2	Loss of one entire foot	70
3	Loss of use of one eye	50
4	Loss of all toes	20
5	Loss of great toe - both phalanges	5
6	Loss of great toe - one phalanx	2
7	Other than great toe if more than one toe lost each	5
8	Loss of use of both ears	75
9	Loss of use of one ear	30
10	Loss of four fingers and thumb of one hand	40
11	Loss of four fingers	35
12	Loss of thumb - both phalanges	25
13	Loss of thumb - one phalanx	10
14	Loss of index finger - three phalanges	10
15	Loss of index finger - two phalanges	8
16	Loss of index finger - one phalanx	4
17	Loss of middle finger - three phalanges	6
18	Loss of middle finger - two phalanges	4
19	Loss of middle finger - one phalanx	2

20	Loss of ring finger - three phalanges	5
21	Loss of ring finger - two phalanges	4
22	Loss of ring finger - one phalanx	2
23	Loss of little finger - three phalanges	4
24	Loss of little finger - two phalanges	3
25	Loss of little finger - one phalanx	2
26	Loss of metacarpus - first or second (additional)	3
27	Loss of metacarpus - third, fourth or fifth (additional)	2

This Benefit shall be payable subject to the following:

i. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Benefit A.1.1.
ii. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.
iii. On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Benefit and the Policy shall continue, subject to the availability of the Sum Insured and the terms, conditions and exclusions of this Policy.

A.1.4 Basic Benefit: Temporary Total Disablement (TTD) Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the incapacitation of the Insured Person which prevents the Insured Person from engaging in any employment or occupation on a temporary basis, then We will pay the weekly amount specified against this Benefit in the Policy Certificate for the duration that the Temporary Total Disablement continues.

This Benefit shall be payable subject to the following:

i. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the total number of weeks specified in the Policy Certificate for any and all claims arising within the Period of Cover under this Benefit.
ii. If the Injury is sustained to or suffered in relation to the spine and its muscular girdle, ligamentous system, cartilage, nervous system and blood supply to the spine which is not detectable by means of radiological scanning, imaging, or neurological fallout testing, then Our liability under this Benefit shall extend for a maximum period of five (5) weeks.
iii. In the event of any dispute as to the date when the Temporary Total Disablement ceased, such date shall be finally determined by an external Medical Practitioner approved by Us who certifies either:
    a) the date upon which the Insured Person recovered; or
    b) the date upon which the Insured Person recovered as far as he/she will ever recover.
iv. If the Insured Person is disabled for a part of a week, then only a proportionate part of the weekly amount will be payable in respect of that week.

A.1.5 Basic Benefit: Common Carrier Accident Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if an Insured Person suffers an Injury due to an Accident to the Common Carrier on which the Insured Person is travelling during the Period of Cover and that Injury solely and directly results in the Insured Person's death or Permanent Total Disablement. We will only accept one claim under this Benefit in the lifetime of the Insured Person.

On the acceptance of a death claim under this Benefit, all cover under this Policy in respect of the Insured Person shall immediately and automatically cease.

On the acceptance of a Permanent Total Disablement claim under this Benefit, all cover under this Benefit and Benefit B.2 in respect of the Insured Person shall immediately and automatically cease.

However, insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.6 Basic Benefit: Adventure Sports Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if an Insured Person suffers an Injury due to an Accident while engaging in Adventure Sports during the Period of Cover and that Injury solely and directly results in the Insured's Person's death or Permanent Total Disablement within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. The Insured Person was engaging in the Adventure Sport under the supervision of a trained professional.
ii. If the Insured Person received or was eligible to receive any kind of remuneration for performing the Adventure Sport, no amount shall be payable under this Benefit. However, we would cover running marathon events provided that the distance of such event does not exceed 42 kilometres
iii. Section A Exclusion (9) shall not apply to the extent of the cover under this Benefit.
iv. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.7 Basic Benefit: Children's Education Grant Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate in respect of the surviving Dependent Children of the Insured Person, irrespective of whether the child is an Insured Person under this Policy. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any

other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

If the Insured Person's Dependent Children also die in the same Accident or due to any event occurring after the death of the Insured Person and before the claim amount payable under this Benefit can be paid in full, the amount payable shall be paid to the Dependent Child's legal heirs in the manner specified in the Policy Certificate.

For the purpose of this Benefit, Dependent Child means a child of the Insured Person who is less than 25 years of Age on the date of Accident and is financially dependent on the Insured Person.

This Benefit shall be payable subject to the following:

i. Our maximum, total and cumulative liability under this Benefit is the Sum Insured specified against this Benefit, irrespective of the number of surviving Dependent Children of the Insured Person.

A.1.8 Basic Benefit: EMI Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Temporary Total Disablement (as defined in Benefit A.1.4) or the Permanent Partial Disablement (which is only of the nature specified in the table below) of the Insured Person, then We will pay the EMI Amount for the number of EMIs specified in the Policy Certificate, from the first EMI Amount falling due after the onset of the Injury in accordance with the loan re-payment schedule issued by the financier on disbursement of the Loan.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irrecoverable loss of use or the actual loss by physical separation of the body parts as specified in the table below:

Permanent Partial Disablement: **LOSSES COVERED**
One entire hand
One entire foot
Loss of Use of one eye
Loss of Use of both ears
Loss of four fingers and thumb of one hand

This Benefit shall be payable subject to the following:

i. We shall not be liable make any payment under this Benefit after the earlier of the Insured Person regaining employment/occupation or the maximum number of EMI Amounts specified in the Policy Certificate being completed.
ii. If a claim is made under this Benefit in respect of the Temporary Total Disablement of the Insured Person, then We will consider the claim under this Benefit only if the Insured Persons continues

to remain in a state of Temporary Total Disablement for a minimum period of 30 consecutive days

iii. The Insured Person must be a salaried employee in order to avail this Benefit on the on-set of Temporary Total Disablement. For the Insured Person to avail this Benefit on the on-set of Permanent Partial Disablement, the Insured Person may be either a salaried employee or self-employed.

iv. Any payments that are overdue and unpaid by the Insured Person prior to the occurrence of the Accident will not be considered for the purpose of this Benefit and shall be deemed as paid by the Insured Person.

v. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.9 Basic Benefit: Loan Protection Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the death or the Permanent Total Disablement of the Insured Person, then We will pay an amount equal to the principal outstanding amount as on the date of Accident in respect of the Insured Person's outstanding Loan specified in the Policy Certificate.

This Benefit shall be payable subject to the following:

i. We will make payment under this Benefit in accordance with the amortization schedule (as on Loan disbursement or the actual amount outstanding on the date of the Accident, which ever is less).

ii. If the Sum Insured under this Benefit is less than the Insured Person's outstanding Loan amount on the date of the Accident, then Our liability under this Benefit shall be reduced proportionately and shall in any event not exceed the Sum Insured.

iii. Any payments that are overdue and unpaid by the Insured Person prior to the occurrence of the Accident will not be considered for the purpose of this Benefit and shall be deemed as paid by the Insured Person.

iv. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.10 Extension: Mobility Benefit

We will pay a lump sum amount which is equal to the claim amount that would be payable under Benefit A.1.2 or A.1.3 (if a claim is accepted under that Benefit) to the Insured Person towards modification of home, office and / or vehicle or towards purchase of an Artificial Limb or any prosthesis or any other expenses because of Permanent Total Disablement or Permanent Partial Disablement (which is only of the nature specified in the table below) covering the disabilities mentioned in the table below suffered by the Insured Person. However, Our liability for payment of all claims under this Benefit in aggregate for Period of Cover shall in no case exceed the Sum Insured for this Benefit as specified in the Policy Certificate.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irrecoverable loss of use or the actual loss by physical separation of the body parts as specified in the table below:

Permanent Partial Disablement: LOSSES COVERED
One entire hand
One entire foot
Loss of Use of one eye
Loss of Use of both ears
Loss of four fingers and thumb of one hand

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit A.1.2 or A.1.3 in respect of that Insured Person.
ii. We will only accept only one claim under this Benefit in the lifetimeof the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.11 Basic Benefit: Orphan Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death, We will pay the Sum Insured in the manner specified in the Policy Certificate in respect of the surviving Dependent Children of the Insured Person, irrespective of whether the child is an Insured Person under this Policy.

For the purpose of this Benefit, Dependent Child means a child of the Insured Person who is less than Age 25 on the date of the Accident and does not have any independent source of income.

This Benefit shall be payable subject to the following:

i. The Dependent Child's other parent also dies as a result of the same Accident or has pre-deceased the Insured Person.
ii. Our maximum, total and cumulative liability under this Benefit is the Sum Insured, irrespective of the number of surviving Dependent Children of the Insured Person.
iii. If the claim payment under this Benefit is being made as per Periodic Claim Payment Clause as specified in the Policy Certificate and the Dependent Child dies before the entire payment has been under this Benefit, then the remaining instalments shall be paid in one lump sum to the Dependent Child's legal heirs.
iv. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the

acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease.

A.1.12 Extension: Repatriation of Mortal Remains Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death, We will pay the Sum Insured specified against this Benefit in the Policy Certificate for transporting the mortal remains (including ash) of the Insured Person from the place of death to the residence of the Insured Person.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit A.1.1 in respect of that Insured Person.
ii. The death of the Insured Person occurred in a location that is not the city/place of residence of the Insured Person.

A.1.13 Extension: Counseling Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of the expenses incurred on professional counselling in respect of the Insured Person or the Nominee/legal heir (as the case may be) provided that We have accepted a claim under Benefit A.1.1 or A.1.2.

We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.14 Basic Benefit: Parental Care Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate in respect of the surviving parents of the Insured Person, irrespective of whether the parent(s) is an Insured Person under this Policy.

This Benefit shall be payable subject to the following:

i. Our maximum, total and cumulative liability under this Benefit is the Sum Insured, irrespective of whether one or both parents of the Insured Person are alive.
ii. If the claim payment under this Benefit is being made as per Periodical Claim Payment Clause as specified in the Policy Certificate and the surviving parents die before the entire payment has been under this Benefit, then the remaining instalments shall be paid in one lump sum to the parent's legal heirs.

iii. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.1.15 Extension: Repatriation in case of Permanent Disability Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Permanent Total Disablement of the Insured Person, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of transporting the Insured Person from the place of Accident or Hospitalization to the residence of the Insured Person.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit A.1.2 in respect of that Insured Person.
ii. The Accident occurred in a location that is not the city/place of residence of the Insured Person.
iii. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

SECTION A.2 – Hospitalization Expenses Related Benefits

A.2.1 Basic Benefit: Accidental Hospitalization Expenses Reimbursement Benefit

We will reimburse the Medical Expenses incurred in respect of the Insured Person for treatment of Injury sustained by the Insured Person in an Accident which occurs within the Period of Cover and solely and directly requires the Insured Person to be Hospitalized.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person is admitted to the Hospital within 7 days of the occurrence of the Accident.
i. We will reimburse only those Medical Expenses that are Reasonable and Customary Charges.
ii. We shall not be liable to make any payment in respect of any non-payable items, the list of which is attached to this Policy and is available on Our website www.icicilombard.com
iii. We shall not be liable to pay any 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 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.
iv. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable
v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person

will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

A.2.2 Extension: Accidental Pre & Post Hospitalization Expenses Benefit

We will reimburse the Pre-hospitalization Medical Expenses incurred for up-to 7 days immediately preceding the Hospitalization of the Insured Person and the Post-hospitalization Medical Expenses incurred for up-to 60 days immediately following the Insured Person's discharge from Hospital.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit A.2.1 in respect of the Insured Person.
ii. We will reimburse only those Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses that are Reasonable and Customary Charges.
iii. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

A.2.3 Basic Benefit: Accidental Hospitalization Daily Cash Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. The Insured Person is admitted to the Hospital within 7 days of the occurrence of the Accident.

iii. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

iv. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured and the maximum number of days as mentioned against this Benefit in the Policy Certificate.

v. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

A.2.4 Extension: Air Ambulance Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of Air Ambulance services for transportation of the Insured Person from the site of the Accident to the nearest Hospital or from the site of first treatment to a higher center of care where the Insured Person is being treated to the nearest Hospital.

This Benefit shall be payable subject to the following:

i. The transportation is required to stabilise the condition of the Insured Person and the Insured Person is alive while boarding the Air Ambulance.

ii. The Air Ambulance services are availed within 7 days from the date of the Accident.

We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.2.5 Extension: Comatose Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person being in a Coma within 30 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. We will only accept one claim under this Benefit during in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.2.6 Extension: Broken Bones Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) in the manner which is specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely, directly and immediately results in a fracture (of the nature specified in the table below).

Sr No.	Region	Fracture	% of the Sum Insured payable
1	Skull	Compound fractures of skull with damage to the brain tissue	100%
		All other fractures	75%

2	Lower jaw	Multiple fractures (at least one compound fracture)	75%
		Compound fracture	50%
		All other fractures	25%
3	Shoulder blade, kneecap, sternum, hand (excluding fingers and wrist), foot (excluding toes and heel)	Multiple fractures (at least one compound fracture)	75%
		Compound fracture	50%
		All other fractures	25%
4	Upper arm (including elbow and wrist)	Multiple fractures (at least one compound fracture)	75%
		Colles type fracture (compound)	50%
		All other fractures	25%
5	Spinal cord	All compression fractures	30%
		All spinous, transverse process or pedicle fractures	25%
		All other vertebral fractures	20%
6	Rib or ribs, cheekbone, coccyx, upper jaw, nose, toe and toes, finger or fingers	Multiple fractures (at least one compound)	50%
		Compound fracture	25%
		All other fractures	20%
7	Thigh or heel:	Multiple fractures (at least one compound)	50%
		Compound fracture	25%
		All other fractures	20%
8	Hip or pelvis (excluding thigh or coccyx):	Multiple fractures (at least one compound)	50%
		Compound fracture	25%
		All other fractures	20%
9	Lower leg, clavicle, ankle,	Multiple fractures (at least one compound)	50%
		Compound fracture	25%
		All other fractures	20%

This Benefit shall be payable subject to the following:

i. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

ii. On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this

Benefit and the Policy shall continue, subject to the availability of the Sum Insured and the terms, conditions and exclusions of this Policy.

iii. We will be liable to pay a claim under this Benefit only if the Insured Person is taken to a medical care facility where he/she is diagnosed for the above mentioned fractures by a Medical Practitioner.

A.2.7 Extension: Compassionate Visit Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of the expenses incurred on tickets on a Common Carrier for an Immediate Family Member of the Insured Person to travel to the place of death or Hospitalization of the Insured Person

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit A.1.1, Benefit A.1.2 or Benefit A.2.6 (where the percentage of the Sum Insured payable is at least 50%) in respect of the Insured Person.
ii. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.
iii. The Medical Practitioner treating the Insured person recommends in writing the personal attendance of an Immediate Family Member.
iv. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.2.8 Extension: Burns Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) which is specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in a Second Degree Burns or Third Degree Burns (of the nature specified in the table below).

	Losses Covered	**% of the Sum Insured payable**
1)Head, Face and Neck	a) Third degree burns	100%
	b) Second degree burns of 10% or more of the total head surface area	75%
	c) Second degree burns of 3% or more, but less than 10% of the total head surface area	25%
2) Rest of Body	a) Third degree burns of 25% or more of the total body surface area	100%
	b) Second degree burns of 25% or more of the total body surface area	75%
	c) Second degree burns of 10% or more, but less than 25% of the total body surface area	50%

	d) Second degree burns of 5% or more, but less than 10% of the total body surface area	25%

For the purpose of this Benefit: **Burn** means an injury caused by exposure to heat or flame including chemical and electric burns. Second Degree Burns - Involves the epidermis and part of the dermis layer of skin and are also known as partial burns

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

First degree burns are not covered under this Policy.

This Benefit shall be payable subject to the following:

i. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

ii. On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Benefit and the Policy shall continue, subject to the availability of the Sum Insured and the terms, conditions and exclusions of this Policy.

A.2.9 Extension: Ambulance Charges Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of road Ambulance Services for transportation of the Insured Person from the site of the Accident to the nearest Hospital or from the site of first treatment to a higher center of care.

This Benefit shall be payable subject to the following:

i. The transportation is recommended in writing by a Medical Practitioner.

ii. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

SECTION A.3 – Other Benefits

A.3.1 Extension: Assault Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if the Insured Person suffers an Injury due to an Accident which is a violent crime or Assault that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized.

We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

A.3.2 Extension: Mysterious Disappearance Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if the Insured Person has disappeared for more than 365 days from the date of the Accident of the Common Carrier on which the Insured Person was travelling during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Insured Person's disappearance is certified in writing by the police authorities.
ii. We shall not be liable to make any payment under this Benefit if the Common Carrier on which the Insured Person was travelling was a private taxi, yacht, charter airline or a rented car.
iii. On the acceptance of a claim under this Benefit, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person.
iv. If after payment of claim under this Benefit, the Insured Person is found to be alive, We reserve the right to recover in full from the Nominee/legal heir of the Insured Person the amount paid under this Benefit as well as stop any future payments due in respect of this Benefit.

SPECIFIC EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION A

We shall not be liable to make any payment for any claim under Section A of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

2. Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution.

3. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world.

4. Breach of law or while being involved in any unlawful activity.

5. Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.

6. Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind.

7. Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel

8. Any Accidental Injury / Illness directly or indirectly caused by venereal disease

9. Injury sustained whilst engaging in Adventure Sports (Unless specifically covered and mentioned in the policy certificate).

10. Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought.

11. Expenses incurred on eyeglasses, contact lenses, hearing aids and examination for the prescription or fitting thereof.

12. Any Illness, complication or ailment not arising out of or connected to Injury.

13. Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, or illness of the Insured Person resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by, childbirth or pregnancy or in consequence thereof.

14. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, or Illness arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

15. Circumcision or strictures, vaccination, inoculation, sex change, beauty treatment of any description, intentional self Injury, , , (which expression shall cover also general debility, "run down" conditions), venereal disease, , use of intoxicating drugs, or any Illness, Injury, death or disablement directly or indirectly due to any one or more of them.

16. Dental treatment, eye treatment and plastic surgery unless medically necessitated as a consequence of an Injury sustained in an Accident during the Period of Cover.

17. Any Hospitalization not arising out of an Injury sustained in an Accident during the Period of Cover.

18. Routine medical, dental, eye and ear examinations.

19. All cosmetic/aesthetic surgeries including but not limited to lasik surgery.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION A.2

We shall not be liable to make any payment for any claim under Section A.2 of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

I. STANDARD EXCLUSIONS

1. **Breach of Law (Code – Excl 10) -** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

2. **Hazardous or Adventure Sport (Code – Excl 09)** - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving. (Unless specifically covered and mentioned in the policy certificate)

3. .

4. **Cosmetic or plastic surgery (Code – Excl 08) -** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

5. **Refractive Error (Code – Excl 15)** - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

6. **Investigation & Evaluation (Code – Excl 04) -**

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

7. **Rest Cure, rehabilitation and respite care (Code – Excl 05)** - Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

8. **Change of Gender Treatments (Code – Excl 07) -** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof**. (Code – Excl 12)**

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code – Excl 13)**

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code – Excl 14)**

12. **Unproven Treatments (Code – Excl 16)** - 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.

13. **Excluded providers (Code – Excl 11) -** 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 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. SPECIFIC EXCLUSIONS

1. War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

2. Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution.

3. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world.

4. Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.

5. Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind.

7. Any Accidental Injury / Illness directly or indirectly caused by venereal disease

6. Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought.

7. Expenses incurred on eyeglasses, contact lenses, hearing aids and examination for the prescription or fitting thereof.

8. Any Illness, complication or ailment not arising out of or connected to Injury.

9. Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, or illness of the Insured Person resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by, childbirth or pregnancy or in consequence thereof.

10. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, or Illness arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

11. Circumcision or strictures, vaccination, inoculation, intentional self Injury (which expression shall cover also general debility, "run down" conditions), venereal disease, or any Illness, Injury, death or disablement directly or indirectly due to any one or more of them.

12. Dental treatment, eye treatment and unless medically necessitated as a consequence of an Injury sustained in an Accident during the Period of Cover.

13. Any Hospitalization not arising out of an Injury sustained in an Accident during the Period of Cover.

14. Routine medical, dental, eye and ear examinations.

CLAIMS DOCUMENTS FOR SECTION A

On the occurrence of an Insured Event or discovery of any Injury which may give rise to a claim under Section A of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of the occurrence of the Insured Event:

Documents Required for Section A.1

S. No.	Benefit Name	Claim Form	MLC or FIR	Cause of Death Certificate and death certificate by municipal	Post Mortem Report	Viscera / Chemical Analysis / Forensic Report	Police Final Charge Sheet / Court Final Order	Spot / Inquest Panchnama	Disability Certificate issued by civil or government hospital	Indoor case papers	Medical Certificate	Fitness Certificate	Leave Certificate from the employer
A.1.1	**Death Benefit**	□	□	□	□	□	□	□	□	□			
A.1.2	**Permanent Total Disablement (PPD) Benefit**	□	□				□	□	□	□	□		
A.1.3	**Permanent Partial Disablement (PPD) Benefit**	□	□				□	□	□	□	□		
A.1.4	**Temporary Total Disablement (TTD) Benefit**	□	□								□	□	□
A.1.5	**Common Carrier Accident Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of injury) & Proof of Travel (Ticket or boarding pass)											
A.1.6	**Adventure Sports Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of injury) & proof of participation in adventure sports such as tickets.											
A.1.7	**Children's Education Grant Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of injury) & Bonafide Certificate from the educational institute certifying the enrolment of the insured's child in his/her educational course Proof of relationship of children with insured such as passport,/Aadhar card with full DOB /election card / PAN card Age proof of children such as passport,/Aadhar card with full DOB /election card / PAN card											

A.1.8	**EMI Benefit**	Documentation requirement mentioned against Benefit A.1.3 or Benefit A.1.4 (As per the nature of injury) & Loan Sanction Letter & Loan Disbursement Letter (including the repayment schedule) & Statement of Account as on date of loss
A.1.9	**Loan protection Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of injury) & Loan Sanction Letter & Loan Disbursement Letter , Original amortization schedule on disbursal letter, statement of account as on date of loss
A.1.10	**Mobility Benefit**	Documentation requirement mentioned against Benefit A.1.2 .
A.1.11	**Orphan Benefit**	As per documentation requirement mentioned against Benefit A.1.1 + Death Certificate of the Insured's spouse Proof of relationship of children with insured such as passport,/Aadhar card with full DOB /election card / PAN card Age proof of children such as passport,/Aadhar card with full DOB /election card / PAN card
A.1.12	**Repatriation of Mortal Remains Benefit**	Documentation requirement mentioned against Benefit A.1.1 & All original bills associated with the repatriation expenses
A.1.13	**Counselling Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of injury)& Proof of counselling sessions along with councillors prescription or certificate
A.1.14	**Parental care Benefit**	Documentation requirement mentioned against Benefit A.1.1 or Benefit A.1.2 (As per the nature of injury)& proof of relation such as passport, birth certificate school/college leaving certificate of insured
A.1.15	**Repatriation in case of Permanent Disability Benefit**	Documentation requirement mentioned against Benefit A.1.2 **& All original bills associated with the repatriation expenses**

	CLAIMS DOCUMENTS FOR SECTION A.2										
S.No.	**Benefit Name**	**Claim Form**	**Indoor Case Papers**	**MLC/ FIR**	**All Diagnostic Reports**	**Complete hospital bills**	**Discharge Summary**	**All receipts & bills related to pre and post hospitalization**	**All receipts related to availment of any Ambulance services**	**Certificate from Medical Practitioner**	**All receipts related to availment of any Travel Service through a licensed common carrier**

A.2.1	**Accidental Hospitalization Expenses Benefit**	□	□	□	□	□	□				
A.2.2	**Accidental Pre & Post Hospitalization Expenses Benefit**	□	□	□	□		□	□		□	
A.2.3	**Accidental Hospitalization Daily Cash Benefit**	□	□	□	□	□	□			□	
A.2.4	**Air Ambulance Benefit**	□	□	□			□		□	□	
A.2.5	**Comatose Benefit**	□	□	□	□	□	□			□	
A.2.6	**Broken Bones Benefit**	□	□	□	□	□	□			□	
A.2.7	**Compassionate Visit Benefit**	□		□							□
A.2.8	**Burns Benefit**	□	□	□	□	□	□			□	
A.2.9	**Ambulance Charges Benefit**	□					□		□	□	

	CLAIMS DOCUMENTS FOR SECTION A.3		

S.NO.	Benefit Name	Claim Form	MLC or FIR	Spot or Inquest Panchnama	Police Final Charge sheet	Hospital discharge summary	Indoor case papers
A.3.1	**Assault Benefit**	□	□	□	□	□	□
A.3.2	**Mysterious Disappearance Benefit**	□ Along with the corresponding proof of travel	Police certificate confirming disappearance		□		

SECTION B – ANIMAL, INSECT & REPTILE ATTACK BENEFIT

Our maximum, total and cumulative liability for claims arising in respect of the Insured Person during the Period of Cover under Benefits B.1 and B.2 shall be limited the Sum Insured as specified against this set of Benefits in the Policy Certificate.

B.1 Basic Benefit: Death due to Animal, Insect & Reptile Attack Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if the Insured Person suffers an Injury due to an Accident caused by bite, attack and/or sting of an animal, reptile or insect through direct violent skin contact that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident.

We will pay the Sum Insured if the Insured Person suffers an Injury due to an Accident caused by bite or attack of an animal through direct violent skin contact that occurs during the Period of Cover and that Injury results in the Insured Person contracting rabies which solely and directly results in the Insured Person's death within 365 days from the date of the Accident. On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all cover under this Policy in respect of the Insured Person shall immediately and automatically cease.

B.2 Basic Benefit: Permanent Total Disablement (PTD) due to Animal, Insect & Reptile Attack Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if the Insured Person suffers an Injury due to an Accident caused by bite, attack and/or sting of an animal, reptile or insect through direct violent skin contact that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's Permanent Total Disablement within 120 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. If the Insured Person suffers Injuries resulting in more than one Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.
ii. If We have admitted a claim for Permanent Total Disablement in accordance with this Benefit, then We shall not be liable to make any payment under the Policy on the death of the Insured Person, if the Insured Person subsequently dies.
iii. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit and under Benefit A.2 in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

B.3 Extension: Hospitalization Expenses due to Animal, Insect & Reptile Attack Reimbursement Benefit

We will reimburse the Medical Expenses incurred if the Insured Person suffers an Injury due to an Accident caused by bite, attack and/or sting of an animal, reptile or insect through direct skin contact that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's Hospitalization within 7 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. We will reimburse only those Medical Expenses that are Reasonable and Customary Charges.
iii. We shall not be liable to make any payment in respect of any non-payable items, the list of which is attached to this Policy and is available on Our website www.icicilombard.com].

iv. 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 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.

v. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.
vi. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.
vii. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We will pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated.

SPECIFIC EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION B

We shall not be liable to make any payment for any claim under Section B of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. Any Injury sustained while working professionally with any animals reptiles or insects.

2. Any Injury or Illness of any kind caused or infected by or transmitted by or in any way attributed to virus, parasite, bacteria or any microorganism including where the virus, parasite, bacteria or any other microorganism is introduced and/ or caused by bites of insects, reptiles, animals and/or other vector.

3. War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, police, military, naval or air service, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

4. Breach of law or being involved in any unlawful activity

5. Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.

6. Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind.

7. Any Injury that has occurred prior to the commencement of Period of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought. Any Illness, complication or ailment arising out of or connected to such Injury.

8. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

9. Any Injury or Illness occurring whilst engaging in any Adventure Sports.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION B.3

We shall not be liable to make any payment for any claim under Section B.3 of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

I. STANDARD EXCLUSIONS

1. Maternity (Code – Excl 18) –

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

2. **Change of gender treatments (Code – Excl 07) -** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

3. **Cosmetic/Plastic surgery (Code – Excl 08) -** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

4. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof **(Code – Excl 12)**

5. **Hazardous or Adventure Sport (Code – Excl 09) -** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

6. **Rest Cure, rehabilitation and respite care (Code – Excl 05) -** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7. **Breach of Law (Code – Excl 10)-** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

8. **Excluded providers (Code – Excl 11) -** 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 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.

9. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code – Excl 13)**

10. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code – Excl 14)**

11. **Unproven Treatments (Code – Excl 16)** - 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.

II. SPECIFIC EXCLUSIONS

1. Circumcision or strictures, vaccination, inoculation, intentional self-Injury (which expression shall cover also general debility, "run down" conditions), venereal disease or any diseases, Injury, death or disablement directly or indirectly due to any one or more of them.

2. Dental treatment, eye treatment unless necessitated as a consequence of an Injury.

3. Any Hospitalization not arising out of an Injury.

4. Any Medical Expenses not incurred in a Hospital.

CLAIMS DOCUMENTS FOR SECTION B

On the occurrence of an Insured Event or discovery of any Injury which may give rise to a claim under Section B of the Policy, We shall be provided with the following necessary and mandatory information and documentation, specified in relation to the Benefit being claimed within 30 days of the occurrence of the Insured Event:

S. No.	Benefit Name	MLC or FIR	Cause of Death Certificate	Post Mortem Report	Vicera / Chemical Analysis / Forensic	Police Final Charge Sheet / Court Final Order	Spot / Inquest Panchnama	Disability Certificate	Indoor case papers	Medical Certificate	Discharge Summary	Complete hospital bills

B.1	**Death due to Animal , Insect and Reptile Attack Benefit**	□	□	□	□	□	□		□	□	□	
B.2	**PTD due to Animal, Insect and Reptile Attack Benefit**	□				□	□	□	□	□		
B.3	**Hospitalization Expenses due to Animal,Insect & Reptile Attack Benefit**	□				□	□		□	□	□	□

SECTION C: SPECIFIC VECTOR BORNE DISEASE OR MALARIA BENEFIT

SECTION C.1: Specific vector borne disease Benefit

Benefit C.1.1: Basic Benefit: Specific Vector Borne Disease related Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with a Specific Vector Borne Disease that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of the Specific Vector Borne Disease and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in the Hospital should continue for a minimum period of 48 successive hours.
iii. We shall not be liable to make any payment under this Benefit, if the Insured Person is first Hospitalized prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if the Insured Person is Hospitalized due to Specific Vector Borne Disease within a period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.
vii. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

CLAIMS DOCUMENTS FOR SECTION C.1

On the occurrence of an Insured Event or diagnosis of any Specific Vector Borne Disease which may give rise to a claim under Section C.1 of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified mandatorily, in relation to the Benefit being claimed within 30 days of the Insured Event:

	CLAIMS DOCUMENTS FOR SECTION C.1						
S.No.	**Benefit**	**Documents common for all specific vector borne disease**	**Specific reports signed and attested by registered pathologist which confirm following diagnosis and laboratory findings positively**				
			Dengue	**Chickunguniya**	**Kala-Azar**	**Japanese encephalitis**	**Filariasis**

C1.1	**Specific vector borne disease related Hospitalization Benefit**	Duly filled claim form	NS1 antigen test or Ig M- Elisa test	Presence of IgM and IgG anti chikungunya antibodies.	Direct Agglutination Test or Rapid dipstick test or ELISA for detecting IgG	Ig M antibody detection in serum or cerebrospinal fluid	Antigen detection in blood sample or IgG4 antibody detection using routine assays
		Out-patient consultation paper			Anemia, Leucopenia, thrombocytopenia and Hypergammaglobulinemia		
		Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis					
		Indoor case papers of treating hospital					

SECTION C.2: Malaria Benefit

Benefit C.2.1: Basic Benefit: Malaria related Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Malaria that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Malaria and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 48 successive hours
iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Malaria is prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Malaria is within a period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.
vii. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

CLAIMS DOCUMENTS FOR SECTION C.2

On the occurrence of an Insured Event or diagnosis of Malaria which may give rise to a claim under Section C.2 of the Policy, We shall be provided with the following necessary and mandatory information and documentation, specified in relation to the Benefit being claimed within 30 days of the Insured Event.

	CLAIMS DOCUMENTS FOR SECTION C2.1

C2.1	**Malaria related Hospitalization Benefit**	Claim form	Diagnosis must be confirmed positive/reactive by microscopy or malaria rapid diagnostic test (RDT) signed and attested by registered pathologist	Treating doctor certificate(duly filled and attested) confirming diagnosis as Malaria	Outpatient consultation paper (wherever applicable)	Hospital discharge summary	In door case papers of the hospital

SECTION D – Basic Benefit: Maternal Complication Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) which is specified in the table below if an Insured Person suffers one or more of the medical complications (of the nature listed below) during maternity during the Period of Cover:

Sr. No.	Maternal Complication	% of Sum Insured payable
1	Eclampsia	100%
2	Abruptio Placenta	100%
3	Placenta Increta	100%
4	Placenta Percreta	100%
5	Amniotic Fluid Embolism	100%
6	Acute Fatty Liver of Pregnancy	100%
7	Disseminated Intravascular Coagulation	100%
8	Still Birth	50%
9	Pre Eclampsia	25%
10	Hyperemesis Gravidarum requiring stay in Hospital as an in patient for at least 48 successive hours	5%
11	Ectopic Pregnancy	25%
12	Any other maternal complication subject to applicable exclusions specified under this section requiring stay in Hospital as an in patient for at least 48 successive hours	25%

For the purpose of this Policy the maternal complications listed above shall have the following meanings:

1. **Eclampsia** means a life threatening pregnancy complication that causes a pregnant woman, usually previously diagnosed with preeclampsia (high blood pressure and protein in the urine), to develop seizures or coma.
2. **Abruptio Placenta** means premature separation of the placenta from the wall of the uterus
3. **Placenta Increta** means a condition in which part or all of the placenta remains firmly attached and invades the muscles of the uterus
4. **Placenta Percreta** means a condition in which part or all of the placenta remains firmly attached and grow through the uterine wall
5. **Amniotic Fluid Embolism** means an obstetric complication in which amniotic fluid, enters the blood stream of the mother to trigger a cardio respiratory arrest and/or massive bleeding

6. **Acute Fatty Liver of Pregnancy** means potentially fatal complication of the liver that occurs in the third trimester or early postpartum period caused by a disordered metabolism of fatty acids by mitochondria in the mother
7. **Disseminated Intravascular Coagulation** means the pathological process characterized by the widespread activation of the clotting cascade that results in the formation of blood clots in the small blood vessels throughout the body.
8. **Still Birth** means baby born with no signs of life at or after 28 weeks' gestation
9. **Pre Eclampsia** means a pregnancy complication characterized by high blood pressure and signs of damage to another organ system, most often the liver and kidneys associated with protienuria and which usually begins after 20 weeks of pregnancy in women whose blood pressure had been normal prior to the initiation of the pregnancy
10. **Hyperemesis gravidarum** is a pregnancy complication that is characterized by severe nausea, vomiting, weight loss, and possibly dehydration.
11. **Ectopic Pregnancy** means a condition where a fertilized egg implants itself outside of the uterus

This Benefit shall be payable subject to the following:

i. If the Insured Person dies undiagnosed before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but We may consider a claim under any other applicable Benefits under the Policy.
ii. We shall not be liable to make any payment under this Benefit, if the maternal complication occurs or is first diagnosed prior to the commencement of the Period of Cover or within a period of 30 days from the commencement of the Period of Cover or after the completion of 30 days following the delivery. This exclusion of first 30 days from the period of commencement of cover shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
iii. If the Insured Person suffers more than one of the maternal complications specified in above, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.
iv. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION D:

We shall not be liable to make any payment for any claim under Section D of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

I. STANDARD EXCLUSIONS

1. **30 day waiting period (Code – Excl 03)** - Any Hospitalization falling within the Waiting Period
   a. Expenses related to the treatment of any illness within the waiting period shall be excluded except claims arising due to an accident, provided the same are covered.

   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

   c. The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

2. **Sterility and Infertility (Code – Excl 17)** - Expenses related to sterility and infertility. This includes:
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy
    d. Reversal of sterilization.
3. Any maternal complication arising out of a **Pre-existing Disease (Code – Excl 01)** -

    a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.

    b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

    c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage

    d. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

4. **Unproven Treatment (Code – Excl 16)** - 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.

5. **Investigation & Evaluation (Code – Excl 04)** -
    a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
    b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
6. **Hazardous or Adventure Sport (Code – Excl 09) -** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. **Breach of Law (Code – Excl 10) -** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded providers (Code – Excl 11)** - 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 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

9. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code – Excl 13)**

10. **Rest Cure, rehabilitation and respite care (Code – Excl 05) -** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
    b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

II. SPECIFIC EXCLUSIONS

1. Medical Termination of Pregnancy
2. Any claim arising on account of or in connection with any Neonatal Illness/condition
3. Any complication that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought.
4. Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.

CLAIMS DOCUMENTS FOR SECTION D

On the occurrence of an Insured Event which may give rise to a claim under Section D of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of the occurrence of the Insured Event:

- Duly filled claim form
- All medical and diagnostic reports including first USG report indicating the date of conception
- Certificate from attending obstetrician clearly indicating the final diagnosis
- Indoor case papers of treating Hospital
- Hospital Discharge summary duly signed and attested by treating Medical Practitioner confirming the diagnosis
- Cause of death certificate filled and duly attested by Hospital
- Any other document required by Us to assess the claim

SECTION E – HOSPITAL DAILY CASH - ILLNESS

E.1 Basic Benefit: Hospital Daily Cash Benefit

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each period of Hospitalization within the Period of Cover.
iii. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.
iv. We shall not be liable to make any payment under this Benefit, if Hospitalization commenced prior

to the commencement of the Period of Cover or within the waiting period specified in the Policy Certificate.

v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

E.2 Extension: Intensive Care Unit (ICU) Cash Benefit

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized in an Intensive Care Unit, then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of confinement in the Intensive Care Unit.

This Benefit shall be payable subject to the following:

i. The Hospitalization in the Intensive Care Unit is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each period of Hospitalization within the Period of Cover.

iii. Our liability to make any payment under this Benefit shall be in excess of the Deductible stated in the Policy Certificate. However, the Deductible shall not apply to the extent of days in respect of which the Insured Person has already been admitted in the Hospital in a non- ICU room.

iv. We shall not be liable to make any payment under this Benefit, if Hospitalization commenced prior to the commencement of the Period of Cover or within the waiting period specified in the Policy Certificate.

v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

E.3 Basic Benefit: Emergency Medical Services Benefit

1. **Emergency Ambulance Service Benefit**

   If the Insured Person suffers and Illness or sustains an Injury during the Period of Cover which requires the Insured Person to be transported to Hospital in an emergency for Medically Necessary Treatment to be rendered, We will pay for the Ambulance Charges incurred on a Cashless Facility basis only

   This Benefit shall be payable subject to the following:

   i. The Ambulance Charges incurred are Reasonable and Customary Charges.

   ii. The transportation is certified in writing to have been necessary by a Medical Practitioner.

iii. The medical condition of the Insured Person requires immediate Ambulance Services from the place where the Insured Person is Injured or is ill to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital with advanced facilities as advised by the treating Medical Practitioner for management of the current Illness or Injury for which the service is called upon.

iv. The Ambulance Service will be offered by Our Service Providers on a Cashless Facility basis provided that the request has been made by the Insured Person or his Family Members on the dedicated helpline 18001028136 (Toll free) and 01244498770 (Charges applicable helpline number). This number if changed will be updated on Our website.

v. We will provide this Benefit only for a one way transfer from the place of Injury or Ilness to the nearest Hospital where necessary treatment facility is available or from one Hospital to another Hospital having advanced facilities.

vi. We will provide this Benefit only for road Ambulance Services availed within the same city.

vii. We will not make any payment under this Benefit if the Insured Person is transferred to any Hospital for evaluation purposes only or for any non-emergency services or if there is no active line of treatment.

viii. Ambulance coordination for emergency cases will be provided through the helpline of Our Service Provider on best effort basis from the communicated location by providing a valid identification for validation of coverage. A Medical Practitioner can accompany the BLS Ambulance or ALS Ambulance, as and when required and as per availability.

ix. The ambulance coordination is available 24*7, 365 days a year and within the jurisdiction of major cities as listed. The list of cities where this facility will be provided shall be available on the Our website.

x. We shall not be liable to pay for any reimbursement for use of an Ambulance Service by the Insured Person.

2. Tele consultation Benefit :

We will make available consultation with Medical Practitioners in case of need through Our service provider helpline for assessing the case situation or routine health issues over the phone. Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis. The prescription / suggestion if given by the Medical Practitioner will be based on the information provided by the Insured Person and interpreted by the Medical Practitioner and We have no responsibility and owe no liability for any discrepancy in the information given.

Features under this Benefit include:

- 24*7, 365 days a year availability
- Consultations by Medical Practitioners
- Over the counter (OTC) medicines may be prescribed/ suggested on case to case basis

- The Insured can reach the Medical Practitioner by calling on the dedicated helpline number: +91 124 4498757. Any change in this helpline number shall be updated on Our website www.icicilombard.com

3. Health Assistance Benefit

Health assistance will be provided through Our dedicated helpline. The health assistance team is dedicated to assist the Insured Person in:

i. Identifying specialist/ Hospital
ii. Fixing an appointment with Medical Practitioners/nutritionist wherever applicable on best effort basis
iii. Facilitation in getting a second opinion and fixing appointments with a Medical Practitioner, wherever applicable. Any service availed by the Insured Person would be on a paid basis and to payment will be made by the Insured Person directly to the Medical Practitioner
iv. Providing options on suitable Network Providers.
v. Providing information on ailments and possible lines of treatment

The facilitation for assistance would be free for the Insured Person. However, the Medical Practitioner's fees or any other diagnostic services availed by the Insured Person would borne by the Insured Person and to be paid directly to service providers i.e. Medical Practitioner, nutritionist or Hospital. Call Helpline no. 040 – 6627 4205 (9:30 am to 6 pm Mon to Fri, excluding public holidays) or write to healthassistance@icicilombard.com to avail this facility. Any change in this helpline number shall be updated on Our website www.icicilombard.com

Any information provided through assistance cannot be used as a substitute for physical examination by a Medical Practitioner.

General Conditions Applicable to Section E.3

Choosing any service is purely on customer's discretion and at their own risk.

The prescription/suggestion will be based on the information provided and We hold no responsibility/ owe no liability for any discrepancy in the information given. The Insured Person should seek assistance from a health care professional when interpreting these materials and applying them to his/her individual circumstances. If the Insured Person has any concerns about his/her health, he/she should consult his/her general practitioner.

By seeking and availing services under this Section the Insured Person is not prohibited or advised against visiting or consulting with any other independent Medical Practitioner or commencing or continuing any treatment advised by such Medical Practitioner.

The Insured Person is free to choose whether or not to obtain services under this Section, and, if obtained, then whether or not to act on the advice received in whole or in part.

The services obtained under this Benefit shall be shall me provided on best effort basis and be limited to defined criteria and shall not be valid for any medico legal purposes.

Annexure A: List of cities where Ambulance Service will be available

Mumbai/Navi Mumbai & Thane, Pune, Delhi/NCR, Chandigarh, Indore , Ahmedabad, Vadodara, Goa, Jaipur, Kochi, Lucknow, Vijaywada, Mysore, Bhopal, Bangalore, Chennai, Hyderabad, Kolkata, Vishakhapatnam, Bhubaneswar, Meerut, Guwahati, Nasik, Aurangabad, Guntur & Coimbatore.

The above mentioned list is for locations where this service is currently active. However, this is subject to change and the updated list shall be available on Our website www.icicilombard.com.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION E

We shall not be liable to make any payment for any claim under Section E of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

I. STANDARD EXCLUSIONS

1. Any Hospitalization falling within the Waiting Period as specified in the Policy Certificate subject to maximum 30 days waiting period. **30 day waiting period (Code – Excl 03) -**

   a. Expenses related to the treatment of any illness within the 30 days / waiting period as mentioned in the policy certificate, shall be excluded except claims arising due to an accident, provided the same are covered.
   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   c. The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

2. **Pre-existing Diseases (Code – Excl 01)** - (Unless specifically covered and mentioned in the policy certificate)
   a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.
   b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage
   d. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3. **Unproven Treatment (Code – Excl 16)** - 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.

4. **Maternity (Code – Excl 18) -** (Unless specifically covered and mentioned in the policy certificate)
   a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period;

5. Sterility and Infertility (Code – Excl 17) - Expenses related to sterility and infertility.
   This includes:
   a. Any type of contraception, sterilization
   b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
   c. Gestational Surrogacy
   d. Reversal of sterilization.

6. **Cosmetic or Plastic Surgery (Code – Excl 08)** - Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

7. **Refractive Error (Code – Excl 15)** - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

8. Investigation & Evaluation (Code – Excl 04) -

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

9. Obesity / Weight Control (Code – Excl 06) -: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

   a. Surgery to be conducted is upon the advice of the Doctor
   b. The surgery/Procedure conducted should be supported by clinical protocols
   c. The member has to be 18 years of age or older and
   d. Body Mass Index (BMI);
      i. greater than or equal to 40 or
      ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
         1. Obesity-related cardiomyopathy
         2. Coronary heart disease
         3. Severe Sleep Apnea
         4. Uncontrolled Type2 Diabetes

9.

10. **Change of Gender Treatments (Code – Excl 07)** - Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

11. **Hazardous or Adventure Sports (Code – Excl 09)** - Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

12. **Breach of Law (Code – Excl 10)** - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

13. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code – Excl 12)**

14. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code – Excl 13)**

15. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code – Excl 14)**

16. **Excluded providers (Code – Excl 11) -** 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 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.

17. Rest Cure, rehabilitation and respite care (Code – Excl 05) -
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

18. **Specific disease/procedure Waiting Period (Code – Excl 02) - (Unless specifically covered and mentioned in the policy certificate)**:

a. Expenses related to the treatment of the below listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of such specific diseases/procedures

i. Deviated Nasal Septum, CSOM-Chronic Suppurative Otitis Media
ii. Stapedectomy, Mastoidectomy, any treatment for conditions related to tonsils, adenoids, sinuses, turbinates/ concha
iii. Fibroids (fibromyoma), Endometriosis, Uterine Prolapse, Polycysyic Ovarian Syndrome(PCOS)
iv. Dilatation and curettage (D&C), Myomectomy, Hysterectomy

v. Arthritis, Gout and Rheumatism
vi. Stones in gall bladder & Biliary System; Cholecystitis, Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles, Esophageal Varices & Gastric Varices, Gastritis, Duodenitis & Pancreatitis
vii. Gastric & Duodenal ulcers, Gastro Esophageal Reflux Disorder (GERD)/Acid Peptic Disease, Ulcerative colitis, Crohn's disease, Irritable Bowel Syndrome, Inflammatory Bowel disease
viii. All forms of cirrhosis, Rectal prolapse, Perineal Abscesses, Perianal Abscesses
ix. Cholecystectomy, Endoscopy
x. Stones in Urinary system, all prostate diseases, chronic renal failure or end stage renal failure or chronic kidney disease, dialysis
xi. Dysfunctional uterine bleeding, pelvic inflammatory diseases, stress incontinence, Hydrocele, varicocele/ rectocele/ spermatocele
xii. Cataract, Glaucoma, Diseases of the vitreous and retina
xiii. Unless malignant, All Internal/ External tumors, cysts, nodules, polyps, sinus, fistula, adenoma, lumps including teratoma, breast lumps, dermoid cyst, ovarian cyst, desmoid tumour, umblical granuloma, mucous cyst of lip/cheek
xiv. Diseases related to thyroid
xv. All skin ailments
xvi. Ulcers of any kind (whether internal or external) including decubitus ulcers
xvii. Varicose veins & Varicose ulcers
xviii. Intervertebral disc disorders , Arthroscopy, Spinal and Vertebral Disorders including diagnosis as low back ache, Surgeries for joint replacements (except if hospitalization is required due to an accidental injury)
xix. All Hernias (except if Hospitalization is required due to an Injury)

II. SPECIFIC EXCLUSIONS

1. All dental treatment or dental surgery of any kind unless necessitated due to an Accident

2. Any treatment received outside India unless specifically covered and specified in the Policy Certificate.

3. Circumcision unless necessary for treatment of an underlying disease.

4. Routine medical, dental, eye and ear examinations is not covered unless specifically covered and specified in the Policy Certificate.

5. Treatment of general debility, convalescence, run-down condition or rest cure, venereal disease.

6. Intentional self Injury, suicide or attempt to suicide.

7. Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought. Any Illness, complication or ailment arising out of or connected to such Injury.

8. Any external congenital anomalies.

9. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world

10. Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.

11. War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, police, military, naval or air service, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

12. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

Claim Documents for Section E (Applicable for Benefit E.1 and E.2)

1. On the occurrence of an Insured Event which may give rise to a claim under Section E of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of the occurrence of the Insured Event: Duly filled claim form

2. Indoor case papers from the Hospital mentioning the diagnosis, date and time of admission and discharge, past medical and surgical history with duration.

3. Hospital Discharge summary filled and attested by Hospital

4. First Information Report (F.I.R.) copy / Medico-legal case papers - Notarized/ Attested by a gazetted officer in case of an Injury

BASIS OF ASSESSMENT OF CLAIM

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.

We shall be given notice of any event that may give rise to a claim on toll free number 1800 2666 or on our website www.icicilombard.com or also in writing at Our address specified in the Policy Certificate:

All claims shall be made within the timelines and in accordance with the procedures set out in the relevant Sections of the Policy. All claims documentation specified within the relevant Section of the Policy for the Benefit being claimed must be submitted in full.

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/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such claim. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's Injury/Illness and treatment and to investigate the facts surrounding the claim.

Our medical or other representative shall be allowed to examine the Insured Person on the occurrence of any alleged Injury or disablement when and as often as the same may reasonably be required on behalf of Us and in the event of death to make a post-mortem examination of the body of the Insured Person. Such evidence as We may require from time to time shall be furnished and a post-mortem examination report, be furnished within a period of thirty days.

The directions, advice and guidance of the treating Medical Practitioner shall be strictly followed. We shall not be obliged to make any payments that are brought about or contributed to as a consequence or failure to follow such directions, advice or guidance.

We shall make the payment of claim that has been admitted as payable by Us under the Policy within 30 days of submission of the last necessary documents and information required for the settlement of the claim. 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.

In case the customer has chosen for claim payout on a pre-determined periodic installment basis, he/she shall not be able to change such claim payment terms within the Policy Period and/or at the time of a claim.

In case of delay in payment of any claim that has been admitted as payable by Us under the Policy, beyond the time period as prescribed under IRDAI (Protection of Policyholders Interests) Regulations, 2017, We shall pay interest at a rate which is 2% above the bank rate where "bank rate" shall mean the bank rate fixed by the Reserve Bank of India at the beginning of the financial year in which claim has fallen due.

NOTE:-

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)

- The scope of cover shall be within the geographical boundaries on India unless specified otherwise.

Terms of Renewal

- The Policy may be renewed by mutual consent 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 Injury or Accident or Illness or Hospitalization that occurred during the Grace Period.

- For Sections C, D and E renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts. However, the maximum renewal age for Section D shall be 40 years. 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. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

- You shall on tendering any premium for the Renewal of this Policy give notice in writing to Us of any disease, physical defect or infirmity with which any of the Insured Person(s) have become affected since the payment of the expiring Policy start date.

- If this product is withdrawn with the IRDAI's approval, then the Policy may be renewed under the nearest substitute product available.

POLICY RELATED TERMS AND CONDITIONS

- Proof satisfactory to Us shall be furnished of all matters upon which a claim is based. Any medical or other agent of Us shall be allowed to examine the Insured Person(s) on the occasion of any alleged Injury or disablement when and as often as the same may reasonably be required on behalf of Us and in the event of death to make a post-mortem examination of the body of the Insured Person. Such evidence as We may from time to time require shall be furnished and a post-mortem examination report, be furnished within a period of thirty days.
- You shall give immediate notice to Us of any change in any of the business or occupation of the Insured Person.
- Any change in the policy terms and conditions including but not limited to sum insured and/or coverage shall will not be permitted within the Period of Cover.
- In case the customer chooses to pay the premium in installments then he/she shall not be able to change the frequency of payments within the Period of Cover.
- In case the customer has opted for auto renewal, the policy shall be Renewed with the same policy terms & conditions including but not limited to the sum insured, coverage, premium paying terms and claim payment terms and policy terms & conditions.
- We shall make payment to assignee/partial assignee/conditional assignee, as the case may be or in the absence of assignee to the Insured Person or the Insured Person's nominee. 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 liability towards the claim.

  For Section C, D and E, the Insured Person shall have the right to migrate from this Policy to a similar individual health insurance policy, if available with Us.

PART III OF THE POLICY SCHEDULE

GENERAL TERMS & CLAUSES

SPECIFIC TERMS AND CLAUSES

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 behalf to obtain any benefit under this Policy.

Proof satisfactory to the Company shall be furnished of all matters upon which a claim is based.

2. Change in Policy

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 the customer chooses to pay the premium in installments then he/she shall not be able to change the frequency of payments within the Policy Period.

3. Material change

The Insured Person shall immediately notify the Company in writing of any material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safe operation, trade or business practices thereby containing the circumstances that may give rise to the claim and We may, adjust the scope of cover and / or premium, if necessary, accordingly.

4. Records to be maintained

The Insured Person shall keep an accurate record containing all relevant particulars and shall allow Us to inspect such record.

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. Overriding effect of Policy Certificate

The terms and conditions contained herein and in the Policy Certificate 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 Certificate, 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 Certificate and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

7. Fraudulent claims

If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy/Certificate of Insurance will be void and all benefits otherwise payable under it will be forfeited.

8. Free Look Period

You have a period of 15 days (30 days if the Policy is sold through distance marketing) from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation and You will be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium. You can cancel Your Policy only if no claims have been made under the Policy. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of Renewal of the Policy.

Free Look Period is applicable only on first purchase of the policy and is not applicable on any Renewals.

9. 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.

You may also give 15 days notice in writing, to Us, for the cancellation of this Policy, in which case We shall from the date of receipt of notice cancel the Policy and refund the premium for the period this Policy has been in force as per the refund grid applicable.

b) Refund Grid applicable to Policies having Policy Period **lesser than or equal to 1 year**:

Day of cancellation	Rate of Premium refunded
Within 30 days	70%
31 – 90 days	60%
91 days – 6 months	45%
Exceeding 6 months	Nil

c) Refund Grid Applicable to policies having Policy Period greater than 1 year:

<table>
<tr><th colspan="5">% of Premium refund</th></tr>
<tr><th rowspan="2">Day of cancellation</th><th colspan="4">Policy Period</th></tr>
<tr><th>2 years</th><th>3 years</th><th>4 years</th><th>5 years</th></tr>
<tr><td>Within 180 days</td><td>60%</td><td>65%</td><td>70%</td><td>75%</td></tr>
<tr><td>181 – 365 days</td><td>40%</td><td>52%</td><td>57%</td><td>61%</td></tr>
<tr><td>366 – 730 days</td><td rowspan="3">NIL</td><td>26%</td><td>38%</td><td>46%</td></tr>
<tr><td>731 – 1095 days</td><td rowspan="2">NIL</td><td>20%</td><td>30%</td></tr>
<tr><td>1096 – 1460 days</td><td>NIL</td><td>15%</td></tr>
<tr><td>More than 1460 days</td><td colspan="4">NIL</td></tr>
</table>

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.

d) **Cancellation of Policy Certificate:**

The Insured Person may cancel the cover under the Policy by giving 15 days prior written notice in writing to Us. We shall from the date of receipt of notice cancel the Insured Person's cover under the Policy and refund the premium for the period the cover under the Policy has been in force as per the refund grid applicable. The Insured Person is not permitted to cancel only a portion of the Benefits available. If opting for cancelation, all Benefits under the Policy will be cancelled.

10. Scope of Cover

The Scope of Cover shall be worldwide unless specified otherwise in the Policy Certificate

11. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be adjudicated or interpreted in accordance with Indian Laws and only competent Indian courts shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

12. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to: In case of the Insured Person, at the address specified in the Policy Certificate.

In case of Us:

ICICI Lombard General Insurance Company Limited, ICICI Lombard House,
414, Veer Savarkar Marg, Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400 025

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.

13. Customer Service

If at any time the Insured Person (or his Nominee/ legal heir, as the case may be) requires any clarification or assistance, they may contact Our offices at the address specified below, during normal business hours.

ICICI Lombard General Insurance Company Limited
ICICI Lombard House 414, Veer Savarkar Marg,
Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025.

14. Grievances

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

1. Call Us at toll free number: 1800 2666 or email us at customersupport@icicilombard.com

2. If You are not satisfied with the resolution then You may successively write to The Manager - Service Quality, at the following address:

ICICI Lombard General Insurance Company Limited
ICICI Lombard House 414, Veer Savarkar Marg,
Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025.

3. If you are not satisfied with the resolution provided, you may approach us at the section “Grievance Redressal” on our website www. icicilombard.com (Customer Support section).

4. If You are not satisfied with Our response or do not receive a response from Us within 15 days, You may approach the Grievance Cell of the Authority at:

Insurance Regulatory and Development Authority of India;
Grievance Call Centre (IGCC) Toll Free No:155255 Email ID: complaints@irda.gov.in.

You can also register Your complaint online at http://www.igms.irda.gov.in
You can also register Your complaint through fax/letter by submitting Your complaint to:
Consumer Affairs Department Insurance Regulatory and Development Authority of India ; 9th floor, United India Towers, Basheerbagh; Hyderabad – 500 029, Telangana; Fax No: 91- 40 – 6678 9768.

If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of the grievance.

The details of Insurance Ombudsman are available below:

S no.	Name of office of insurance Ombudsman	Territorial Area of jurisdiction
1	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@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
2	BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
3	BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor,	Madhya Pradesh Chattisgarh.

	6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	
4	BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
5	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@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
6	CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
7	DELHI	Delhi

	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	
8	ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
9	GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
10	HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 – 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.

11	JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan.
12	KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
13	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@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
14	MUMBAI	Goa,

	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@cioins.co.in	Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
15	NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur
16	PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
17	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,	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

	Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	

The updated details of Insurance Ombudsman are available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: www.generalinsurancecouncil.org.in, website of the Company www.icicilombard.com or from any of the offices of the Company

ENDORSEMENTS AVAILABLE UNDER THIS POLICY

Endorsement I: Periodical Claim Payment Clause

We will pay the claim amount for the Payout Period by way of periodical installments as per the Periodicity opted by the Insured Person (or his Nominee/ legal heir, as the case may be) for a given period as specified in the Policy Certificate.

We shall be liable to pay only for the amount and period specified in the Policy Certificate.

"Payout Period" and "Periodicity" means the period and payout frequency respective, as specified in the Policy Certificate for which the periodical benefit shall be paid.

Endorsement II: Premium Installment Clause

a. We will accept payment of the premium applicable taxes, charges, cess etc. in monthly/quarterly/semi-annual/annual installments as specified in the Policy Certificate 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 Certificate, 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.

Endorsement III: Auto Renewal Clause

a. We will automatically renew the Policy for the Policy Period as opted by the policyholder. However, after completing its entire auto Renewal period on expiry of the Policy on the Policy End Date, We shall not be bound to accept any Renewal premium nor give notice that such Renewal premium is due.

b. Every Renewal premium shall be paid and accepted as per the terms of Renewal specified under this Policy and upon the distinct understanding that no alteration has taken place in the facts contained in the Proposal and Declaration Form herein before mentioned and that nothing is known to the Insured Person that may result to enhance the risk of We under the guarantee hereby given. Any change in the risk will be intimated to the Company by the Policyholder/ Insured Person. Nothing herein or otherwise shall affect Our right to impose any additional terms and conditions on Renewal or restrict any Renewal terms as to premium or otherwise.

c. No Renewal receipt shall be valid unless it is on the printed form of Our and signed by Our authorized official.