

Prospectus

1. Suitability:

- This policy covers persons in the age group of 5 years onwards (Dependent children between 91 days and 5 years can be insured only when both parents are getting insured). The minimum entry age for adults is 18 years and maximum entry age is 65 years.
- There is no maximum cover ceasing age under this policy.
- The policy will be issued for a period 1/2/3 years.
- This policy can be issued to an individual and/or family.
- The family includes spouse and economically dependent children and dependent parents.
- The policy offers coverage on family floater basis.
- Maximum 7 members of a family are covered in one Individual Plan Policy (Self, spouse, 3 dependent children and 2 dependent parents).
- Maximum 7 members are covered in one Family Floater Plan policy (Self, spouse, 3 dependent children (Up to the age of 25 Years) and 2 dependent parents. In case of family floater, where age of the dependent child is crossing 25 years, the child can be covered under a separate policy with eligible continuity benefit.

2. Key Benefits:

- Range of benefits:** Indemnity based health insurance cover with range of benefits without any sub-limit unless otherwise mentioned.
- Network of hospitals:** We are equipped to offer you health care with our network of 4000+ hospitals across India.
- Lifelong renewal:** We offer you a lifelong renewal for your policy provided premium is paid without any break. Your premiums will be basis the age, sum insured, deductible and plan. Your renewal premium will be basis your age on renewal and there will be no extra loadings based on your individual claim.
- Global Cover (Optional Cover):** We will cover Medical Expenses of the Insured Person incurred outside India, upto the sum insured in excess of deductible provided that the diagnosis was made in India and the insured travels abroad for treatment.
- Consumables Benefit:** We will pay for expenses incurred, for specified consumables which are listed in 'Annexure I – List I as Optional Items' 'Items for which optional cover may be offered by insurers' under 'Guidelines on Standardization in Health Insurance, 2016 and its amendments', which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items are available on our website (www.tataaig.com).
- Cumulative bonus:** 50% increase in cumulative bonus for every claim free year In the case a claim is made during the policy year, the cumulative bonus would reduce by 50% in the following year.
- Tax Benefit:** The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.
- Aggregate Deductible:** All claims under the policy benefits shall be payable only if the aggregate of covered medical expenses, in respect to hospitalizations in a policy year is in excess of deductible specified in policy schedule. In case of family floater policy, the deductible shall be per policy per year and in case of individual policy, the deductible shall be per insured person per year

3. Discounts on premium:

- 10% long term discount on premium in case insured opts policy term of 3 years
- 5% long term discount on premium in case insured opts policy term of 2 years
- Family floater discount on premium:
 - 2 members -20%
 - 3 members -28%
 - >3 members-32%

4. Salient Features:

- In-patient Treatment:** We will cover expenses for hospitalization due to disease/illness/Injury during the policy period that requires an Insured Person's admission in a hospital as an inpatient. Medical expenses directly related to the hospitalization would be payable
- Pre-Hospitalisation:** We will cover for expenses for Pre-Hospitalization consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital.
- Post-Hospitalisation:** We will cover for expenses for Post-Hospitalization consultations, investigations and medicines incurred upto 90 days after discharge from the hospital.
- Day Care Procedures:** We will cover expenses for listed Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. The list of such day care procedures covered is available on our website (www.tataaig.com)

5. **Organ Donor:** We will cover for Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient.
6. **Domiciliary Treatment:** The Medical Expenses incurred by an Insured Person for availing medical treatment at his home which would otherwise have required Hospitalisation. We will also cover pre and post hospitalization expenses in case of domiciliary hospitalization.
7. **In-patient Dental Treatment-** We will cover for medical expenses incurred towards hospitalization for dental treatment under anesthesia necessitated due to an accident/injury/illness.
8. **AYUSH benefit -** Medical Expenses incurred for In-patient treatment in AYUSH Hospital.
9. **Ambulance cover-** We will cover for expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency or from one hospital to another hospital for better medical facilities and treatment, subject to Rs. 3000 per Hospitalization.
10. **Health Check-up-** Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured subject to a maximum of Rs. 10,000/- per policy once in block of every two continuous claim free policy years with us.
11. **Second Opinion-** We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with the listed Illnesses in policy during the Policy Period.
12. **Consumables Benefit-** We will pay for expenses incurred, for specified consumables which are listed in 'Annexure I – List I as Optional Items' 'Items for which optional cover may be offered by insurers' under 'Guidelines on Standardization in Health Insurance, 2016 and its amendments', which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items are available on our website (www.tataaig.com).
13. **Global Cover (Optional Cover):** We will cover Medical Expenses of the Insured Person incurred outside India, upto the sum insured in excess of provided that the diagnosis was made in India and the insured travels abroad for treatment. The Medical Expenses payable shall be limited to Inpatient and daycare Hospitalization only on reimbursement basis.

5. Sum Insured options: (in Rs.)

- 3 Lacs
- 5 Lacs
- 10 Lacs
- 15 Lacs
- 20 Lacs
- 25 Lacs
- 50 Lacs
- 1 Crore

6. Deductible options: (in Rs.)

- 2 Lacs
- 3 Lacs
- 5 Lacs
- 10 Lacs
- 15 Lacs
- 20 Lacs

7. Renewal Incentives:

- a. **Cumulative Bonus:** We will offer Cumulative Bonus of 50% of the Sum Insured for every claim free year accumulating up to 100% of sum insured. In the event of a claim, the cumulative bonus shall be reduced by 50% at the time of renewal/in subsequent policy year.
- b. **Health Check-up-** Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured subject to a maximum of Rs. 10,000/- per policy once in block of every two continuous claim free policy years with us.

8. Portability:

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer Guidelines issued IRDAI(Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: : IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 IRDAI/ HLT/ REG/ CIR/ 003/ 01/2020 dated 01/01/20and subsequent amendments thereof.

9. Free Look Period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

10. Waiting Period:

i. 30 days Waiting Period (Code- Excl 03):

- a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date 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 is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Specified Disease/Procedure Waiting Period (Code- Excl 02):

- a. Expenses related to the treatment of the 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 Specific Diseases/procedures as furnished below:

- I. Tumors, Cysts, polyps including breast lumps (benign)
- II. Polycystic ovarian disease
- III. Fibromyoma
- IV. Adenomyosis
- V. Endometriosis
- VI. Prolapsed Uterus
- VII. Non-infective arthritis
- VIII. Gout and Rheumatism
- IX. Osteoporosis
- X. Ligament, Tendon or Meniscal tear (due to injury or otherwise)
- XI. Prolapsed Inter Vertebral Disc (due to injury or otherwise)
- XII. Cholelithiasis
- XIII. Pancreatitis
- XIV. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
- XV. Ulcer & erosion of stomach & duodenum
- XVI. Gastro Esophageal Reflux Disorder (GERD)
- XVII. Liver Cirrhosis
- XVIII. Perineal Abscesses
- XIX. Perianal / Anal Abscesses
- XX. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.
- XXI. Benign Hyperplasia of prostate
- XXII. Varicocele
- XXIII. Cataract

- XXIV. Retinal detachment
- XXV. Glaucoma
- XXVI. Congenital Internal Diseases

The following treatments are covered after a waiting period of two years irrespective of the illness for which it is done:

- XXVII. Adenoidectomy
- XXVIII. Mastoidectomy
- XXIX. Tonsillectomy
- XXX. Tympanoplasty
- XXXI. Surgery for nasal septum deviation
- XXXII. Nasal concha resection
- XXXIII. Surgery for Turbinate hypertrophy
- XXXIV. Hysterectomy
- XXXV. Joint replacement surgeries Eg: Knee replacement, Hip replacement
- XXXVI. Cholecystectomy
- XXXVII. Hernioplasty or Herniorraphy
- XXXVIII. Surgery/procedure for Benign prostate enlargement
- XXXIX. Surgery for Hydrocele/ Rectocele
- XL. Surgery of varicose veins and varicose ulcers

iii. Pre-existing Diseases Waiting Period(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 36 months of continuous coverage after the date of inception of the first policy with us.
- 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 36 months for any pre -existing disease is subject to the same being declared at the time of application and accepted by us

11. General Exclusions:

We will neither be liable nor make any payment for any claim in respect of any Insured Person which is caused by, arising from or in any way attributable to any of the following exclusions, unless expressly stated to the contrary in this Policy.

1. Medical Exclusions

- i. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12).
- ii. Alcoholic pancreatitis
- iii. Obesity/ Weight Control(Code- Excl 06)

Expenses related to surgical treatment of obesity that does not fulfil 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
- iv. Congenital External Diseases, defects or anomalies
- v. Stem cell therapy; however hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under benefit B1 or B4 of this policy
- vi. Growth hormone therapy;
- vii. Sleep-apnoea

- viii. Admission primarily for administration of Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid
- ix. Investigation and 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.
- x. Venereal disease, sexually transmitted disease or illness;
- xi. Sterility and Infertility (Code- Excl 17):

Expenses related to Sterility and infertility. This includes:

 - i. Any type of contraception, sterilization
 - ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - iii. Gestational Surrogacy
 - iv. Reversal of sterilization
- xii. Refractive error (Code - Excl 15):

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
- xiii. 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.
- xiv. 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.
- xv. Rest cure, rehabilitation and respite care (Code- Excl 05):
 - a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - i. 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.
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- xvi. All preventive care, vaccination including inoculation and immunisations ;
- xvii. 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
- xviii. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization & any dental treatment other than specified in 'Inpatient Treatment – Dental'
- xix. 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.
- xx. Treatments received in health spas, 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-Excl13)
- xxi. 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-Excl14)
- xxii. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule

2. Non-Medical Exclusions

- i. War or any act of war, invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.
- ii. Any Insured Person's participation or involvement in naval, military or air force operation.
- iii. 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.
- iv. 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.
- v. Intentional self-injury or attempted suicide while sane or insane.

- vi. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service
- vii. Treatment rendered by a Medical Practitioner which is outside his discipline
- viii. Doctor's fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family.
- ix. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy
- x. Any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.
- xi. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
- xii. Crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively and explicitly stated and covered in the policy).
- xiii. Any illness diagnosed or injury sustained or where there is change in health status of the member after date of proposal and before commencement of policy and the same is not communicated and accepted by us.
- xiv. 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
- xv. Any claim within the deductible limit as specified in the policy schedule.

12. Claim Procedure:

The final decision on all claims is taken by Tata AIG General Insurance Company Limited.

a. Intimation & Assistance:

Please contact our designated TPA/Us atleast 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact us within 24 hours of the event.

b. Claim Related Information:

For any claim related query, intimation of claim and submission of claim related documents, You can contact us through:

Claim Servicing Details	
Name	TAGIC Health Claims
Claims Administrator Address	TATA AIG General Insurance Company Limited, 5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No - 615,616, Ameerpet, Hyderabad – 500016, Telangana, Phone-040-66864900
Email	healthclaimsupport@tataaig.com
Toll Free	1800 266 7780 or 1800 229 966 (For Senior Citizens)
Website	www.tataaig.com

Any change in TPA by Us shall be communicated to You 30 days before such effect of change.

c. Procedure for reimbursement claims:

- Our TPA/We must be informed TPA within 7 days of completion of such treatment, consultation or procedure and send all the claim related documents to our TPA/Us within 15 days of the occurrence of the Incident.
- On receipt of the complete set of claim documents, We will send the payment for the admissible amount, along with a settlement statement within 30 days.

d. Procedure for availing cashless facility:

- For any emergency Hospitalisation, our TPA/We must be informed within 24 hours after hospitalization and in case of planned hospitalization, cashless authorization to be sought atleast 48 hours prior to the hospitalization.
- TPA/We shall communicated our decision within 6 hours of receipt of complete claim documents.

e. Claim settlement (provision for Penal Interest)Procedure:

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).The Clause shall be suitably modified by the insurer based on the amendment(s), if any to the relevant provisions of Protection of Policyholder's Interests Regulations, 2017)

13. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience

14. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

15. Sum Insured Enhancement

- Sum Insured can be enhanced only at the time of renewal subject to underwriting guidelines of the company.
- In case of increase in the Sum Insured waiting period and exclusions will apply afresh in relation to the amount by which the Sum Insured has been enhanced. However, the acceptance of Sum Insured enhancement request & quantum of increase shall be as per Our underwriting guidelines. For claims arising in respect of accident, injury or illness contracted or suffered during a preceding Policy period, liability of the Company shall be only to the extent of the Sum Insured under the Policy in force at the time when it was contracted or suffered.

16. Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer Guidelines issued by IRDAI (Insurance Regulatory and Development Authority of India) on Migration and Portability of Health Insurance policies – Ref: IRDAI/HLT/REG/CIR/194/07/2020) dated 22nd July 2020 and subsequent amendments thereof.

17. Withdrawal of the policy:

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

18. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

19. Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

20. Requirement:

- Completed proposal form,
- Supporting Medical papers (wherever applicable),
- Previous policy copies, IRDAI portability form (as applicable)

21. Pre-policy medical calling (Tele-MER):

Pre-Policy medical calling would be done based upon the age and/or total of Sum Insured and Deductible. The Tele MER (Tele Medical Examination Report) expenses incurred per insured person will be payable by Tata AIG for all proposals. Based on the type of medical conditions disclosed to us at the time of Tele MER, we may call for additional medical tests, if required. In such cases, additional

medical test expenses incurred per insured person will be payable by Tata AIG only on acceptance of proposal as per the grid below :

Policy Tenure(in years)	Additional Medical Test Expenses to be borne by Tata AIG
1	50%
2	100%
3	100%

Pre-policy Tele MER grid:

Age(in years)/ Sum Insured	Upto 50 lacs	> 50 Lacs
Upto age 45	No PPC	Tele MER
46- 65	Tele MER	Tele MER
	Tele MER	Tele MER
	Tele MER	Tele MER
	Tele MER	Tele MER

22. Premium Rates*:

- The premium will be charged on the completed age of the Insured Person.
- Premium rates are subject to change with prior approval from IRDAI.
- The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.
- For family floater, premium is calculated by adding the premium of respective individual members and applying family floater discount.
- In case the insured person opts for Global Cover, additional 10% premium loading shall be applicable for each insured person.
- Monthly instalment option would be allowed and following loadings shall be applicable:

Term of Policy	Loading%
1 year Policy	5%
2 year Policy	9%
3 year Policy	13%

If the insured person has opted for Payment of Premium on an installment basis i.e. Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

- Grace Period of 15 days would be given to pay the installment premium due for the policy.
- During such grace period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.
- The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- No interest will be charged If the installment premium is not paid on due date
- In case of installment premium due not received within the grace period, the policy will get cancelled.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

*Annexure enclosed

23. Loadings:

- We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance).
- The maximum risk loading applicable for an individual shall not exceed 100% of premium per diagnosis / medical condition and an overall risk loading of over 150% of premium per person.
- The loading shall only be applied basis an outcome of Our medical underwriting.
- These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).
 - We will inform You about the applicable risk loading through a counter offer letter.
 - You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.
 - In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 10 days subject to deduction of the Pre-Policy Check up charges, as applicable.
- Please note that We will issue Policy only after getting Your consent.

24. Cancellation:

You may terminate this Policy at any time by giving Us written notice, and the Policy shall terminate when such written notice is received. The cancellation shall be from the date of receipt of such notice. If and only if no claim has been made under the Policy, then We will refund premium in accordance with the table below:

- i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Length of time Policy in force	Year		
	1	2	3
Upto 1 Month	75.00%	87.50%	91.5%
>1 month & Upto 3 Months	50.00%	75.00%	88.5%
>3 months & Upto 6 Months	25.00%	62.50%	75%
>6 months & Upto 12 Months	Nil	50.00%	66.5%
>12 months & Upto 15 Months	NA	25%	50%
>15 months & Upto 18 Months	NA	12.5%	41.5%
>18 months & Upto 24 months	NA	Nil	33%
>24 months & Upto 30 months	NA	NA	8%
Exceeding 30 months	NA	NA	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

- i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

25. Redressal of Grievance:

In case of any grievance the insured person may contact the company through

- Website: www.tataaig.com
- Toll Free: 1800 266 7780 or 1800 22 9966 (only for Senior Citizen policyholders)
- Email: customersupport@tataaig.com
- Fax: 022 66938170
- Courier: Customer Support, Tata AIG General Insurance Company Limited A-501 Building No. 4 IT Infinity Park, Dindoshi, Malad (E), Mumbai – 400097

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at manager.customersupport@tataaig.com.

For updated details of grievance officer, kindly refer the link (<https://www.tataaig.com/grievance-redressal-policy>)

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region (details as mentioned in the Annexure A of this policy) for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI Integrated Grievance Management System (<https://igms.irda.gov.in/>)

26. Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

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

IRDAI REGULATION: This policy is subject to IRDAI (Protection of Policyholder's Interests) Regulations, 2017.

Note: Policy Term and Conditions & Premium rates are subject to change with prior approval from IRDAI.

Disclaimer: "Insurance is the subject matter of the solicitation". For more details on benefits, exclusions, limitations, terms & conditions, please refer sales brochure/ policy wordings carefully, before concluding a sale."

Commencement of risk cover under the policy is subject to receipt of premium by Tata AIG General Insurance Company Limited.

Benefit Illustration in respect of Policies offered on Individual and Family Floater basis

Age of the members insured (in years)	Coverage opted on individual basis covering each member of the family separately(at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy(Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured(only one sum insured is available for entire family)			
	Premium(₹)	Sum Insured(₹)*	Premium (₹)	Discount if any	Premium after Discount(₹)	Sum Insured(₹)*	Premium or consolidated premium for all members of the family(₹)	Floater discount if any	Premium after discount(₹)	Sum Insured (₹)*
42	1441	5,00,000	1441	0%	1441	5,00,000	1441	32%	980	5,00,000
37	1441	5,00,000	1441	0%	1441	5,00,000	1441		980	
19	1177	5,00,000	1177	0%	1177	5,00,000	1177		800	
15	1010	5,00,000	1010	0%	1010	5,00,000	1010		687	
	Total Premium for all members of the family is ₹ 5069 when each member is covered separately		Total Premium for all members of the family is ₹ 5069 when they are covered under a single policy				Total Premium when policy is opted on floater basis is ₹ 3447			
	Sum Insured available for each individual is ₹ 5,00,000		Sum Insured available for each family member is ₹ 5,00,000				Sum Insured of ₹ 5,00,000 is available for the entire family			

Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also, the premium rates shall be exclusive of taxes applicable

*Sum Insured is with a Aggregate Deductible of 5,00,000