Model Policy for Persons with Disabilities and HIV/AIDS, Tata AIG - Prospectus

1. Suitability:

a. Policy can be availed on Individual basis.
   Age eligibility for adults: 18 years to 65 years
   Age eligibility for Children: Newborn to 17 years
b. There is no maximum cover ceasing age under this policy.
c. The policy will be issued for a period 1 year.
d. This policy can be issued to an individual.
e. Eligibility Criteria

All Persons with Disability who have at least one of the disabilities as defined under Specified Disability under The Rights Of Persons With Disabilities Act, 2016 with valid disability certificate are eligible to enroll this product.

2. Salient Features:

This policy is specially designed for:

A) Covering Persons with Disability as per 'The Rights of Persons with Disabilities Act, 2016' and 'The Mental Healthcare Act, 2017'. The cover under this policy is available for persons with the following disability/disabilities as defined under 'the Rights of Persons with Disabilities Act, 2016' and any subsequent additions / modifications to the list in the Act.

1. Blindness	2. Muscular Dystrophy
3. Low vision	4. Chronic Neurological conditions
5. Leprosy Cured persons	6. Specific Learning Disabilities
7. Hearing Impairment (deaf and hard of hearing)	8. Multiple Sclerosis
9. Locomotor Disability	10. Speech and Language disability
11. Dwarfism	12. Thalassemia
13. Intellectual Disability	14. Haemophilia
15. Mental Illness	16. Sickle Cell disease
17. Autism spectrum disorder	18. Multiple Disabilities including deaf/ blindness
19. Cerebral Palsy	20. Acid Attack victim
21. Parkinson's disease	

a) It is Condition Precedent that this cover can be availed only on mandatory submission of Disability certificate issued by the Medical Board appointed by the government for certifying Disability.
b) Disability for the purpose of this policy means a person with not less than forty percent of a specified disability as per the Act, where, specified disability has not been defined in measurable terms and includes an Insured Person with disability where specified disability has been defined

in measurable terms, as Certified by the Medical Board appointed by the government for certifying Disability.

Or / and

B) Individuals with HIV/AIDS as defined under the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017.

3. Base Cover

i. In-Patient Care

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy Year, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay as specified in the policy), for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up maximum of to2% of Sum Insured per day.
iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating Medical Practitioner/ surgeon or to the hospital
iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits.
ii. Dental treatment necessitated due to disease or injury (for inpatient care only).
iii. Plastic surgery necessitated due to disease or injury.
iv. All day care treatments

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. The above-mentioned Medical Expenses shall be payable only after the first commencement of the Policy with the Company.
3. If the Insured Person is admitted in a room where the Room Rent expenses incurred are higher than the above specified limit, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon), except pharmacy charges, diagnostic costs, costs of implants & medical devices and consumables expenses, in the

proportion of the difference between the Incurred Room Rent and Eligible Room Rent to the Incurred Room Rent.

Expenses to be borne by Insured Person = {(Associated Medical Expenses) X (Incurred Room Rent– Eligible Room Rent)} / Incurred Room Rent

Proportionate Expenses is applied in respect of the Hospital which follow differential billing or for those expenses in respect of which differential billing is adopted based on the Room Category.

ii. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to 50% of sum insured as specified in the policy schedule in any AYUSH Hospital.

iii. Pre-Hospitalization medical expenses

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient care, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy during the policy period.

Conditions:

I. The claim is accepted under Section i (Inpatient Care) or Section ii (AYUSH Treatment) or Section vii (Modern Treatments) in respect of that Insured Person.

II. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

iv. Post-Hospitalization medical expenses

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during the policy period.

Conditions:

I. The claim is accepted under Section i (Inpatient Care) or Section ii (AYUSH Treatment) or Section vii (Modern Treatments) in respect of that Insured Person.

II. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

v. Emergency Ground Ambulance

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards ambulance charges for transportation of an Insured person, per hospitalization as per the limit mentioned in Policy Schedule.

Specific Conditions:

I. The Company will reimburse payments under this Benefit provided that.
II. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
III. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.
IV. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
V. The original Ambulance bills and payment receipt is submitted to the Company.
VI. The Company has accepted a claim under Section i (Inpatient Care) above in respect of the same period of Hospitalization or Section ii (AYUSH Treatment) or Section vii (Modern Treatments).
VII. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

vi. Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of Rs.40,000/-, per each eye in one policy year.

vii. Modern Treatment

The following procedures will be covered (wherever medically indicated) either as In patient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period.

(a) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
(b) Balloon Sinuplasty
(c) Deep Brain stimulation
(d) Oral chemotherapy
(e) Immunotherapy- Monoclonal Antibody to be given as injection.
(f) Intra Vitreal injections
(g) Robotic surgeries
(h) Stereotactic radio Surgeries
(i) Bronchial Thermoplasty
(j) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
(k) IONM- (Intra Operative Neuro Monitoring)
(l) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4. Sum Insured options (₹):

- 4 Lacs
- 5 Lacs

5. Portability:

The Insured Person will have the option to port the Policy to same product of other insurers as per extant Guidelines related to portability, If such person is presently covered and has been continuously covered without any lapses under this health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

I. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
II. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link - https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

6. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals of 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
III. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

7. Waiting Period:

1. 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 24 months for pre-existing disability (as mentioned in Policy Schedule)/ 48 months for all pre-existing conditions and HIV/AIDS, 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/ 48 months, as applicable, for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. First 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.

3. 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 (mentioned in Policy Schedule) 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.

24 months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps.
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non-Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders

17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers

4. Specific Conditions Applicable For Persons with Disability

The Company will indemnify reasonable and customary charges for medical expenses incurred towards Inpatient Hospitalisation arising due to the pre-existing disability covered, or condition as listed under The Rights of Persons With Disabilities Act, 2016 subject to the terms and limits mentioned below.

I. Any treatment for the pre-existing disability covered, will have a waiting period of 24 months from the first policy inception date.
II. Any reconstructive / Cosmetic / prosthesis / external or internal device implanted/ used at home for the purpose of treatment of existing disability or used for activities of daily living are/is excluded from the policy.

5. Specific Conditions Applicable For Persons with HIV/AIDS

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition which requires Inpatient Hospitalization of the Insured Person, up to the sum insured opted as mentioned in the Policy Schedule, provided,

Condition

I. This cover will exclude cost for any Anti-Retroviral Treatment.

8. General Exclusions:

8.1 Standard Exclusions

1. Investigation & Evaluation- Code- Excl04

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.

2. Rest Cure, rehabilitation, and respite care- Code- Excl05

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.

3. **Obesity/ Weight Control: Code- Excl06**
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor.
   2) The surgery/Procedure conducted should be supported by clinical protocols.
   3) The member must be 18 years of age or older and
   4) Body Mass Index (BMI).
      a) greater than or equal to 40 or
      b) 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:
         i. Obesity-related cardiomyopathy
         ii. coronary heart disease
         iii. Severe Sleep Apnoea
         iv. Uncontrolled Type2 Diabetes

4. **Change-of-Gender treatments: Code- Excl07**
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. **Cosmetic or plastic Surgery: Code- Excl08**
   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.

6. **Hazardous or Adventure sports: Code- Excl09**
   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- Excl10**
   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- Excl11**
   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. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl12**

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- Excl13**

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- Excl14**

12. Refractive Error: Code- Excl15
Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

13. Unproven Treatments: Code- Excl16
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.

14. Sterility and Infertility: Code- Excl17
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

15. Maternity: Code Excl18

I. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
II. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

8.2 Specific Exclusions

1. Any medical treatment taken outside India.

2. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.

3. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:
   a. any nuclear fuel or from any nuclear waste; or
   b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);
   c. nuclear weapons material.
   d. nuclear equipment or any part of that equipment.

4. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or

confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.

5. Injury or Disease caused by or contributed to by nuclear weapons/materials.

6. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.

7. Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.

8. Suicide, Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

9. Vaccination or inoculation except as post bite treatment for animal bite.

10. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.

11. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.

12. Dental treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental Bodily Injury.

13. Venereal/ Sexually Transmitted disease

14. Stem cell storage.

15. Any kind of service charge, surcharge levied by the hospital.

16. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

17. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II

18. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

9. Claim Procedure:

The final decision on all claims is taken by Tata AIG General Insurance Company Limited. We may have a Specified Third Party Administrator (TPA) duly licensed by IRDAI to administer all claims under this policy.

1. Procedure for Cashless claims:

I. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA,

II. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

III. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

IV. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

V. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details,

VI. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

2. Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to Company within the prescribed time limit as specified hereunder.

S. No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and prehospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

3. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

Cashless Claims:

I. Within 24 hours from the date of emergency hospitalization required or before the Insured Person’s discharge from Hospital, whichever is earlier.

II. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

4. Documents to be submitted

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

I. Duly Completed claim form.

II. Photo Identity proof of the patient
III. Medical practitioner's prescription advising admission.
IV. Original bills with itemized break-up
V. Payment receipts
VI. Discharge summary including complete medical history of the patient along with other details.
VII. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
VIII. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
IX. Sticker/invoices of the Implants, wherever applicable.
X. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
XI. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
XII. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
XIII. Legal heir/succession certificate, wherever applicable
XIV. Any other relevant document required by Company/TPA for assessment of the claim.

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

Insurer shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of benefit as per the contract. In case if the claim is repudiated Insurer will inform the Insured about the same in writing with reason for repudiation.

5. Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 20% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

6. Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include:

I. Claim settlement and claim rejection.

II. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

7. Payment of Claim

All claims under the Policy shall be payable in Indian currency only.

8. Claim Related Information:

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

- Name of Claims Administrator : TAGIC Health Claims
- Website : www.tataaig.com
- Email : customersupport@tataaig.com
- Toll Free : 1800 266 7780 and 1800 229 966 (for Senior Citizens)
- Submit claim : 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

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

9. Claim Settlement (provision for Penal interest)

I. The Company shall settle or reject a claim as the case may be, 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.

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

I. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.

II. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.

III. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

IV. If not renewed within Grace Period after due renewal date, the Policy shall terminate.
V. No loading shall apply on renewals based on individual claims experience.

11. 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 (3) months before the changes are affected.

12. Change of Sum Insured

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhance portion of the Sum Insured.

13. 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.

14. Nomination

The policy holder 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 policy holder. 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 Insured Person, the Company will pay the nominee (as named in the Policy Schedule/endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

15. Requirement:

- Completed proposal form,
- Supporting Medical papers/ disability papers (wherever applicable)

16. Pre-policy medical check-up:

Pre-Policy Check-up at our network is required for all individuals. 50% of the expenses incurred per insured person will be payable by Tata AIG only on the acceptance of the proposal. The medical reports are valid for a period of 90 days from the date of Pre-Policy Checkup.

Pre-policy medical examination gird:

Pre-Policy Medical Checkup Grid	Pre-policy Checkup Tests*
Tests for Non-Declared Hemophiliacs	FMR, CBC ESR, HbA1c, Lipid Profile, Sr. Creat, SGOT, SGPT, Urine Routine, 2D Echo, USG
Tests for Declared Hemophiliacs	FMR, Urine Routine,2D Echo, USG

Note: We may call for additional medical tests at our diagnostic centre as required

17. Premium Rates:

Refer Rate Chart

18. Loadings

I. Additional loadings for other comorbid conditions (i.e. other than disability (as mentioned in section 1a or/ and HIV/AIDS)

a) 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).

b) The loading shall only be applied basis on outcome of Our medical underwriting.

c) 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).

   i. We will inform You about the applicable risk loading through a counter offer letter.

   ii. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.

   iii. 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.

d) Please note that We will issue Policy only after getting Your consent.

19. Cancellation:

The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Yr**
Up to to 30 days	75.00%
31 to 90 days	50.00%
91 days to 180 days	25.00%
181 days to 365 days	0.00%

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 You under this Policy.

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.

20. Redressal of Grievance:

Grievance—In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.
For details of grievance officer, kindly refer the link http://ecoi.co.in/ombudsman.html
IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/
Insurance Ombudsman —The insured person many also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-I

21. Section 41 of Insurance Act1938 (Prohibition of Rebates):

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 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 prospectus or tables of the insurer.
2. Any person making default in complying with the provision of this section shall be liable for 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:
This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of your insurance advisor if you require any further information or clarification.
"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.

Tata AIG General Insurance Company Limited
Registered Office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai- 400013.
24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens) Email: customersupport@tataaig.com Website: www.tataaig.com IRDA of India Registration No: 108 CIN: U85110MH2000PLC128425