Arogya Sanjeevani Policy,
Tata AIG General Insurance Company Ltd.

TATA AIG INSURANCE
WITH YOU ALWAYS

Prospectus

1. Suitability:

a. This policy covers persons in the age group of 3 months onwards (Dependent children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals). The minimum entry age for adults is 18 years and maximum entry age is 65 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 and/or family.

e. The family includes legally wedded spouse, Parents and Parents-in-law and dependent children.

f. The policy offers coverage on family floater basis.

2. Key Benefits:

a. **Range of benefits:** Indemnity based health insurance cover with range of benefits.

b. **Network of hospitals:** We are equipped to offer you health care with our network of 4000+ hospitals across India.

c. **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, and plan. Your renewal premium will be basis your age on renewal and there will be no extra loadings based on your individual claim.

d. **Cumulative bonus:** Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued would be reduced at the same rate at which it has accrued.

e. **Tax Benefit:** The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

f. **Modes of premium payment** - All the modes (Yearly, Half yearly, Quarterly, Monthly) are allowed for this policy. ECS (Auto Debit facility) is also allowed.

3. Discounts on premium:

a. Family floater discount on premium:

- 2 members -20%
- 3 members -28%
- > 3 members-32%

4. Salient Coverages

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1 **Hospitalization**

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.

iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital

iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits

ii. Dental treatment, necessitated due to disease or injury

iii. Plastic surgery necessitated due to disease or injury

iv. All the day care treatments

v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/ - per hospitalisation.

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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. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.2 **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 the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3 **Cataract Treatment**

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs. 40,000/-, whichever is lower, per each eye in one policy year.

4.4 **Pre Hospitalization**

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.

4.5 **Post Hospitalisation**

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.

4.6 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 Sinoplasty
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. BronchialThermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. ION M - (Intra Operative Neuro Monitoring)
L. Stem Cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

4.7. The expenses that are not covered in this policy are placed under List -I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

Please refer our website (www.tataaig.com) for these annexures.

5. Sum Insured options: (in ₹)

Sum insured options available are from INR 50,000 to 10 Lakhs (Multiples of ₹50,000)

6. Renewal Incentives:

Cumulative Bonus: Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

7. Portability:

The Insured Person will have the option to port the Policy to other Insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any 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 6 of the policy 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 base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link Guidelines on Migration and Portability of Health Insurance policies – Ref: IRDAI/ HLT/ REG/ CIR/ 003/ 01/2020

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8. Free Look Period:

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

9. Premium Payment in Installments:

If the insured person has opted for Payment of Premium on an installment basis i.e., Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy.

ii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.

iii. The Benefits provided under — "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

10. 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 affected.

11. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.

   However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

12. Waiting Period:

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 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 48 months for any pre -existing disease is subject to the same being declared at the time of application and accepted by us.

First Thirty Days Waiting Period

i. 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.

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

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

Specific Waiting Period:

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

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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.

I. 24 Months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. AdenoIdectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, 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
20. Internal Congenital Anomalies

ii. 48 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

13. Exclusions:

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

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

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.

Obesity/ Weight Control

Expenses related to the surgical treatment of obesity that does not fulfill 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 has to 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 Apnea

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IV. Uncontrolled Type 2 Diabetes

Change-of-Gender treatments:

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

Cosmetic or plastic Surgery:

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.

Hazardous or Adventure sports:

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.

Breach of law:

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

Excluded Providers:

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders 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.

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

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.

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

Refractive Error:

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

Unproven Treatments:

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

Sterility and Infertility:

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 1VF, Z1FT, GIFT, ICS1

iii. Gestational Surrogacy

iv. Reversal of sterilization

Maternity Expenses:

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 o f pregnancy during the policy period.

War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or- biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Any expenses incurred on Domiciliary Hospitalization and OPD treatment

Treatment taken outside the geographical limits of India

In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

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14. TPA Details (if any):

- Name of TPA : Tata AIG Health Claim
- Website : www.tataaig.com
- Email : healthclaimsupport@tataaig.com
- Toll Free : 18002667780
  : 1800229966 (For Senior Citizens)
- Submit claim : TAGIC Health Claims, 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

Procedure for Cashless Claims:

(i)Treatment may be taken in a network provider and is subject to pre authorization 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.

Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

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

Notification of Claim

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

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.

Co-payment

Each and every claim under the Policy shall be subject to a Co -payment of 5% 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.

Claim Settlement (provision for Penal Interest)

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 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 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 at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Payment of Claim

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

15. Renewal Terms:

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.

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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. A Grace Period of 30 days for renewing the Policy is provided under this Policy (For cases other than Premium payment in instalments.)

16. Sum insured enhancement :

a. Sum Insured can be enhanced/ can be changed only at the time of renewal subject to underwriting guidelines of the company.

b. If the Insured Person increases the Sum Insured one grid up, no fresh medicals shall be required, subject to Our underwriting guidelines. However any such subsequent sum insured increase by one grid up would be subject to our underwriting guidelines.

c. In cases where the Sum Insured increase is more than one grid up, the case shall be subject to medicals or Tele MER (Medical Examination Report). 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.

17. Option to Migrate:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to 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, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii .Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

Policyholder should initiate action to approach the insurer to exercise migration option well before the renewal date to avoid any break in the policy coverage

For Detailed Guidelines on Migration, kindly refer Guidelines on Migration and Portability of Health Insurance policies – Ref: IRDAI/ HLT/ REG/ CIR/ 003/ 01/2020

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

Pre-Policy medical calling would be done based upon the age. The Tele MER(Tele Medical Examination Report)expenses incurred per insured person will be payable by the Company for all proposals. Based on the type of medical conditions disclosed to us at the time of Tele MER, the Company may call for additional medical tests, if required. In such cases, 50% of additional medical test expenses incurred per insured person will be payable by Tata AIG only on acceptance of proposal.

Pre-policy Tele MER gird:

Age(in years)	All Sum Insured Options
0-45	No TeleMER
46-50	Tele MER and Medical if required
51-55	Tele MER and Medical if required
56-60	Tele MER and Medical if required
61-65	Tele MER and Medical if required

19. Premium Rates:

a. The premium will be charged on the completed age of the Insured Person.

b. Premium rates are subject to change with prior approval from IRDAI.

c. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.

d. For family floater, premium is calculated by adding the premium of respective individual members and applying family floater discount.

Gross Premium (Pre-tax) per member (INR):

Age\Sum Insured	50,000	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000
91days-18 yrs	1,919	2,237	2,257	2,266	2,380	2,457	2,620	2,731	2,856	3,019
19-35 yrs	2,462	2,788	2,934	2,948	3,099	3,221	3,429	3,578	3,750	3,971
36-45 yrs	3,151	3,509	3,709	3,766	3,962	4,111	4,380	4,568	4,782	5,067
46-50 yrs	4,555	5,299	5,585	5,657	6,150	6,541	7,091	7,529	7,996	8,552
51-55 yrs	6,347	7,466	7,664	7,752	8,359	8,861	9,568	10,119	10,721	11,427
56-60 yrs	8,187	9,536	10,043	10,095	10,988	11,793	12,827	13,646	14,497	15,521
61-65 yrs	10,183	12,078	12,778	12,880	14,065	15,133	16,540	17,606	18,711	20,029
66-70 yrs	13,111	15,503	16,495	16,642	18,424	20,086	22,121	23,679	25,303	27,152
70+ yrs	14,751	18,515	19,771	20,007	22,559	24,854	27,582	29,673	31,724	34,172

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Age\Sum Insured	5,50,000	6,00,000	6,50,000	7,00,000	7,50,000	8,00,000	8,50,000	9,00,000	9,50,000	10,00,000
91 days-18 yrs	3,151	3,274	3,385	3,492	3,596	3,697	3,795	3,890	3,997	4,085
19-35 yrs	4,141	4,304	4,447	4,586	4,719	4,850	4,983	5,103	5,233	5,348
36-45 yrs	5,297	5,512	5,703	5,885	6,053	6,227	6,398	6,557	6,727	6,879
46-50 yrs	8,895	9,327	9,717	10,087	10,440	10,780	11,112	11,418	11,753	11,989
51-55 yrs	11,924	12,454	12,934	13,388	13,818	14,235	14,626	14,992	15,364	15,623
56-60 yrs	16,354	17,134	17,842	18,515	19,154	19,762	20,345	20,893	21,471	21,775
61-65 yrs	20,974	21,995	22,924	23,811	24,657	25,467	26,247	26,989	27,795	28,140
66-70 yrs	28,288	29,746	31,079	32,357	33,585	34,768	35,912	37,012	38,195	38,671
70+ yrs	35,637	37,513	39,235	40,887	42,476	44,010	45,493	46,925	48,470	48,915

20. Premium Loadings:

The Company may apply a risk loading on the premium payable (based upon the declarations made in the proposal form, medical history noted during the TeleMER and the health status of the persons proposed for insurance).

The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person.

The loading shall only be applied basis an outcome of the Company's medical underwriting.

These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with the Company or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

a. The Company will inform Insured Person about the applicable risk loading through a counter offer letter.

b. Insured Person need to revert to the Company with consent and additional premium (if any), within 30 days of the issuance of such counter offer letter.

c. In case, you neither accept the counter offer nor revert to the Company within 30 days, the Company shall cancel Insured Person's 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 the Company will issue Policy only after getting Insured Person consent.

21. Cancellation:

c) 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 30 days	75.00%
31 to 90 days	50.00%
3 to 6 months	25.00%
6 to 12 months	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 the Insured person under the Policy.

d) The Company may cancel the Policy at any time on grounds of mis -representation, 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 mis -representation, non-disclosure of material facts or fraud.

22. Grievance Redressal Procedure:

We are committed to extend the best possible services to You. However, if you are not satisfied with our services and wish to lodge a complaint, please call our 24X7 Toll free number 1800-266-7780 or 1800 22 9966 (For Senior Citizens) or you may email to the customer service desk at customersupport@tataaig.com.

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.

Disclaimer: "Insurance is the subject matter of the solicitation". For more details on benefits, exclusions, limitations, terms & conditions, please refer 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 - 400 013.
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 | UIN: TATHLIP20169V011920

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	5037	5,00,000	5037	0%	5037	5,00,000	5037	32%	3446	5,00,000
37	5067	5,00,000	5037	0%	5037	5,00,000	5037		3446	
19	3971	5,00,000	3971	0%	3971	5,00,000	3971		2700	
15	3019	5,00,000	3019	0%	3019	5,00,000	3019		2053	
	Total Premium for all members of the family is ₹ 17,124 when each member is covered separately		Total Premium for all members of the family is ₹ 17,124 when they are covered under a single policy				Total Premium when policy is opted on floater basis is ₹ 11,644			
	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

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