Prospectus
Kotak Health Super Top Up - Prime

1. WHAT WE WILL PAY (SCOPE OF COVER OF BENEFITS AVAILABLE UNDER THE POLICY)

The Benefits available under this Policy are described below. Benefits will be payable in excess of Deductible stated in the Policy Schedule, subject to

i) availability of Base Annual Sum Insured and Cumulative Bonus
ii) the terms, conditions and exclusions of this Policy and
iii) any sub-limits specified in respect of that Benefit and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule.

1.1 In-patient Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization that occurs during the Policy Period following an Illness or Injury provided that:

(a) The Hospitalisation is for a minimum and continuous period of 24 hours
(b) the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(c) the Medical Expenses incurred are Reasonable and Customary;

1.2 Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment that occurs during the Policy Period following an Illness or Injury provided that:

(a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(b) the Medical Expenses incurred are Reasonable and Customary ;
(c) We will only cover the Medical Expenses for those Day Care Treatments which are listed in Annexure II of the Policy. The complete list of Day Care Treatments covered is also available on Our website [www.kotakgeneralinsurance.com];
(d) We will not cover any OPD Treatment under this Benefit.

1.3 Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses that occurs during the Policy Period following an Illness or Injury provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;
(b) We will not be liable to pay Pre-Hospitalisation Medical Expenses for more than 30 days preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;

(c) We will not be liable to pay Post-Hospitalisation Medical Expenses for more than 60 days immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

1.4 Ambulance Cover

We will indemnify the Ambulance Charges incurred up to Rs. 2000 per Hospitalization, for the reasonable expenses incurred by You on availing ambulance services offered by a healthcare or Ambulance service provider for you necessary transportation to the Hospital for treatment of an Illness or Injury following an Emergency provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the Ambulance service relates to the same illness / medical condition
(b) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;
(c) We will also provide cover under this Benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.
(d) The limit under Ambulance cover is applicable for each claim admitted under the policy.

1.5 Organ Donor Cover

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ provided that:

(a) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules;
(b) The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advise;
(c) We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;
(d) The payment under this benefit is within the opted Base Annual Sum Insured.
(e) We will not cover expenses towards the donor in respect of:
    (i) Any Pre-Hospitalization Medical Expenses or Post-Hospitalization Medical Expenses;
    (ii) Costs directly or indirectly associated to the acquisition of the organ;
    (iii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

1.6 Alternative Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment up to INR 50,000/- provided that:
(a) The Alternative Treatment is administered by a Medical Practitioner;
(b) The Insured Person is admitted to Hospital as an Inpatient for the Alternative Treatment to be administered.

(c) The payment under this benefit is within the opted Base Annual Sum Insured.
(d) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy.

1.7 Restoration of Sum Insured

We will provide a 100% restoration of the opted Base Annual Sum Insured once in a Policy Year if the opted Base Annual Sum Insured and the Cumulative Bonus (if any) is insufficient as a result of previous Claims in that Policy Year, provided that:

(a) The restored Base Annual Sum Insured will only be available for future Claims under the Policy and not in respect of any Illness (including its complications) for which a Claim has already been accepted / paid in that Policy Year for the same person;
(b) No Cumulative Bonus will apply on the restored Base Annual Sum Insured;
(c) The restored Base Annual Sum Insured will apply to all Insured Persons on the same basis as the opted Base Annual Sum Insured;
(d) Any restored Base Annual Sum Insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;
(e) Restoration of Sum Insured will be in addition to opted Base Annual Sum Insured.
(f) In case of Individual policy, payment under this cover shall be available on Individual basis and In case of floater the payment shall be available on floater basis.
(g) The restored Base Annual Sum Insured will not be available, in case of admissible claim under 1.8 “Double Sum Insured for Hospitalization due to Accident”.

1.8 Double Sum Insured for Hospitalization due to Accident

We will indemnify Medical Expenses incurred in respect of the Insured Person’s Hospitalization during the Policy Period in respect of an Injury sustained solely and directly due to an Accident which occurs during the Policy Period upto the Sum Insured mentioned in the Policy Schedule, against this cover and up to the maximum limit of INR 40 lakhs provided that:

(a) In calculating the amount available to the Insured Person under this Cover, We shall deduct any amount previously paid from available Sum Insured during the Policy Year;
(b) The amount calculated under this Cover shall not be available for Medical Expenses incurred for treatment of any other Illness;
(c) The amount calculated under this Cover shall not be available for payment of benefits under any provision other than the In-patient Treatment cover under the Policy;
(d) The payment under this benefit is over and above the opted Base Annual Sum Insured.

If this amount is un-utilised (in whole or in part) in any Policy Year, it shall not be carried forward to any subsequent Policy Year.

Kotak Mahindra General Insurance Company Ltd.
CIN: U66000MH2014PLC260291; Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai - 4000051. Office: 8th Floor, Zone IV, Kotak Infiniti, Bldg. 21,Infinity IT Park, Off WEH, Gen. AK Vaidya Marg, Dindoshi, Malad (E), Mumbai – 400097. India.
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1.9 Cumulative Bonus

We will increase Your Base Annual Sum Insured by 10% at the end of the Policy Year if the Policy is renewed with Us provided that:

(a) If the Policy is a Family Floater Policy, then the Cumulative Bonus will accrue only if no claims have been made in respect of all the Insured Persons in the expiring Policy Year;
(b) If the Policy is an Individual policy, then Cumulative Bonus will accrue only if no claim has been made in the expiring Policy Year in respect of that Insured Person;
(c) The Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;
(d) If any Claim is made under the Policy after a Cumulative Bonus has been applied under the Policy, then the accrued Cumulative Bonus under the Policy will reduce by 10% on the commencement of the next Policy Year or the next Renewal of the Policy (as applicable);
(e) The Cumulative Bonus will not accrue in excess of 50% of the Base Annual Sum Insured;
(f) If the Base Annual Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated based on the Base Annual Sum Insured of the immediately completed Policy Year;
(g) If the Base Annual Sum Insured is reduced at the time of Renewal, then the applicable cumulative bonus will be applicable on the renewed policy Base Annual Sum Insured.
(h) Cumulative bonus will be carried forward to the next policy year, provided the Insured Person renews the policy before the expiry of the grace period.

If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.

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2. SAILENT FEATURES

<table>
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<tr><td>Plan</td><td colspan="2">Prime</td></tr>
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<tr><td>Entry Age:</td><td colspan="2">91 Days</td></tr>
<tr><td>Maximum Entry Age:</td><td colspan="2">65 Years</td></tr>
<tr><td>Maximum Entry age for dependent children</td><td colspan="2">25 Years</td></tr>
<tr><td>Exit Age / Renewal</td><td colspan="2">The Policy provides for life-long renewal</td></tr>
<tr><td>Annual Sum Insured & Deductible</td><td colspan="2">
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<tr><td>4 lakhs</td><td>6 lakhs</td><td>11 lakhs</td><td>16 lakhs</td><td></td></tr>
<tr><td>5 lakhs</td><td>5 lakhs</td><td>10 lakhs</td><td>15 lakhs</td><td>20 lakhs</td></tr>
<tr><td>10 lakhs</td><td>20 lakhs</td><td>25 lakhs</td><td>30 lakhs</td><td>40 lakhs</td></tr>
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<tr><td rowspan="9">Basic Covers</td><td>In-patient Treatment</td><td>Upto opted Base Annual Sum Insured</td></tr>
<tr><td>Day Care Treatment</td><td>405 listed Day care procedures</td></tr>
<tr><td>Pre-Hospitalization Medical Expenses</td><td>Upto 30 days</td></tr>
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<tr><td>Ambulance Cover</td><td>Rs. 2000/- per event.</td></tr>
<tr><td>Organ Donor Cover</td><td>Upto opted Base Annual Sum Insured</td></tr>
<tr><td>Alternative Treatment</td><td>up to Rs.50,000/- (subject to availability of opted Base Annual Sum Insured)</td></tr>
<tr><td>Restoration of Sum Insured</td><td>Upto opted Base Annual Sum Insured</td></tr>
<tr><td>Double Sum Insured for Hospitalization due to Accident</td><td>Double of opted Base Annual Sum Insured up to the maximum limit of INR 40 lakhs.</td></tr>
<tr><td>Cumulative Bonus</td><td>10% of the Sum Insured for each claim free year, upto a maximum of 50%</td></tr>
<tr><td>Policy Period</td><td colspan="2">1/2/3 years</td></tr>
<tr><td>Premium Rate</td><td colspan="2">Premium rate is as per Annexure_2.1_Annexure to prospectus</td></tr>
<tr><td rowspan="2">Policy Type</td><td colspan="2">Individual/ Floater</td></tr>
<tr><td colspan="2">Available for all Sum Insured Options</td></tr>
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Waiting period for Pre-existing Illnesses	24 months for all age groups
Relationship Covered	
For Individual	Self, Spouse, Dependent children, Dependent parents, Employer, Employee
For Family Floater*	Self, Spouse, Dependent children, Dependent parents, Dependent Parents in law, Employer, Employee
Pre-Policy Medical Check-up	We will require the insured person to undergo a medical check-up based on age and the Sum Insured opted, Wherever any pre-existing disease or any other adverse medical history is declared, We may ask such member to undergo specific tests as we may deem fit to evaluate such member. Medical tests will be facilitated by us and conducted at Our network of diagnostic centers. The validity of such tests will be up to 30 days.

*Dependent Child under family floater policies after completion of 25 years shall be considered as adult for premium computation.

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3. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE UNDER THE POLICY)

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based upon, arising out of or howsoever attributable to any of the exclusions listed below. All waiting periods will apply individually to each Insured Person:

3.1 Pre-Existing Diseases (Code – Excl01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48/ 36/ 24 months (as mentioned in the Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.
ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
iii. 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.
iv. Coverage under the policy after the expiry of 48 / 36/ 24 months (as mentioned in the Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3.2 30 Day Waiting Period (Code – Excl03)

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.

3.3 Specified disease/ procedure waiting period (Code – Excl02)

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

(a) Cataract*;
(b) Benign Prostatic Hypertrophy;
(c) Myomectomy, Hysterectomy unless because of malignancy;
(d) All types of Hernia, Hydrocele;
(e) Fissures and/or Fistula in anus, haemorrhoids/piles;
(f) Arthritis, gout, rheumatism and spinal disorders;
(g) Joint replacements unless due to Accident;
(h) Sinusitis and related disorders;
(i) Stones in the urinary and biliary systems;
(j) Dilatation and curettage, Endometriosis;
(k) All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
(l) Dialysis required for chronic renal failure;
(m) Surgery on Tonsilitis, adenoids and sinuses;
(n) Gastric and duodenal erosions and ulcers;
(o) Deviated nasal septum;
(p) Varicose Veins/ Varicose Ulcers.

*Our maximum liability for any Claim for an Insured Person's cataract treatment shall not exceed INR 20,000 per eye, during each Policy Year of the Policy Period.

3.4 Permanent Exclusions:

(a) Up to Deductible amount mentioned

(b) 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

(c) 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.

(d) 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

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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
        iv. Uncontrolled Type2 Diabetes

(e) 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.

(f) 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.

(g) 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.

(h) 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.

(i) 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.

(j) Code- Excl12

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

(k) Code- Excl13

Treatments received in health 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.

(l) Code- Excl14

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.

(m) Refractive Error (Code- Excl15)

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

(n) 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.

(o) 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

(p) **Maternity (Code- Excl18)**

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

(q) Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;

(r) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;

(s) Expenses incurred on all dental treatment unless necessitated due to an Accident;
(t) Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services;
(u) Acupressure, acupuncture, magnetic and such other therapies;
(v) Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;
(w) Vaccination or inoculation of any kind, unless it is post animal bite;
(x) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
(y) Treatment relating to Congenital external Anomalies;
(z) any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition
(aa) Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;
(bb) Any expenses arising out of Domiciliary Hospitalization;
(cc) Any treatment taken outside India;
(dd) Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;
(ee) Any consequential or indirect loss arising out of or related to Hospitalization;
(ff) Any Injury or Illness directly or indirectly caused by or arising from or attributable to 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;
(gg) Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;
(hh) All non-medical expenses listed in Annexure III (List I) of the Policy.
(ii) Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

4. CLAIM ADMINISTRATION

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be conditions precedent to admission of Our liability under this Policy:

(a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;
(b) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person;

(c) We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;

(d) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

5. CLAIMS PROCEDURE

On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to Our liability under the Policy the following procedure shall be complied with:

5.1 For Cashless Facility

Cashless Facility is only available at a Network Provider. The complete list of Network Providers is available on Our website (The list is updated as and when there is any change in the Network Provider) or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

(a) Pre-authorization for Planned Hospitalization:

At least 48 hours prior to a planned Hospitalization, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that planned Hospitalisation. Each such request must be accompanied by all the following details:

(i) The Health Card We have issued to the Insured Person;
(ii) The Policy Number;
(iii) Name of the Policyholder;
(iv) Name and address of Insured Person in respect of whom the request is being made;
(v) Nature of the Illness/Injury and the treatment/surgery required;
(vi) Name and address of the attending Medical Practitioner;
(vii) Hospital where treatment/surgery is proposed to be taken;
(viii) Proposed date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

Turn Around Time (TAT) for issue of Pre-Authorization within 6 hours from receipt of complete documents

In Case of Claim Contact Us at:
24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@kotak.com

In the event of claims, please send the relevant documents to:
Family Health Plan (TPA) Ltd,
Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad, 500 034.

(b) Pre-authorization for Emergency Care:

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

(i) The Health Card We have issued to the Insured Person;
(ii) The Policy Number;
(iii) Name of the Policyholder;
(iv) Name and address of Insured Person in respect of whom the request is being made;
(v) Nature of the Illness/Injury and the treatment/surgery required;
(vi) Name and address of the attending Medical Practitioner;
(vii) Hospital where treatment/surgery is being taken;
(viii) Date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/ Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre-authorisation as there is insufficient Base Annual Sum Insured there is insufficient information to determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

Turn Around Time (TAT) for settlement of Reimbursement is within 15 days from the receipt of the complete documents.

5.2 For Reimbursement Claims

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

(a) The Policy Number;
(b) Name of the Policyholder;
(c) Name and address of the Insured Person in respect of whom the request is being made;
(d) Nature of Illness or Injury and the treatment/surgery taken;
(e) Name and address of the attending Medical Practitioner;
(f) Hospital where treatment/surgery was taken;
(g) Date of Admission and date of discharge;
(h) Any other information that may be relevant to the Illness/ Injury/ Hospitalization**.**

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

6. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided with these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

(a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
(b) Original Pre – authorization request
(c) Copy of Pre – authorization approval letter
(d) Copy of the photo identity document of the Insured Person;
(e) Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner;
(f) Original bills from chemists supported by proper prescription;
(g) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
(h) Indoor case papers (if available);
(i) Medical Practitioner's referral letter advising Hospitalization in non-Accident cases and referral slip for all investigations carried out;
(j) Hospital discharge summary;
(k) FIR (if done) or MLC (if conducted) for Accident cases;
(l) Post mortem report (if applicable and conducted);
(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

7. CLAIMS FOR PRE-HOSPITALISATION MEDICAL EXPENSES AND POST-HOSPITALISATION MEDICAL EXPENSES

(a) All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Investigation Payment Receipt
(iii) Original Investigation Report
(iv) Original Pharmacy Bills
(v) Original Pharmacy Prescription
(vi) Copy of Discharge Summary

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Investigation Payment Receipt
(iii) Original Investigation Report
(iv) Original Pharmacy Bills
(v) Original Pharmacy Prescription
(vi) Copy of Discharge Summary

(c) If the Claim is not notified to Us within these specified timeframes, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

8. 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 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)

PART III OF THE POLICY

General Terms and Conditions

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Material Change

Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

5. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

6. Terms and condition of the Policy

The terms and conditions contained herein and in the Policy Schedule / Certificate of Insurance shall be deemed to form part of the Policy and shall be read together as one document.

7. Multiple Policies:

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

8. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

9. Limitation of Liability

If a Claim is rejected or partially settled under the terms of the Policy and is not the subject of a pending suit or other proceedings within the applicable period specified under the Limitation Act 1963 (as amended and any other applicable law), the Claim shall be deemed to have been closed and Our liability in respect of it shall be extinguished.

10. Underwriting and Loadings

We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levies & taxes) based on declarations on proposal form, your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent on the applicable additional premium.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 100% of Premium excluding applicable Taxes
In case policies are accepted with loadings, waiting period for Pre-Existing Disease Waiting Period (Section 3.1) as well as 2 Year Waiting Period (Section 3.3) shall continue to be applicable.

11. 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

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

12. Cancellation

i. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.
For Policyholder's initiated cancellation, the Company would compute refund amount as pro-rata (for the unexpired duration) premium. This would further be deducted by 25% of computed refundable premium.

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.

ii. 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.

13. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

Kotak Mahindra General Insurance Company Ltd.
CIN: U66000MH2014PLC260291; Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai - 4000051. Office: 8th Floor, Zone IV, Kotak Infiniti, Bldg. 21,Infinity IT Park, Off WEH, Gen. AK Vaidya Marg, Dindoshi, Malad (E), Mumbai – 400097. India.
IRDAI Reg. No. 152

14. Policy Disputes

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

15. 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: IRDAI/HLT/REG/CIR/003/01/2020

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 atleast 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: IRDAI/HLT/REG/CIR/003/01/2020

17. 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 atleast 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.

18. Withdrawal of 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.

19. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

20. Communications & Notices

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

In Your case, at Your last known address per Our records in respect of this Policy.

In Our case, at Our address specified in the Policy Schedule.

No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

21. Customer Service

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

22. Premium Payment in Instalments: If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, 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 instalment premium due for the policy.

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

iii. 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.

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

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

23. ECS/ Auto Debit Payment Facility:

You are eligible for availing the ECS / Auto Debit payment facility for your premium payments under this Policy. This facility can be opted for automatic premium payment under this Policy for such premium paying term as availed by you under this Policy by submitting a duly signed ECS / Auto Debit mandate form. You may opt for any premium payment term as per your convenience but in accordance with the Policy terms and conditions. Please note that this facility may not be available for all the Banks at present however and you are requested to kindly visit website: www.kotakgeneralinsurance.com to check the updated list of all partner banks facilitating the ECS /Auto Debit facility from time to time. Additionally, the following conditions shall apply in case of ECS / Auto Debit facility opted by you –

a. The premium payment under the Policy shall be subject to change on renewal which would be in accordance with the terms and conditions of the Policy
b. The Policy shall get cancelled in the event of failure of ECS transaction towards payment of premium under the Policy and/or non-receipt of premium within the Grace Period under the Policy
c. The renewal premium amount under the Policy shall be communicated to you in advance i.e. minimum 45 days before the renewal date
d. You have the right to withdraw the ECS /Auto Debit mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The term ECS / Auto Debit herein shall be governed by the Electronic Clearing Service (Debit) Procedural Guidelines issued by the Reserve Bank of India (as may be amended from time to time) and shall mean an electronic facility for effecting periodic insurance premium payment transactions in an automated manner.

24. 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.

25. 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.

26. 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.

27. Redressal of Grievance

In case of any grievance the insured person may contact the company through
Website: www.kotakgeneralinsurance.com
Toll free: 18002664545
E-mail: care@kotak.com
Fax: 022-28401823
Courier: Kotak General Insurance 2nd Floor, Zone II, Building No.21, Infinity IT park, Off Western Express Highway, Goregaon, Mulund Link Road, 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 grievanceofficer@kotak.com
For updated details of grievance officer, kindly refer the link:
https://www.kotakgeneralinsurance.com/customer-support/grievance-redressal-process

For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@kotak.com

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 for redressal of grievance as per Insurance Ombudsman Rules 2017.

The details of the Insurance Ombudsman is available at:
https://www.kotakgeneralinsurance.com/customer-support/grievance-redressal-process
The updated details of Insurance Ombudsman offices are also available on the website of Executive Council of Insurers: www.ecoi.co.in/ombudsman.html
The details of the Insurance Ombudsman is available at Annexure I

Grievance may also be lodged at IRDAI Integrated Grievance Management System –
https://igms.irda.gov.in/

28. Statutory Warning - Prohibition Of Rebates (Under Section 41 of Insurance Act 1938)

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.

Kotak Mahindra General Insurance Company Ltd.
CIN: U66000MH2014PLC260291; Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai - 4000051. Office: 8th Floor, Zone IV, Kotak Infiniti, Bldg. 21,Infinity IT Park, Off WEH, Gen. AK Vaidya Marg, Dindoshi, Malad (E), Mumbai – 400097. India.
IRDAI Reg. No. 152

Benefit Illustration in respect of policies offered on individual and family floater basis

Kotak Health Super Top Up (UIN: KOTHLIP21162V032021) Plan: Excel
Sum Insured - **5 lacs**; Deductible - **5 lacs**; Coverage for - **2A + 2C**

Age of the members insured	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 the entire family)			
	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount, if any	Premium after Discount (₹)	Sum Insured (₹)
Member 1 - Age - 36	1,650	5,00,000	1,650	NA	1,650	5,00,000	3,550	NA	NA	5,00,000
Member 2 - Age - 26	1,400	5,00,000	1,400	NA	1,400	5,00,000				
Member 3 - Age <20	1,300	5,00,000	1,300	NA	1,300	5,00,000				
Member 4 - Age <20	1,300	5,00,000	1,300	NA	1,300	5,00,000				
	Total Premium for all members of the family is ₹5,650/-, when each member is covered separately. Sum insured available for each individual is ₹5,00,000/-		Total Premium for all members of the family is ₹5,650/-, when they are covered under a single policy. Sum insured available for each family member is ₹5,00,000/-				Total Premium when policy is opted on floater basis is ₹3,550/- Sum insured of ₹5,00,000/- is available for the entire family.			
Member 1 - Age - 56	5,300	5,00,000	5,300	NA	5,300	5,00,000	11,350	NA	NA	5,00,000
Member 2 - Age - 46	2,950	5,00,000	2,950	NA	2,950	5,00,000				
Member 3 - Age <20	1,300	5,00,000	1,300	NA	1,300	5,00,000				
Member 4 - Age <20	1,300	5,00,000	1,300	NA	1,300	5,00,000				
	Total Premium for all members of the family is ₹10,850/-, when each member is covered separately. Sum insured available for each individual is ₹5,00,000/-		Total Premium for all members of the family is ₹10,850/-, when they are covered under a single policy. Sum insured available for each family member is ₹5,00,000/-				Total Premium when policy is opted on floater basis is ₹11,350/- Sum insured of ₹5,00,000/- is available for the entire family.			
Member 1 - Age - 66	9,850	5,00,000	9,850	NA	9,850	5,00,000	21,200	NA	NA	5,00,000
Member 2 - Age - 61	7,750	5,00,000	7,750	NA	7,750	5,00,000				
Member 3 - Age <20	1,300	5,00,000	1,300	NA	1,300	5,00,000				
Member 4 - Age <20	1,300	5,00,000	1,300	NA	1,300	5,00,000				
	Total Premium for all members of the family is ₹20,200/-, when each member is covered separately. Sum insured available for each individual is ₹5,00,000/-		Total Premium for all members of the family is ₹20,200/-, when they are covered under a single policy. Sum insured available for each family member is ₹5,00,000/-				Total Premium when policy is opted on floater basis is ₹21,200/- 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.										

The Benefit Illustration given above shows premium only for base covers. Optional Covers are available at an extra cost. Please get in touch with the company representative by calling on 1800 266 4545 / writing at care@kotak.com for more details.
This illustration is indicative. For customised Benefit Illustration for your opted plan and sum insured please visit our website www.kotakgeneralinsurance.com.