Kotak Mahindra General Insurance Company Ltd. (Formerly Kotak Mahindra General Insurance Ltd.)
Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai - 400051. Maharashtra, India.

Kotak Health Premier
Prospectus
Key Highlights Of The Policy (covers)

Covers will be available to the Insured Person, only if that particular cover is specifically mentioned in the Policy Schedule and as per the Plan opted by the Insured Person

In-patient Treatment	Day Care Treatment	Pre-Hospitalization Medical Expenses	Post-Hospitalization Medical Expenses
Ambulance Cover	Organ Donor Cover	Alternative Treatment	Domiciliary Hospitalisation
Annual Health Check-up	Restoration Benefit	Cumulative Bonus	Second E-Opinion Cover
Health and Rewards	Value Added Benefits	Hospital Daily Cash	Convalescence Benefit
Home Nursing Benefit	Daily Cash for Accompanying an Insured Child	Compassionate Visit	Maternity Benefit
New Born Baby Cover	Vaccination Expenses	Air Ambulance Cover	Cap on Room Rent
Critical Illness Cover		Personal Accident Cover	

1. SAILENT FEATURES OF THE POLICY

Eligibility	
Entry Age:	91 Days for Child and 18 years for Adult
Maximum Entry Age:	65 Years for Adult
Maximum Entry age for children	25 years, after which the Child will be considered as an Adult
Exit Age / Renewal	The Policy provides for life-long renewal
Sum Insured	The sum insured would range from Rs. 2 Lacs to Rs. 200 Lacs
Policy Period	1/2/3 years
Policy Type	Individual/ Family Floater
	For 2 lacs Sum Insured only Individual option is available
Relationship Covered	
For Individual	In case of an Individual Policy, each Insured person under the policy will have a separate sum insured. Relationships covered: Self, Your legally married spouse, Your natural or adopted dependent children, Your parents, Your parents-in-law and Your siblings, Employer-Employee Natural/ Appointed Guardian can also take insurance for minor under their guardianship
For Family Floater (*)	In case of a Family Floater policy, one family will share a single Sum Insured. A Family Floater policy can cover a maximum of 2 adults and3 dependent children under a single policy. Relationships covered:Self, Your legally married spouse, Your natural or adopted dependent children, Your parents, Your parents-in-law and Your siblings, Employer-Employee Natural/ Appointed Guardian can also take insurance for minor under their guardianship
Premium Rate	Premium rate is as per Annexure_2.1_Annexure to prospectus
Instalment Facility	Quarterly, Monthly and Half-yearly
Waiting period for Pre-existing Diseases	As per Plan opted

Discounts and Loadings under the Policy	• Discounts
	  • Long Term Discount –
	  o 2 year policy - 2.5%
	  o 3 year policy - 5%
	  • Kotak Group Employees – 5%
	  • Online Policy Issuance – 2.5%
	  • Family Discount(Not applicable for Floater Policies) –
	  o 2 eligible members - 2.5%
	  o More than 2 members - 5%
	  • Cross Sell Discount(Applicable if the policyholder has one live policy) –10%
	• Loadings
	  • Instalment facility(Applicable for one year policies)–
	  o Monthly Premium - 10.00%
	  o Quarterly Premium - 7.50%
	  o Semi Annual Premium - 4.00%
	  • Pre-Existing Disease Waiting Period
	  o Reducing the waiting period from 48 months to 36 months: 7%
	  o Reducing the waiting period from 48 months to 24 months: 20%
	  o Reducing the waiting period from 36 months to 24 months: 12.15%

<table>
<tr><td>Pre-Policy Medical check-up</td><td>
<table>
<tr><td>Sum Insured</td><td>2/ 3/4 /5 Lacs</td><td>10 lacs</td><td>15/ 20/ 25 Lacs</td><td>50/ 75/ 100/ 150/ 200 Lacs</td></tr>
<tr><td>Age</td><td>51 Years & Above</td><td>51 Years & Above</td><td>36 Years & Above</td><td>All ages</td></tr>
</table>
In addition to the above, based on the declarations made in the proposal form and the medical assessment done by the Underwriter, the customer may be requested to undergo medical tests.
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. If we accept your proposal, we will reimburse 50% of the cost of such pre-insurance medical tests.
The charges of the medical test and the centre at such tests shall be conducted will be informed to you before the medical examination.
</td></tr>
<tr><td>Underwriting Loading</td><td>Underwriting loading up to 200% based on criteria mentioned in underwriting manual.</td></tr>
</table>

- Dependent Child under family floater policies after completion of 25 years shall be considered as adult for premium computation.
- 80 D benefit will not be available if any member other than self, spouse, dependent children, parents covered under Family Floater Policy
- In case of Individual Policy, if any member other than self, spouse, dependent children, parents are covered then 80D benefit will not be available to these members.

2. COVERS AVAILABLE UNDER THE POLICY

The Covers available under this Policy are described below. Covers will be available to the Insured Person, only if that particular cover is specifically mentioned in the Policy Schedule as per the Plan opted by You, subject to

I) availability of Base Sum Insured and Cumulative Bonus(if any)
ii) the terms, conditions and exclusions of this Policy and
iii) any sum insured or sub-limits specified in respect of that Cover and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule

2.1 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 hour
(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 and may be for one or more of the following:
    i. Room Rent and other boarding charges;
    ii. ICU Charges;
    iii. Operation theatre expenses;
    iv. Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
    v. Qualified Nurses' charges;
    vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
    vii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized
    viii. Anaesthesia, blood, oxygen and blood transfusion charges;
    ix. Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
    x. Inpatient physiotherapy charges;

2.2 Day Care Treatment

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

Further,

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

2.3 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 following an Illness or Injury that occurs during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy and the Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;

Further,

(a) We will pay Pre-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;
(b) We will pay Post-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

2.4 Ambulance Cover

We will indemnify the amount incurred up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You on availing ambulance services offered by a healthcare or Ambulance service provider for your 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;

Further,

(a) 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.
(b) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.5 Organ Donor Cover

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;
(b) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other

applicable laws and rules;

(c) The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advise;

Further,

(a) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

(b) 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.

2.6 Alternative Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) The Alternative Treatment is administered by a Medical Practitioner;

(b) The Insured Person is admitted to Hospital(For AYUSH treatment) as an Inpatient for the Alternative Treatment to be administered.

Further,

(a) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.7 Domiciliary Hospitalisation

We will indemnify the Medical Expenses incurred on the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) We will cover medical expenses of an Insured person for treatment of a disease, Illness or Injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable.

(b) The domiciliary hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner

(c) The Medical Expenses incurred are Reasonable and Customary Charges;

(d) The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses from the first day of Domiciliary Hospitalisation;

Further,

(a) We shall not indemnify for any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions under this Cover:
   i. Asthma;
   ii. Bronchitis;
   iii. Chronic Nephritis and Chronic Nephritic Syndrome;
   iv. Diarrhoea and all types of Dysenteries including Gastro- enteritis;
   v. Diabetes Mellitus and Insipidus;
   vi. Epilepsy;
   vii. Hypertension;
   viii. Influenza, cough and cold;
   ix. All psychiatric or psychosomatic disorders;
   x. Pyrexia of unknown origin for less than 10 days;
   xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
   xii. Arthritis, Gout and Rheumatism.

(b) In case of Individual Policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.8 Annual Health Check-up

We will arrange for one free health check-up at Our Network Provider for each Insured Person that is above 18 years of Age, for each Policy Year for the specified tests. Availing the Annual Health Check-up will not impact the Base Sum Insured or the Cumulative Bonus. This will be offered regardless of any claim admitted/ registered under the Policy.

The health check-up will consist of the following tests for all eligible Insured Persons, however, these tests are subject to revision at Our discretion and will be communicated to Insured Person(s).

(a) CBC;
(b) MER;
(c) Serum Cholesterol;
(d) Serum Creatinine;
(e) SGPT/SGOT
(f) ECG;
(g) Random Blood Sugar.

2.9 Restoration Benefit

We will provide a 100% restoration of the Base Sum Insured amount once in a Policy Year if the Base 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 sum insured will not be available in respect of any Illness (including its complications) for which a Claim has already been accepted / paid in that Policy Year for the same Insured Person.

(b) The restoration of sum insured shall not apply to the first claim in that Policy Year unless related to an Injury due to Accident where the claim amount exceeds the Base Sum Insured.

Further,

(a) No Cumulative Bonus will apply on the restored sum insured;

(b) The restored sum insured will apply to all Insured Persons on the same basis as the Base Sum Insured i.e. individual sum insured in case of Individual Policy and floater sum insured in case of Floater Policy;

(c) Any restored sum insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;

(d) Restoration of sum insured will be in addition to the Base Sum Insured.

2.10Cumulative Bonus

We will increase Your Base Sum Insured by 10% subject to the maximum limit specified in the Policy Schedule at the end of the Policy Year if the Policy is renewed with Us provided that:

(a) Cumulative Bonus will accrue only if no claims have been made in respect of the Insured Person(s) in the expiring Policy Year;

(b) 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;

Further,

(a) If the Base Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated on the Base Sum Insured of the immediately completed Policy Year;

(b) If the Base Sum Insured is reduced at the time of Renewal, then the applicable Cumulative Bonus will be applicable on the renewed policy Base Sum Insured.

(c) Cumulative Bonus will be carried forward to the next Policy Year, provided the Insured Personrenews the Policy before the expiry of the Grace Period.

(d) 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.

(e) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.

(f) If the Insured Persons in the expiring Policy are covered on a floater basis and such Insured Persons renew their expiring Policy with Us into two or more floater/individual policies then the Cumulative Bonus of

the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Base Sum Insured of each Renewed Policy.

(g) Any earned Cumulative Bonus shall not be available for claims under Maternity Benefit, New Born Baby Cover, Vaccination Expenses, Critical Illness Cover and Personal Accident Cover.

(h) The Cumulative Bonus is provisional and is subject to revision if a Claim is made after the acceptance of renewal premium in respect of the expiring Policy Year. . Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the Claim was admitted. Cumulative Bonus will be provided if any Claim made under the Policy has been repudiated/withdrawn.

2.11Second E-Opinion Cover

We will facilitate the Insured person for availing a Second E-Opinion on his / her medical condition occurring during the Policy Period, provided that:

(a) We shall only provide access to an E-opinion and this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;

Further,

(a) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(b) The Insured person is free to choose whether or not to obtain the expert opinion and if obtained whether or not to act on it

2.12 Health and Rewards

We will provide incentives to reward the Insured Person(s) for taking care of his her health/fitness through regular preventative and wellness habits. You can earn reward points for the activities mentioned below. The activities may attract additional charges (decided at Our discretion) to be directly payable by You. The activities undertaken by You will be rewarded by Us in the form of reward points as per the terms and conditions mentioned below. You can redeem these reward points in accordance with the redemption terms and conditions.

- **List of Wellness Activities:**

(a) Health Risk Assessment (HRA)

Health Risk Assessment questionnaire is used as a tool for evaluation of health and quality of life. It helps you to understand your lifestyle and its impact on your health status. The HRA will be an online assessment provided by Us through vendor tie-ups. This can be undertaken only once per Insured Person in a Policy Year.

You can earn 250 reward points on completion of HRA per Insured Person,in case of Individual Policy and maximum up to 500 reward points per family in case of Floater Policy in a Policy Year.

Insured Person(s)only above 18 years of Age will be eligible to undergo HRA.

However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.

We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made thereby.

(b) Health Check-Up

The Company provides for health check-up as per Benefit 2.8 Annual Health Check-Up. You will be provided reward points for undergoing the Health Check-Up. We will facilitate in booking the appointment and arrange for the check-up through any of our Network Providers.

You can earn 500 reward points for undergoing Health Check-Up per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy in a Policy Year. If the result of all themedical test parameters are within normal limit/ range, additional 500 reward points per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy will be awarded in a Policy Year.

However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the test and if done whether or not to act on it.

We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(c) Preventive Check-Up

You can also earn reward points by undergoing certain other diagnostic and preventive health check-up at any diagnostic centre at Your own expenses. You shall have to submit medical reports of these tests to Us.

List of the Tests eligible under this are mentioned below:

Name of the Test	Applicability
Heart related screening tests (2D echo/ TMT/ ECG)	Individual above the age of 45 years
HbA1c / Complete lipid profile	Any age
PAP Smear/ Mammogram/ CA-125	Females above the age of 40 years
Prostate Specific Antigen (PSA)	Males above the age of 45 years
Vitamin Profile test (D3, B12 and TSH)	Any age
USG whole abdomen	Any age
Kidney Function test	Any age
Renal function test	Any age
Cardiac biomarker test	Any age
Body Fat Analysis	Any age

You can earn 250 reward points for undergoing preventive check-upper test per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy in a Policy Year. If the result of themedical test parameters mentioned above are within normal limits/ range, additional 250 reward points per test per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy will be awarded in a Policy Year.One test will be considered only once for reward points during a Policy Year.

However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the test and if done whether or not to act on it.

We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(d) Fitness Initiatives

We will reward You for the following fitness & health related activities as given below which are undertaken after Policy Start Date.

Fitness Activities	Reward Points
Participation in Professional sporting events like Marathon/ Swimathon/Triathlon, etc.	500 points per event and 1000 points per Policy Year
Gym/ Yoga membership for 1 year	1000 per Policy Year
Sports Activity membership (Swimming/ Tennis/ Badminton/ for 1 year	1000 per Policy Year
Share your Fitness story	250 per Policy Year
Winning Health Quiz/ Contests organized by Us	250 per event and 500 points per Policy Year

- **Terms for Reward Point Accumulation under Health and Rewards:**

You can earn maximum 5,000 reward points per InsuredPerson in case of Individual Policy and a maximum of 10,000 reward points per family in case of Floater Policy in a Policy Year. You should notify and submit relevant documents, bills etc. for various wellness activities within sixty (60) days of undertaking such activity.

- **Redemption of Reward Points:**

  Each Reward Point will be equivalent to 0.25 Rupees.

  You can redeem these Reward points (after conversion to the equivalent rupee amount) against any of the following options:

  (i) i) Outpatient medical expenses like consultation charges, medicine & drugs, dental expenses, wellness & preventive care and other miscellaneous charges
  ii) Diagnostic expenses and health check-ups through our Network providers.

  (ii) In-patient Treatment and Day Care Treatment claims, provided that the Base Sum Insured, Cumulative Bonus and Restoration Sum Insured (if applicable) are exhausted during the Policy Year.

  (iii) Payment of Co-payment, if applicable

  (iv) Non-medical expenses listed under Annexure III

- **Terms for Redemption:**

  (a) Reward points not redeemed in the given Policy Year can be carried forward for a maximum up to 1 year from the date of expiry of the Policy Year in which they are earned.

  (b) Reward Points shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued Points (from Previous Policy Year/ month) shall be available for redemption up to 1 year from the date of cancellation of the Policy unless the policy has been cancelled by Uson grounds of misrepresentation, fraud, nondisclosure or non-cooperation of the Insured.

  (c) Reward Points cannot be redeemed for the same activity against which the Reward points were earned at first. For e.g. If reward points are earned for undergoing "Preventive Check-Up – HbA1c/ Lipid Profile" then the same points cannot be used for claiming under the diagnostic expenses for undergoing the said test.

  (d) Redemption of the rewards points can be done twice during a Policy Year.

  (e) Redemption of rewards points does not entail any cash benefit to be provided to You.

2.13 Value Added Benefits

The Benefits listed below are Value Added Benefits and shall be available to the Insured Persons specified in the Policy Schedule. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The activities may attract additional charges (decided at Our discretion) to be payable by You directly to the vendor.

Claims under this Section will not impact the Sum Insured or the eligibility for Cumulative Bonus.

VA 1	VA 2	VA 3
Online customer profile	Online customer profile	Online customer profile
Doctor directory	Doctor directory	Doctor directory
Doctor appointment	Doctor appointment	Doctor appointment
Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking
Health tips/ articles	Health tips/ articles	Health tips/ articles
Home Health	Home Health	Home Health
	E-consultation	E-consultation
		Dietician/ Nutritionist opinion

(a) Online customer profile
Based on the HRA taken and health check-ups, if any, undertaken by the Insured Person, We will maintain an online customer profile through our vendor tie-up which can be accessed by the Insured Person to review his Health status.

(b) Doctor directory
We will provide with or arrange for an online platform through our vendor tie-up for providing access to information on general physicians, specialists and super specialists.

(c) Doctor appointment
We will provide with or arrange for an online platform through vendor tie-ups for fixing up doctor appointments for the Insured Person(s).

(d) Online Pharmacy, Diagnostic tests and other Health/ Wellness Offering
We will facilitate the Insured Person for various offerings on health and wellness services like Diagnostic Centers, Pharmacy, Gymnasiums, Yoga, etc. through the Network Providers/ vendor tie-ups.

(e) Health tips/ articles
We will provide You information on various health related applications, wellness training, maintaining fitness and good health, information on various diseases, dietary plans, etc. through periodic communications and through online platform.

(f) Home Health
We will provide through vendor tie-ups, Home Health services like physiotherapy, nursing care, trained attendants and medical equipments, for the Insured Person.

(g) E-consultations
We will provide with or arrange for an online platform through vendor tie-ups for providing with E-consultations to the Insured Person.

(h) Dietician & Nutritionist opinion
We will arrange for dieticians/ nutritionists through our vendor tie-ups to provide for counselling to the Insured Person.

Terms and Conditions for 2.12 Health and Rewards and 2.13 Value Added Benefits

- Any information provided by You shall be kept confidential
- For services which are provided through empanelled medical experts/ centres/ service providers, We are only acting as a facilitator, hence We would not be liable for any incremental cost of the services.
- All medical services are being provided by empanelled medical experts/ centres/ service providers who are empanelled after full due diligence. Nonetheless, Insured Person may consult their personal doctor before availing the medical services. The decisions to utilise the services will solely be at the Insured Person's discretion.
- We/Company/Us or its group entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person/ You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
- This shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the same and if done whether or not to act on it.
- We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

2.14 Hospital Daily Cash

We will pay the daily cash amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy;

(b) The Insured Person's Hospitalization extends for at least 3 consecutive days, in which case We will make payment under this Benefit from the first day of Hospitalization;

(c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

(b) The payment under this benefit is over and above the Base Sum Insured.

2.15 Convalescence Benefit

We will pay the amount specified in the Policy Schedule for this Benefit if the Insured Person is admitted in Hospital for a minimum period of 10 consecutive days provided that:

a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalization;

Further,

(a) We shall not be liable to make payment under this Benefit in respect of an Insured Person more than once during the Policy Year.
(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(c) The payment under this benefit is over and above the Base Sum Insured.

2.16 Home Nursing Benefit

We will indemnify the amount specified in the Policy Schedule for this Benefit incurred for medical care services of a qualified nurse at the residence of the Insured Person following discharge from hospital after treatment for Illness/ Injury provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) Such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to Illness/ Injury for which the Insured Person has undertaken treatment during the hospitalisation

Further,

(a) The cover is applicable for a maximum of 15 days during the Policy Year and after the completion of the number of days mentioned in the Post-Hospitalization Medical Expenses cover (2.3).
(b) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(c) The payment under this benefit is within the Base Sum Insured.

2.17 Daily Cash for Accompanying an Insured Child

We will pay the Daily Cash Amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy;
(b) The Insured Person hospitalized is a Child aged 12 years or below
(c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) The payment under this benefit is over and above the Base Sum Insured.

2.18 Compassionate Visit

We will indemnify the costs of a return journey undertaken by air/ rail/ road (to and fro) up to the limit specified in the Policy Schedule under this Benefit for one of the Insured Person's Immediate Relative to travel from the place of the Immediate Relative's residence to the Hospital where the Insured Person is hospitalized, in case Hospitalization of the Insured Person extends beyond 5 consecutive days provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy

Further,

(a) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(b) The payment under this benefit is over and above the Base Sum Insured.
(c) For the purpose of this Benefit, the term "Immediate Relative" would mean the Insured Person's spouse, children or parents.

2.19 Maternity Benefit

We will indemnify the Medical Expenses incurred up to the Maternity Benefit Sum Insured specified in the Policy Schedule for the delivery of the Insured Person's child (including cesarean section) or the Medically Necessary and lawful medical termination of pregnancy during the Policy Period provided that:

(a) The treatment is taken as an In-patient in a Hospital;
(b) The cover shall be available to the Insured Person who has been continuously covered for at least 36 months under this Benefitsubject to the Portability & Continuity Benefits as applicable.

Further,

(a) We shall not be liable to pay for more than 2 events of deliveries across all Policy Periods with Us;
(b) We will cover pre-natal and post-natal expenses up to the amount specified in the Policy Schedule for this Benefit provided that We have accepted a Claim for delivery/termination under this Benefit;
(c) Ectopic pregnancy shall not be covered under this Benefit , but any Claims will be considered under In-patient Treatment;
(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(d) The payment under this benefit is over and above the Base Sum Insured.

Permanent Exclusion 3.5(13) of the Policy Wordings stands deleted to the extent of this Benefit only.

2.20 New Born Baby Cover

We will indemnify the Medical Expenses incurred on the Hospitalization of the Insured Person's New Born Baby during the Policy Period within the limits of the Maternity Sum Insured subject to the following:

(a) We have accepted a Claim for Maternity Benefit under the Policy.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) Any pre and post hospitalization expenses for the new born shall not be covered under this benefit.

You can cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby by way of anendorsement or at the next Renewal, whichever is earlier.

2.21 Vaccination Expenses

We will cover the Vaccination Expenses incurred on the Insured Person's Baby during the Policy Period up to the limit specified in the Policy Schedule subject to the following:

(a) We have accepted a Claim for Maternity Benefit under the Policy.
(b) The Insured Person whose maternity claim has been accepted by Us continues to renew the Policy with Us subsequently.

Further,

(a) The expenses will be covered from the birth till the Baby completes two years.
(b) Reimbursement claims for vaccination expenses can be submitted once during a Policy Year.
(c) The payment under this benefit is over and above the Base Sum Insured.

Permanent Exclusion 3.5(7) of the Policy Wordings stands deleted to the extent of this Benefit only.

The Covers under Benefits 2.19, 2.20 and 2.21 are not available on a standalone basis and need to be availed in conjunction only.

2.22 Air Ambulance Cover

We will indemnify the amount up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions which require immediate and rapid ambulance

transportation from the site of first occurrence of the Illness /Accident to the nearest hospital provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the air ambulance service relates to the same Illness / medical condition
(b) The necessity of the use of the Air Ambulance is certified by the treating Medical Practitioner;

Further,
(a) 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.
(b) Return transportation to Your home by air ambulance is excluded
(c) In case of Individual policy, this payout will available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(d) The payment under this benefit is within the Base Sum Insured.

2.23 Critical Illness Cover

If the Insured Person is first diagnosed to be suffering from any of the following Critical Illnesses during the Policy Period, We will pay sum insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.
(b) We shall not be liable to accept any Claim under this Cover if it pertains to any Critical Illness diagnosed within 90 days of the commencement of the first Policy Period of this Cover with Us;
(c) We shall not be liable in case any of the Critical Illnesses is a consequence of or arises out of any Pre-Existing Condition(s)/Disease.
(d) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,
(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater) and available for Insured Persons aged 18 years or above.
(b) The payment under this benefit is over and above the Base Sum Insured and will not impact the Base Sum Insured or the Cumulative Bonus (if any).
(c) Once a Claim has been accepted and paid for anyof the listed Critical Illness, this benefit shall cease in respect of that Insured Person, but shall continue to be in force for other Insured Persons.
(d) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;
(e) In the event of a Claim arising under this Cover, We shall be given written notice of the Claim within 30 days from the date of the first diagnosis of the Critical Illness and We shall be provided the following information and documentation:
(i) The Claim documents stated in the Policy, provided that We will accept duly certified copies of the listed documents if the originals are required to be submitted to any other insurance company;
(ii) Written confirmation of the diagnosis of the Critical Illness from the treating Medical Practitioner;

"Critical Illness" for the purpose of this Cover is as mentioned below:

- First diagnosis of the below-mentioned Illnesses more specifically described below

1. Cancer of specified severity
2. Kidney failure requiring regular dialysis;
3. Multiple Sclerosis with persisting symptoms;
4. Motor Neurone Disease with Permanent Symptoms
5. Benign Brain Tumor
6. Primary Pulmonary Hypertension
7. End Stage Liver Failure

- Undergoing for the first time of the following surgical procedures, more specifically described below:

8. Major Organ / Bone Marrow Transplant;
9. Open heart replacement or repair of heart valves
10. Open chest CABG
11. Aorta Graft Surgery

- Occurrence for the first time of the following medical events more specifically described below:

12. Coma of Specified Severity
13. Stroke resulting in permanent symptoms;
14. Permanent Paralysis of Limbs;
15. First Heart Attack of specified severity.
16. Third Degree (or Major) Burns
17. Deafness
18. Loss of Speech

The Critical Illnesses and the conditions applicable to the same are more particularly described in Annexure IV.

2.24 Personal Accident Cover

We will pay Sum Insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.
(b) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,
(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater)
(b) The payment under this benefit is over and above the Base Sum Insured and will not impact the Base Sum Insured or the Cumulative Bonus (if any).
(c) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;

- **Accidental Death**

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person dies solely and directly due to an Injury sustained in an Accident which occurs during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of that Accident.

Once a Claim has been accepted and paid under this Benefit then this Policy will automatically terminate in respect of that Insured Person only.

- **Permanent Total Disablement (PTD)**

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person suffers Permanent Total Disablement of the nature specified below solely and directly due to an Accident which occurs during the Policy Period provided that the Permanent Total Disablement occurs within 12 months from the date of that Accident:

(I) Loss of Use of both eyes, or Physical Separation/ Loss of Use of two entire hands or two entire feet, or one entire hand and one entire foot, or of such Loss of Use of one eye and such Physical Separation/ Loss of Use of one entire hand or one entire foot.
(ii) Physical Separation/ Loss of Use of two hands or two feet, or of one hand and one foot, or of Loss of Use of one eye and Loss of Use of one hand or one foot.
(iii) If such Injury shall as a direct consequence thereof, permanently, and totally, disable the Insured Person from engaging in any employment or occupation of any description whatsoever.

Once a Claim has been accepted and paid under this Benefit then the Personal Accident Cover will automatically terminate in respect of that Insured Person only.

2.25 Cap on Room Rent

If We have accepted a Claim for In-patient Hospitalization under the Policy and if the Insured Person incurs Room Rent that is higher than the eligible Room Rent as specified in the Policy Schedule then We will be liable to pay only a rateable proportion of the Associated Medical Expenses incurred in the proportion of the difference between the eligible Room Rent and the Room Rent actually incurred, provided that Reasonable and Customary costs incurred on medicines/pharmacy, medical consumables and medical implants will be reimbursed based on the actual amounts incurred.

In case this Cover is not opted for, Insured will get the eligible Room Rent and Associated Medical Expenses subject to Base Sum Insured including Cumulative Bonus and Restoration Benefit, if applicable.
Under this Cover, the Insured is entitled for a discount in the premium on opting for Cap on Room Rent.

3. 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 Disease Waiting Period

Pre-existing disease waiting period will be as mentioned in the Policy Schedule.

Any Pre-Existing Disease will not be covered until waiting period months (as mentioned in the Policy Schedule) of continuous coverage has elapsed for the Insured Person, since the inception of the this Policy with Us.

This waiting period will be reduced by number of continuous preceding years of coverage of the Insured Person under previous health insurance policy by Us or any other health insurance plan with an Indian non-life insurer/ health insureras per guidelines on portability issued by the insurance regulator.

3.2 30 Day Waiting Period

Any Illness contracted or Medical Expenses incurred in respect of an Illness will not be covered during the first 30 days from the Policy Period Start Date. This exclusion does not apply to any Medical Expenses incurred as a result of Injury or to Renewals of the Policy with Us or to any Insured Person whose Policy has been accepted under the Portability Benefit under this Policy.

3.3 2 Year Waiting Period

Any Medical Expenses incurred on the treatment of any of the following Illnesses/ conditions (whether medical or surgical and including Medical Expenses incurred on complications arising from such Illnesses/conditions) shall not be covered during the first 2 consecutive years from inception of the this Policy with Us or date of the Insured Person being included under the Policy, whichever is later:

(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) Tonsillitis, 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 be 10% of the Base Sum Insured up to a maximum of INR 100,000 per eye for each Policy Year of the Policy Period.

In the event that any of the above Illnesses/conditions are Pre-existing Diseases at the Policy Period Start Date or are subsequently found to be Pre-Existing Diseases, then that Illness/condition shall be covered in accordance with the terms, conditions and exclusions of the Policy after the completion of the Pre-Existing Diseases waiting period stated above.

3.4 Maternity Benefit Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until 36 months of continuous coverage has elapsed for that particular Insured Person since the inception of the Maternity Expenses Benefit under the Policy for that Insured Person.

This waiting period will be reduced by number of continuous preceding years of Maternity coverage of the Insured Person under previous health insurance policy by Us or any other health insurance plan with an Indian non-life insurer/ health insurer as per guidelines on portability issued by the insurance regulator.

3.5 Permanent Exclusions

We will not be liable under any circumstances, for any Claim in connection with or with regard to any of the following permanent exclusions as specified below:

1. 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;
2. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnea 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;
3. Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services, medical supplies including elastic stockings, diabetic test strips, and similar products.
4. Expenses incurred on all dental treatment unless necessitated due to an Accident and treatment is taken in in-patient department of hospital or day care centre;
5. Acupressure, acupuncture, magnetic and such other therapies;
6. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;
7. Vaccination or inoculation of any kind, unless it is post animal bite and there is hospitalisation as an in-patient;
8. Sterility, venereal disease or any sexually transmitted disease;
9. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) and Injury or Illness due to use, misuse or abuse of intoxicating drugs or alcohol;
10. Any expenses incurred on treatment of mental Illness, stress, psychiatric or psychological disorders;
11. Any aesthetic treatment, cosmetic surgery or plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness;
12. Any treatment/surgery for change of sex or treatment/surgery /complications/Illness arising as a consequence thereof;
13. Any expenses incurred on treatment arising from or traceable to pregnancy [including voluntary termination of pregnancy, childbirth, miscarriage (unless caused due to accident), abortion or complications of any of these, including cesarean section] and any fertility, infertility, sub fertility or assisted conception treatment or sterilization or procedure, birth control procedures and hormone replacement therapy. However, this exclusion does not apply to ectopic pregnancy proved by diagnostic means and which is certified to be life threatening by the Medical Practitioner;
14. Treatment relating to Congenital external Anomalies;
15. All expenses arising out of any condition directly or indirectly caused to or associated with Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus

Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind;

16. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done.
17. Charges incurred at Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization;
18. Expenses on supplements, vitamins and tonics unless forming part of treatment for Injury or Illness taken in in-patient department in hospital / day care centre and as certified by the attending Medical Practitioner;
19. Weight management services and treatment, vitamins and tonics related to weight reduction programs including treatment of obesity (including morbid obesity), any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition or rest cures;
20. 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;
21. Experimental, unproven or non-standard treatment which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury;
22. Any Claim directly or indirectly related to criminal acts;
23. Any treatment taken outside India;
24. 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;
25. Any consequential or indirect loss arising out of or related to Hospitalization;
26. 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;
27. 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;
28. All non-medical expenses listed in Annexure III of the Policy.
29. Any OPD treatment will not be covered
30. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
31. Treatment for Age Related Macular Degeneration (ARMD), Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), and Hyperbaric Oxygen Therapy will not be covered unless it forms a part of In-Patient Treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the Policy Schedule.

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

(c) 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;

(d) 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;

(e) 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) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor
(ii) Copy of the Health Card We have issued to the Insured Person;
(iii) Proposed date of Admission.
(iv) Medical papers viz. All prescriptions, medical investigation reports etc.
(v) Photo ID
(vi) Address proof, and photo to comply with KYC norms

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) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor
(ii) Copy of the Health Card We have issued to the Insured Person;
(iii) Medical papers viz. All prescriptions, medical investigation reports etc.
(iv) Photo ID
(v) Address proof, and photo to comply with KYC norms

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 Sum Insured or 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.

Turn Around Time (TAT) for settlement of Reimbursement is within 30 days from the receipt of the complete documents.

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.

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:

(i) The Policy Number;
(ii) Name of the Policyholder;
(iii) Name and address of the Insured Person in respect of whom the request is being made;
(iv) Nature of Illness or Injury and the treatment/surgery taken;
(v) Name and address of the attending Medical Practitioner;
(vi) Hospital where treatment/surgery was taken;
(vii) Date of Admission and date of discharge;
(viii) Approximate claim amount (if available)
(ix) 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.

Kindly note that Company may de-list few of the hospitals and the Company shall not service any claims including re-imbursement claims for the treatment undertaken at these hospitals other than in case of medical Emergency. List of de-listed hospitals would be available on our website and is subject to updates from time to time.

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) Hospital discharge summary;
(c) First consultation and follow up treatment papers;
(d) Original bills and receipts from the Hospital/Medical Practitioner;
(e) Original bills from chemists supported by proper prescription;
(f) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
(g) Indoor case papers, if available;
(h) Implant Invoice/ Sticker, if available;
(i) Ambulance Invoice, if applicable;
(j) FIR (if done) or MLC (if conducted) for Accident cases ;
(k) Post mortem report (if conducted);
(l) KYC documents viz. Photo ID and address proof along with duly completed form.
(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

For claims under which cashless facility has been approved, following documents will be provided by the Network hospital along with the above:

(n) Original Pre – authorization request
(o) Copy of Pre – authorization approval letter
(p) Copy of the photo identity document of the Insured Person;
(q) KYC documents obtained at the time of cashless facility.

- **Additional Documents for Personal Accident Cover:**

Accidental Death

(a) Original Death certificate issued by the office of Registrar of Birth & Deaths;
(b) Death summary issued by a Hospital, if applicable;

Permanent Total Disablement (PTD) resulting from Accident

(a) Original treating Medical Practitioner's certificate describing the disablement;
(b) Photograph of the Insured Person reflecting the disablement;
(c) Prescriptions and consultation papers of the treatment;
(d) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

- **Critical Illness Claim Documents**
  a. Common list of documents for all Critical Illness:
     1) Duly completed claim form;
     2) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
        i. Name of the Insured Person;
        ii. Name, date of occurrence and medical details confirming the event giving rise to the Claim.
        iii. Written confirmation from the treating Medical Practitioner that the event giving rise to the Claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the first 90 days of commencement of first Policy Period with Us.
     3) Original Policy document;
     4) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;
     5) Original investigation test reports, indoor case papers;
     6) In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate (if done/conducted) will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.
     7) Any other documents as may be required by Us.

If the Claim is not notified to Us within the time period specified above, 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.

b. Specific Documentation Required for each of the Critical Illnesses
Please note that the following are illustrative lists and we may seek additional documentation based on the facts and circumstances of the Claim and if done/conducted/available

1) CANCER OF SPECIFIED SEVERITY
   i. Hospital Discharge Card photocopy
   ii. Hospital Bills photocopy
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Details of the treatment received by the Insured Person from the inception of the ailment.
   vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
   vii. Histopathology / Cytology/ FNAC / Biopsy / Immuno-histochemistry reports.
   viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
   ix. Blood Tests.
   x. Any other specific investigation done to support the diagnosis like the PAP Smear/ Mammography, etc.
   xi. Any other documents as may be required by Us.

2) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Blood Tests- Renal Function Tests specifically: Serum Creatinine, Blood Urea Nitrogen,
   Serum Electrolytes done in the recent past (Not more than Two Week period from the date of intimation of Loss)
   vii. Dialysis Papers/Receipts done in recent past.
   viii. Renal scan
   ix. Letter from the nephrologists stating the diagnosis of End Stage Kidney Failure.
   x. Any other documents as may be required by Us.

3) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. MRI / CT Scan Report.
   vii. Electro-myogram report
   viii. Biopsy / Cytology Report
   ix. Specific Blood Tests: Creatinine Phosphokinase /Anti-nuclear antibodies, C- reactive protein /autoimmune work up
   x. Any other relevant Blood investigations.
   xi. Confirmation from the Central/State Government Hospital about diagnosis of Multiple Sclerosis and the duration of the same.
   xii. Any other documents as may be required by Us.

4) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS
   i. Hospital Discharge Card photocopy (in case of Hospitalization)
   ii. Investigations Reports like Blood tests, EEG, Nerve Conduction test, etc
   iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
   iv. Electro-myogram Report
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status
   vii. Any other document as may be required by the company

5) BENIGN BRAIN TUMOR
   i. Hospital Discharge Card photocopy
   ii. Hospital Bills photocopy
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Details of the treatment received by the Insured Person from the inception of the ailment.
   vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
   vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
   viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
   ix. Blood Tests.
   x. Neurological examination report by Neurologist
   xi. Any other documents as may be required by Us.

6) PRIMARY PULMONARY HYPERTENSION
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. MRI / CT Scan Report.
   vii. Echocardiography report
   viii. Computed tomography (CT), magnetic resonance imaging (MRI), and lung scanning
   ix. Pulmonary angiography
   x. Any other documents as may be required by Us.

7) END STAGE LIVER DISEASE / FAILURE
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Ultrasound scan of liver
   vii. CT and/or MRI scan of the liver
   viii. X-ray and Liver function test
   ix. Biopsy / FNAC (where applicable)
   x. Any other documents as may be required by Us.

8) MAJOR ORGAN /BONE MARROW TRANSPLANT
   i. Hospital Discharge Card photocopy
   ii. Photocopy Hospital Bills.
   iii. Pharmacy/Investigations Bills
   iv. Investigations Reports
   v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   vi. Scan / Histopathology / Cytology / FNAC / Biopsy report suggesting irreversible & non-compensatory changes of the particular organ. 8 Bone Marrow Biopsy Reports (Specifically In Case of Bone Marrow Transplant)
   vii. Letter from a specialist Doctor confirming the need of transplantation (Organs Specified are: Heart, lung, Liver, pancreas, kidney, bone marrow)
   viii. Any other documents as may be required by Us.

9) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. X-ray and 2D-Echocardiography Report.
vii. Letter from the Cardiologist / Cardiothoracic Surgeon suggesting valve replacement with the type of valve to be used.
viii. Any other documents as may be required by Us.

10) OPEN CHEST CABG
i. Photocopy Hospital Discharge Card
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Angiography Report
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Any other documents as may be required by Us.

11) AORTA GRAFT SURGERY
i. Photocopy Hospital Discharge Card
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Scan
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Bio-markers for Aortic dissection
xv. Any other documents as may be required by Us.

12) COMA OF SPECIFIED SEVERITY
i. Hospital Discharge Card photocopy
ii. Investigations Reports like Blood tests, EEG, etc
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
iv. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Glasgow coma scale grading.
v. Indoor case papers and / or ICU case papers indicating the history, signs, symptoms, line of treatment and daily charts like TPR, etc
vi. FIR / MLC / Panchnama for accident induced coma
vii. Any other document as may be required by the company

13) STROKE RESULTING IN PERMANENT SYMPTOMS
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit.
vii. MRI / CT scan/ 2D Echocardiography Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
viii. Blood tests (Lipid profile/Random Blood Sugar / Prothrombin Time/APTT/ Bleeding Time/ Clotting Time/Homocystiene levels)
ix. Any other documents as may be required by Us.

14) PERMANENT PARALYSIS OF LIMBS
i. Hospital Discharge Card photocopy
ii. Investigations Reports
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
iv. Electro-myogram Report
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status and duration of the Paralysis.
vii. Any other document as may be required by the company

15) FIRST HEART ATTACK - OF SPECIFIED SEVERITY
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Casualty Medical Officers/Emergency room papers with all details of Presenting Complaints and the Medical Examination by the attending physician.
vi. Subsequent Consultation Papers with the treating Medical Practitioner and the treatment received
vii. ECG on admission and subsequent ECG's
viii. Stress test/ Tread Mill Test
ix. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT, LDH / Electrolytes
x. X-ray / 2D-Echocardiography Report
xi. Thallium Scan Report
xii. Any other documents as may be required by Us.

16) THIRD DEGREE (OR MAJOR) BURNS
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports, treatment papers
v. Certificate from the treating specialist Doctor indicating the classification / degree of burns
vi. Following medico-legal documents if applicable
(i) FIR
(ii) Panchanama
(iii) Inquest Panchanama
(iv) Police Final Report/Charge Sheet (Based on FIR)
vii. Any other documents as may be required by Us.

17) DEAFNESS OR LOSS OF HEARING
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Pure tone testing report
vii. Audiometry report
viii. Confirmation of Diagnosis by ENT specialist along with duration
ix. All treatment papers and medical investigation test reports
x. Any other documents as may be required by Us.

18) LOSS OF SPEECH
i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Confirmation of Diagnosis by ENT specialist along with cause and duration
vii. All treatment papers and medical investigation test reports

Any other documents as may be required by Us.

- **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) Original bills and receipts from the Hospital/Medical Practitioner;
(iii) Investigation Payment Receipt
(iv) Original Investigation Report
(v) Original Pharmacy Bills
(vi) Original Pharmacy Prescription
(vii) Copy of Discharge Summary

7. CLAIM INVESTIGATION, SETTLEMENT & REPUDIATION

(a) We may investigate claims at Our own discretion to determine the validity of a claim. This investigation will be conducted within 15 days of the date of assigning the claim for investigation and not later than 30 days from the date of receipt oflast necessary document. All costs of investigation will be borne by Us and all investigations will be carried out by those individuals/entities that are authorised by Us in writing.
(b) We shall settle or repudiate a Claim within 30 days of the receipt of the last necessary information and documentation. In case of suspected frauds, where Investigation is initiated, We shall settle the claim within 45 days from the date of receipt ofthe last necessary document.
(c) Payment for reimbursement claims will be made to You. In the unfortunate event of Your death, We will pay the Nominee named in the Policy Schedule.
(d) In case of delay in payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

General Terms and Conditions

1. Eligibility

Self, Your legally married spouse, Your natural or adopted dependent children, Your parents, Your parents-in-law and Your siblings

Natural/ Appointed Guardian can also take insurance for minor under their guardianship.

In case of multiple Insured Person(s) covered under a Policy, the covers mentioned in Part II are applicable to all the Insured Person(s) in accordance with the premium paid and Plan opted unless specifically excluded as per the terms and conditions of the respective Cover.

2. Disclosure of Information

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or devices being used by You/Insured Person or any one acting on Your/Insured Person's behalf to obtain any benefit under this Policy.

3. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by You, shall be a Condition Precedent to any of Our liability to make any payment under this Policy.

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 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 shall be deemed to form part of the Policy and shall be read together as one document.

7. Multiple Policies:

a. If two or more policies are taken by an Insured during a period from one or more insurers, the contribution shall not be applicable where the cover/ benefit offered:
   - o Is fixed in nature;
   - o Does not have any relation to the treatment costs;

b. In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar policies.
c. If two or more policies are taken by an insured during a period from one more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.
   - o In all such cases the insurer who has issued the chosen policy 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.

- o Policyholder having multiple policies shall also have the right to prefer claims from other policy/ policies for the amount disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

d. If the amount to be claimed exceeds the Base Sum Insured under a single policy after considering the deductible or co-pays, the policy holder shall have the right to choose insurers from whom he/she wants to claim balance amount.

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

8. Zone Classification

Zone I: Mumbai (including Thane and Navi Mumbai) and Delhi (including NCR areas)
Zone II: Kolkata, Hyderabad, Chennai, Pune, Bangalore and Gujarat
Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

- Identification of Zone will be based on the city of the Proposer.
- A single Zone shall be applicable to all members covered under the Policy.
- You also have an option of selecting another Zone from the applicable Zones of any of the Insured Person(s) in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

Co-payment

- Persons paying Zone I premium can avail treatment all over India without any Co-payment.
- Persons paying Zone II premium can avail treatment in Zone II and Zone III without any co-payment
- Persons paying Zone III premium can avail treatment in Zone III only without any co-payment

Co-payment for treatment in a Higher Zone

In case of treatment taken in a city, in a Zone higher than the eligible Zone for the Insured Person, the Co-payment percentages as below shall apply:

Applicable Zone	Treatment Taken at	Co-payment applicable
Zone II	**Zone I**	**10%**
Zone III	**Zone I**	**20%**
Zone III	**Zone II**	**10%**

9. Underwriting and Loadings

We may apply a risk loading up to a maximum of 200 % per Insured Person on the premium payable (excluding statutory levies & taxes) based on the declarations made in the proposal form and the health status of the persons proposed for insurance.

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.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 200% of Premium excluding applicable Taxes.

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 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.

10. Free Look Period

The free look period shall be applicable at the inception of the policy and:

(a) The insured will be allowed a period of at least 15 days(Health Insurance policy contracts with a term of 3 years or more offered over distance marketing mode viz. telephone, website, internet, etc. shall have 30 days provided no claim has already been made on the policy) from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable

(b) If the insured has not made any claim during the free look period, the insured shall be entitled to

- o A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;
- o Where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;
- o Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

11. Cancellation/ Termination/ Refund

(a) 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.

This is provided no claim has been made under the Policy.

(b) No refund of premium is applicable when policy is cancelled by the Insurer on grounds of misrepresentation, fraud, nondisclosure or non-cooperation of the Insured.

12. 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.

13. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreedby 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.

14. Portability & Continuity Benefits

Portability means the right accorded to an individual health insurance policyholder (includingfamily cover), to transfer the credit gained for pre-existing conditions and time bound exclusions,from one insurer to another or from one plan to another plan of the same insurer.

It is further agreed and understood that:

(a) You have been covered under an Indian health insurance policy from a non-life insurance company or Health Insurance company registered with IRDAI without any break;

(b) We should have received Your application for Portability with complete documentation at least 45 days, but not earlier than 60 days from the premium renewal date of his/her existing policy;

(c) If the Base Sum Insured under the previous Policy is higher than the Base Sum Insured chosen under this Policy, the applicable waiting periods under Section 3 shall be waived to the extent of the Base Sum Insured and eligible cumulative bonus under the expiring policy with the previous insurer;

(d) In case the proposed Base Sum Insured opted for under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods under Sections 3 shall be applicable afresh to the extent of the amount by which the Base Sum Insured under this Policy exceed the total of Base Sum Insured and eligible cumulative bonus under the expiring health insurance policy;

(e) We will apply the waiting periods under Sections 3 individually for each Insured Person based on his previous policy details and claims shall be assessed accordingly.

(f) Portability benefit will be offered to the extent of sum of previous Base Sum Insured (if opted for), and Portability shall not apply to any other additional increased Base Sum Insured.

(g) Portability benefit will be offered to the nearest Base Sum Insured, in case exact Sum Insured option is not available.

(h) Portability benefit will be offered to any other suitable policy, in case exact option is not available.

(i) We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be as per our underwriting practices and underwriting policy of the Company.

(j) There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have given Us all documentation.

(k) We should have received the database and claim history from the previous insurance company for Your previous policy.

(l) Portability will be allowed in the following cases:
- o All Individual health insurance policies issued by General Insurers and Health Insurers including family floater policies
- o Individual members, including the family members covered under any group health insurance policy of a General Insurers and Health Insurers shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, he or she shall be accorded the right mentioned in clause (b) above.

(m) The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals. In case You have opted to switch to any other insurer under Portability provisions and the outcome of acceptance of the Portability request is awaited from the new insurer on the date of renewal,
- o We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis
- o If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternately We may deduct the premium for the balance period.

15. Grace Period & Renewal

(a) A health insurance Policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured, provided the Policy is not withdrawn.

(b) The Policy will automatically terminate at the end of the Policy Period and must be renewed within the Grace Period of at least 30 days or as informed by Insurer from time to time. The provisions of Section 64VB of the Insurance Act 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

(c) If We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI

(d) You shall make a full disclosure to Us in writing of any material change in the health condition of any Insured Person at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.

(e) We may, revise the Renewal premium payable under the Policy or the terms of cover, provided that all such changes are approved by IRDAI and in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premium will not alter based on individual claims experience. We will intimate You of any such changes at least 90 days prior to date of such revision or modification.

(f) Alterations such as increase/ decrease in Base Sum Insured or change in plan/product or addition/deletion of Insured Persons will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. Underwriting in relation to acceptance of request for changes will be based mainly as per underwriting policy of the company. The terms and conditions of the existing policy will not be altered. Increase/ Enhancement of Base Sum Insured shall be allowed up to maximum Base Sum Insured available under the Plan.

(g) On Renewal of the Policy if an increased Base Sum Insured is requested then the elapsed period for existing diseases/ illness / injury shall be limited to the Base Sum Insured of the immediately completed Policy Period. Further, the waiting periods will apply afresh in relation to the amount by which the Base Sum Insured has been enhanced.

16. 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.

17. 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.

18. 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.

19. Instalment Facility:

If You have opted for a Policy Period of one year and payment of premium on an instalment basis of monthly / quarterly / half yearly, as specified in the Schedule, the following conditions shall apply (notwithstanding any terms contained elsewhere in the Policy):

(a) Premiums on policies may be accepted in instalment provided that the instalments covering a particular period shall be received within the 15 days relaxation period from the due date of payment of instalment premium.

(b) The Policy will get cancelled in the event of non-receipt of premium within the relaxation period.

(c) Coverage will be available during the relaxation period of 15 days.

(d) In case of any admissible claim in a Policy year:
- o If the claim amount is equivalent or higher than the balance

of the instalment premiums payable in that Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person.

- If the claim amount is lesser than the balance premium payable, then no claim would be payable till the applicable premium is recovered.

20. Electronic Transactions:

You agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured.

21. Grievances:

For resolution of any query or grievance, insured may contact the respective branch office of the Company or may call at 18002664545 or may write an e- mail at care@kotak.com.

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.

In case the insured is not satisfied with the response of the office, insured may contact the Grievance Officer of the Company at grievanceofficer@kotak.com. In the event of unsatisfactory response from the Grievance Officer, he/she may, subject to vested jurisdiction, approach the Insurance Ombudsman for the redressal of grievance. The details of the Insurance Ombudsman is available at website: www.kotakgeneralinsurance.com

The updated details of Insurance Ombudsman offices are also available on the website of Executive Council of Insurers: www.gbic.co.in/ombudsman.html

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.

Sr. No.	Plan Name	Standard	Advantage	Edge	Elite	Absolute	360	Total
	Base Sum Insured	2 lac	3 lac/ 4 lac/ 5 lac/ 7.5 lac/ 10 lac	5 lac/ 7.5 lac/ 10 lac/ 15 lac/ 20 lac	10 lac/ 15 lac/ 20 lac/ 25 lac	25 lac/ 50 lac/ 75 lac/ 100 lac/ 150 lac/ 200 lac	2 lac/ 3 lac/ 4 lac/ 5 lac/ 7.5 lac/ 10 lac/ 15 lac/ 20 lac/ 25 lac/ 50 lac/ 75 lac/ 100 lac/ 150 lac/ 200 lac	2 lac/ 3 lac/ 4 lac/ 5 lac/ 7.5 lac/ 10 lac/ 15 lac/ 20 lac/ 25 lac/ 50 lac/ 75 lac/ 100 lac/ 150 lac/ 200 lac
1	In-patient Treatment	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured
2	Day Care Treatment	405 Named Day-care Surgeries & Procedures	405 Named Day-care Surgeries & Procedures	405 Named Day-care Surgeries & Procedures	405 Named Day-care Surgeries & Procedures	405 Named Day-care Surgeries & Procedures	405 Named Day-care Surgeries & Procedures	405 Named Day-care Surgeries & Procedures
3	Pre-Hospitalization Medical Expenses	60 days	60 days	60 days	60 days	90 days	2 lacs - 20 lacs - 60 days 25 lacs - 200 lacs - 90 days	2 lacs - 20 lacs - 60 days 25 lacs - 200 lacs - 90 days
	Pre-Hospitalization Medical Expenses	90 days	90 days	90 days	90 days	180 days	2 lacs - 20 lacs - 90 days 25 lacs - 200 lacs - 180 days	2 lacs - 20 lacs - 90 days 25 lacs - 200 lacs - 180 days
4	Ambulance Cover	Upto INR 20000 per year	Upto INR 20000 per year	Upto INR 20000 per year	Upto INR 20000 per year	Upto INR 50000 per year	2 lacs - 20 lacs - Upto INR 20000 per year 25 lacs - 200 lacs - Upto INR 50000 per year	2 lacs - 20 lacs - INR 20000 per year 25 lacs - 200 lacs - INR 50000 per year
5	Organ Donor Cover	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured
6	Alternative Treatment	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured
7	Domiciliary Hospitalisation	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured	Upto Base Sum Insured
8	Annual Health Check-up	For each Insured Person above 18 years of Age, each Policy Year for specified tests	For each Insured Person above 18 years of Age, each Policy Year for specified tests	For each Insured Person above 18 years of Age, each Policy Year for specified tests	For each Insured Person above 18 years of Age, each Policy Year for specified tests	For each Insured Person above 18 years of Age, each Policy Year for specified tests	For each Insured Person above 18 years of Age, each Policy Year for specified tests	For each Insured Person above 18 years of Age, each Policy Year for specified tests
9	Restoration Benefit	Additional Sum Insured equivalent to Base Sum Insured	Additional Sum Insured equivalent to Base Sum Insured	Additional Sum Insured equivalent to Base Sum Insured	Additional Sum Insured equivalent to Base Sum Insured	Additional Sum Insured equivalent to Base Sum Insured	Additional Sum Insured equivalent to Base Sum Insured	Additional Sum Insured equivalent to Base Sum Insured
10	Cumulative Bonus	10% of the Base Sum Insured, upto a maximum of 50% for each claim free year; No reduction in case of claim	10% of the Base Sum Insured, upto a maximum of 50% for each claim free year; No reduction in case of claim	10% of the Base Sum Insured, upto a maximum of 100% for each claim free year; No reduction in case of claim	10% of the Base Sum Insured, upto a maximum of 100% for each claim free year; No reduction in case of claim	10% of the Base Sum Insured, upto a maximum of 100% for each claim free year; No reduction in case of claim	2 lacs - 20 lacs - 10% of the Base Sum Insured, upto a maximum of 50% for each claim free year; No reduction in case of claim 25 lacs - 200 lacs - 10% of the Base Sum Insured, upto a maximum of 100% for each claim free year; No reduction in case of claim	2 lacs - 20 lacs - 10% of the Base Sum Insured,upto a maximum of 50% for each claim free year; No reduction in case of claim 25 lacs - 200 lacs - 10%of the Base Sum Insured, upto a maximum of 100% for each claim free year; No reduction in case of claim
11	Second E-Opinion Cover	Not Available	Available	Available	Available	Available	Available	Available
12	Health and Rewards	Not Available	Available	Available	Available	Available	Available	Available
13	Value Added Benefits	Not Available	VA1	VA2	VA2	VA3.	2 lacs - 7.5 lacs - VA1 10 lacs - 20 lacs - VA2 25 lacs - 200 lacs - VA3	Not Available
14	Hospital Daily Cash	INR 500 per day for minimum 3 days of hospitalization subject to maximum of 10 days	INR 500 per day for minimum 3 days of hospitalization subject to maximum of 10 days	INR 1000 per day for minimum 3 days of hospitalization subject to maximum of 10 days	INR 1500 per day for minimum 3 days of hospitalization subject to maximum of 10 days	INR 2000 per day for minimum 3 days of hospitalization subject to maximum of 10 days	**Optional Cover** 2 lacs - 20 lacs - INR 1000 per day for minimum 3 days of hospitalization subject to maximum of 10 days 25 lacs - 200 lacs - INR 2000 per day for minimum 3 days of hospitalization subject to maximum of 10 days	**Optional Cover** 2 lacs - 20 lacs - INR 1000 per day for minimum 3 days of hospitalization subject to maximum of 10 days 25 lacs - 200 lacs - INR 2000 per day for minimum 3 days of hospitalization subject to maximum of 10 days

15	Convalescence Benefit	INR 10,000 (minimum hospitalisation of 10 days)	INR 10,000 (minimum hospitalisation of 10 days)	INR 15,000 (minimum hospitalisation of 10 days)	INR 20,000 (minimum hospitalisation of 10 days)	INR 25,000 (minimum hospitalisation of 10 days)	**Optional Cover** 2 lacs - 20 lacs - INR 15,000 (minimum hospitalisation of 10 days) 25 lacs - 200 lacs - INR 25,000 (minimum hospitalisation of 10 days)	**Optional Cover** 2 lacs - 20 lacs - INR 15,000 (minimum hospitalisation of 10 days) 25 lacs - 200 lacs - INR 25,000 (minimum hospitalisation of 10 days)
16	Home Nursing Benefit	**Optional Cover** Upto INR 3,000 per day for a maximum of 15 days after completion of number of days under Post hospitalisation cover for the medical services of a nurse at your residence	**Optional Cover** Upto INR 3,000 per day for a maximum of 15 days after completion of number of days under Post hospitalisation cover for the medical services of a nurse at your residence	Upto INR 3,000 per day for a maximum of 15 days after completion of number of days under post hospitalisation cover for the medical services of a nurse at your residence	Upto INR 3,000 per day for a maximum of 15 days after completion of number of days under post hospitalisation cover for the medical services of a nurse at your residence	Upto INR 3,000 per day for a maximum of 15 days after completion of number of days under post hospitalisation cover for the medical services of a nurse at your residence	**Optional Cover** Upto INR 3,000 per day for a maximum of 15 days after completion of number of days under post hospitalisation cover for the medical services of a nurse at your residence	**Optional Cover** Upto INR 3,000 per day for a maximum of 15 days after completion of number of days under post hospitalisation cover for the medical services of a nurse at your residence
17	Daily Cash for Accompanying an Insured Child	**Optional Cover** ₹ 500 per day for minimum 3 days of hospitalization subject to maximum of 10 days	**Optional Cover** ₹ 500 per day for minimum 3 days of hospitalization subject to maximum of 10 days	₹ 1000 per day for minimum 3 days of hospitalization subject to maximum of 10 days	₹1500 per day for minimum 3 days of hospitalization subject to maximum of 10 days	₹ 2000 per day for minimum 3 days of hospitalization subject to maximum of 10 days	**Optional Cover** 2 lacs - 20 lacs - INR 1000 per day for minimum 3 days of hospitalization subject to maximum of 10 days 25 lacs - 200 lacs - INR 2000 per day for minimum 3 days of hospitalization subject to maximum of 10 days	**Optional Cover** 2 lacs - 20 lacs - INR 1000 per day for minimum 3 days of hospitalization subject to maximum of 10 days 25 lacs - 200 lacs - INR 2000 per day for minimum 3 days of hospitalization subject to maximum of 10 days
18	Compassionate Visit	**Optional Cover** Upto INR 20000	**Optional Cover** Upto INR 20000	**Optional Cover** Upto INR 20000	**Optional Cover** Upto INR 20000	Upto INR 20000	**Optional Cover** Upto INR 20000	**Optional Cover** Upto INR 20000
19	Maternity Benefit* (with 3 year waiting period)	Not Available	Not Available	**Optional Cover** Upto INR 25,000 for Normal and 35,000 Cesarean	**Optional Cover** Upto INR 50,000 Normal and Cesarean	Upto INR 50,000 Normal and Cesarean	**Optional Cover** 5 lacs - 20 lacs - Upto INR 25,000 for Normal and 35,000 Cesarean 25 lacs - 200 lacs - Upto INR 50,000 Normal and Cesarean	**Optional Cover** 5 lacs - 20 lacs - Upto INR 25,000 for Normal and 35,000 Cesarean 25 lacs - 200 lacs - Upto INR 50,000 Normal and Cesarean
20	New Born Baby Cover* (with 3 year waiting period)	Not Available	Not Available	**Optional Cover** Within Maternity Benefit Sum Insured	**Optional Cover** Within Maternity Benefit Sum Insured	Within Maternity Benefit Sum Insured	**Optional Cover** Within Maternity Benefit Sum Insured	**Optional Cover** Within Maternity Benefit Sum Insured
21	Vaccination Expenses* (with 3 year waiting period)	Not Available	Not Available	**Optional Cover** Upto INR 5000	**Optional Cover** Upto INR 7500	Upto INR 10000	**Optional Cover** 5 lacs - 20 lacs - Upto INR 5000 25 lacs - 200 lacs - Upto INR 10000	**Optional Cover** 5 lacs - 20 lacs - Upto INR 5000 25 lacs - 200 lacs - Upto INR 10000
22	Air Ambulance Cover	Not Available	Not Available	**Optional Cover** Upto 10% of Base Sum Insured and subject to a maximum of 5lacs	Upto 10% of Base Sum Insured and subject to a maximum of 5lacs	Upto 10% of Base Sum Insured and subject to a maximum of 5lacs	**Optional Cover** Upto 10% of Base Sum Insured and subject to a maximum of 5lacs	**Optional Cover** Upto 10% of Base Sum Insured and subject to a maximum of 5lacs
23	Critical Illness Cover (Available for Age 18 years and above)	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 10 lacs	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 10 lacs	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 10 lacs	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 10 lacs	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 10 lacs
24	Personal Accident Cover	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 25 lacs	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 25 lacs	**Optional Cover** Additional Sum Insured equivalent to Base Sum Insured and subject to a maximum of 25 lacs

25	Cap on Room Rent	**Optional Cover** 1% of base sum insured in case of stay in Non ICU; 2% of base sum insured in case of stay in ICU	**Optional Cover (Applicable for Sum Insured 3, 4 and 5 lacs)** 1% of base sum insured in case of stay in Non ICU; 2% of base sum insured in case of stay in ICU	Not Available	Not Available	Not Available	**Optional Cover (Applicable for Sum Insured 2, 3, 4 and 5 lacs)** 1% of base sum insured in case of stay in Non ICU; 2% of base sum insured in case of stay in ICU	**Optional Cover (Applicable for Sum Insured 2, 3, 4 and 5 lacs)** 1% of base sum insured in case of stay in Non ICU; 2% of base sum insured in case of stay in ICU
	Individual/ Floaterr	Individual	Both	Both	Both	Both	2 lacs - Individual 3 lacs and above - Both	2 lacs - Individual 3 lacs and above - Both
	Waiting period for PED	48 months for all age groups Option of 36 months to be provided	48 months for all age groups Option of 36 months to be provided	48 months for all age groups Option of 36 months to be provided	36 months for all age groups Option of 24 months to be provided	36 months for all age groups Option of 24 months to be provided	48 months for all age groups Option of 36 months/ 24 months to be provided	48 months for all age groups Option of 36 months/ 24 months to be provided
	Instalment Facility	Available	Available	Available	Available	Available	Available	Available

* You need to opt for Maternity Benefit/ New Born Baby Cover/ Vaccination Expenses together.

Kotak Mahindra General Insurance Company Ltd. (Formerly Kotak Mahindra General Insurance Ltd.)
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