Kotak Health Super Top up - Classic
PROSPECTUS

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

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

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

1.1 In-patient Treatment

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

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

1.2 Day Care Treatment

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

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

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

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

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;
(b) We will not be liable to pay Pre-Hospitalisation Medical Expenses for more than 30 days preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;
(c) We will not be liable to pay Post-Hospitalisation Medical Expenses for more than 60 days immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

1.4 Ambulance Cover

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

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

1.5 Organ Donor Cover

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

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

1.6 Alternative Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment up to ₹50,000/- provided that:

(a) The Alternative Treatment is administered by a Medical Practitioner;
(b) The Insured Person is admitted to Hospital as an Inpatient for the Alternative Treatment to be administered.
(c) The payment under this benefit is within the opted Base Annual Sum Insured.
(d) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy.

1.7 Restoration of Sum Insured

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

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

1.8 Double Sum Insured for Hospitalization due to Accident

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

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

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

1.9 Cumulative Bonus

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

(a) If the Policy is a Family Floater Policy, then the Cumulative Bonus will accrue only if no claims have been made in respect of all the Insured Persons in the expiring Policy Year;
(b) If the Policy is an Individual policy, then Cumulative Bonus will accrue only if no claim has been made in the expiring Policy Year in respect of that Insured Person;
(c) The Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;
(d) If any Claim is made under the Policy after a Cumulative Bonus has been applied under the Policy, then the accrued Cumulative Bonus under the Policy will reduce by 10% on the commencement of the next Policy Year or the next Renewal of the Policy (as applicable);
(e) The Cumulative Bonus will not accrue in excess of 50% of the Base Annual Sum Insured;

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

(g) If the Base Annual Sum Insured is reduced at the time of Renewal, then the applicable cumulative bonus will be applicable on the renewed policy Base Annual Sum Insured.

(h) Cumulative bonus will be carried forward to the next policy year, provided the Insured Person renews the policy before the expiry of the grace period.

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

2. SAILENT FEATURES

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<tr><td>Entry Age</td><td>91 Days</td></tr>
<tr><td>Maximum Entry Age</td><td>65 Years</td></tr>
<tr><td>Maximum Entry age for dependent children</td><td>25 Years</td></tr>
<tr><td>Exit Age / Renewal</td><td>The Policy provides for life-long renewal</td></tr>
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<table>
<tr><th>Deductible</th><th colspan="3">Sum Insured Options</th></tr>
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<tr><td>Basic Covers</td><td>
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<tr><td>In-patient Treatment</td><td>Upto opted Base Annual Sum Insured</td></tr>
<tr><td>Day Care Treatment</td><td>405 listed Day care procedures</td></tr>
<tr><td>Pre-Hospitalization Medical Expenses</td><td>Upto 30 days</td></tr>
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<tr><td>Ambulance Cover</td><td>₹ 2000/- per event.</td></tr>
<tr><td>Organ Donor Cover</td><td>Upto opted Base Annual Sum Insured</td></tr>
<tr><td>Alternative Treatment</td><td>Up to ₹ 50,000/- (subject to availability of opted Base Annual Sum Insured)</td></tr>
<tr><td>Restoration of Sum Insured</td><td>Upto opted Base Annual Sum Insured</td></tr>
<tr><td>Double Sum Insured for Hospitalization due to Accident</td><td>Double of opted Base Annual Sum Insured up to the maximum limit of ₹40 lakhs.</td></tr>
<tr><td>Cumulative Bonus</td><td>10% of the Sum Insured for each claim free year, upto a maximum of 50%</td></tr>
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<tr><td>Policy Period</td><td>1/2/3 years</td></tr>
<tr><td>Premium Rate</td><td>Premium rate is as per Annexure_2.1_Annexure to prospectus</td></tr>
<tr><td>Mandatory Medical check-up</td><td>Individual greater than 50 years / All ages if pre-existing disease is declared.</td></tr>
<tr><td rowspan="2">Policy Type</td><td>Individual/ Floater</td></tr>
<tr><td>Available for all Sum Insured Options</td></tr>
<tr><td>Waiting period for Pre-existing Illnesses</td><td>48 months for all age groups</td></tr>
<tr><td colspan="2">Relationship Covered</td></tr>
<tr><td>For Individual</td><td>Self, Spouse, Dependent children, Dependent parents, Employer, Employee</td></tr>
<tr><td>For Family Floater*</td><td>Self, Spouse, Dependent children, Dependent parents, Dependent Parents in law, Employer, Employee</td></tr>
<tr><td>Pre-Policy Medical Check-up</td><td>
We will require the insured person to undergo a medical check-up based on age and the Sum Insured opted, Wherever any pre-existing disease or any other adverse medical history is declared, We may ask such member to undergo specific tests as we may deem fit to evaluate such member. Medical tests will be facilitated by us and conducted at Our network of diagnostic centers. The validity of such tests will be up to 30 days. 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.
The following criteria would be applied for medical examination:
<table>
<tr><th>Age</th><th>> 50 years</th></tr>
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<tr><td>ECG</td></tr>
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</td></tr>
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*Dependent Child under family floater policies after completion of 25 years shall be considered as adult for premium computation.

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

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

3.1 Pre-Existing Disease Waiting Period

Pre-existing disease waiting period will be as mentioned in the policy schedule and as per plan opted.

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 first 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 as 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 Years 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 first 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) Surgery on Tonsilitis, adenoids and sinuses;
(n) Gastric and duodenal erosions and ulcers;
(o) Deviated nasal septum;
(p) Varicose Veins/ Varicose Ulcers.

*Our maximum liability for any Claim for an Insured Person's cataract treatment shall not exceed ₹ 20,000 per eye, during 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 Permanent Exclusions

(a) Up to Deductible amount mentioned
(b) 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;
(c) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;
(d) Expenses incurred on all dental treatment unless necessitated due to an Accident;
(e) Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services;
(f) Acupressure, acupuncture, magnetic and such other therapies;
(g) Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;
(h) Vaccination or inoculation of any kind, unless it is post animal bite;
(i) Sterility, venereal disease or any sexually transmitted disease;
(j) 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;
(k) Any expenses incurred on treatment of mental Illness, stress, psychiatric or psychological disorders;
(l) 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;
(m) Any treatment/surgery for change of sex or treatment/surgery /complications/Illness arising as a consequence thereof;
(n) 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 caesarean 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;
(o) Treatment relating to Congenital external Anomalies;
(p) Genetic disorder (not relating to internal congenital conditions) and stem cell implantation/surgery, harvesting, storage or any kind of treatment using stem cells.
(q) 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;
(r) 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;
(s) Expenses on supplements, vitamins and tonics unless forming part of treatment for Injury or Illness as certified by the attending Medical Practitioner;
(t) 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;
(u) 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;
(v) Experimental, unproven or non-standard treatment which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury;
(w) Any Claim directly or indirectly related to criminal acts;
(x) Any expenses arising out of Domiciliary Hospitalization;
(y) Any treatment taken outside India;
(z) 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;
(aa) Any consequential or indirect loss arising out of or related to Hospitalization;
(bb) 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;
(cc) 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;
(dd) All non-medical expenses listed in Annexure III of the Policy.

4. CLAIM ADMINISTRATION

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

(a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;
(b) 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 or 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) The Health Card We have issued to the Insured Person;

(ii) The Policy Number;

(iii) Name of the Policyholder;

(iv) Name and address of Insured Person in respect of whom the request is being made;

(v) Nature of the Illness/Injury and the treatment/surgery required;

(vi) Name and address of the attending Medical Practitioner;

(vii) Hospital where treatment/surgery is proposed to be taken;

(viii) Proposed date of Admission.

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

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

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

In Case of Claim Contact Us at:

24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@kotak.com

In the event of claims, please send the relevant documents to:

Family Health Plan (TPA) Ltd, Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills, Hyderabad, 500 034.

(b) Pre-authorization for Emergency Care:

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

(i) The Health Card We have issued to the Insured Person;

(ii) The Policy Number;

(iii) Name of the Policyholder;

(iv) Name and address of Insured Person in respect of whom the request is being made;

(v) Nature of the Illness/Injury and the treatment/surgery required;

(vi) Name and address of the attending Medical Practitioner;

(vii) Hospital where treatment/surgery is being taken;

(viii) Date of Admission.

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

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

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

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

5.2 For Reimbursement Claims

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

(a) The Policy Number;

(b) Name of the Policyholder;

(c) Name and address of the Insured Person in respect of whom the request is being made;

(d) Nature of Illness or Injury and the treatment/surgery taken;

(e) Name and address of the attending Medical Practitioner;

(f) Hospital where treatment/surgery was taken;

(g) Date of Admission and date of discharge;

(h) Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

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

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 a 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) Original Pre – authorization request

(c) Copy of Pre – authorization approval letter

(d) Copy of the photo identity document of the Insured Person;

(e) Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner;

(f) Original bills from chemists supported by proper prescription;

(g) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;

(h) Indoor case papers (if available);

(i) Medical Practitioner's referral letter advising Hospitalization in non-Accident cases and referral slip for all investigations carried out;

(j) Hospital discharge summary;

(k) FIR (if done) or MLC (if conducted) for Accident cases;

(l) Post mortem report (if applicable and conducted);

(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

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

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

(i) Duly Completed Claim Form

(ii) Investigation Payment Receipt

(iii) Original Investigation Report

(iv) Original Pharmacy Bills

(v) Original Pharmacy Prescription

(vi) Copy of Discharge Summary

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

(i) Duly Completed Claim Form

(ii) Investigation Payment Receipt

(iii) Original Investigation Report

(iv) Original Pharmacy Bills

(v) Original Pharmacy Prescription

(vi) Copy of Discharge Summary

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

8. CLAIM 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 6 months from the date of receipt of claim intimation. 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, the last "necessary" documents will include the receipt of the investigation report from Our representatives.

(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.

PART III OF THE POLICY

General Terms and Conditions

1. 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.

2. 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.

3. 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.

4. No constructive Notice

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

5. Terms and condition of the Policy

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

6. 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 befenhan applicable where the cover/ benefit offered:

- Is fixed in nature;
- 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.

- 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.
- 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 Annual 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.

7. Limitation of Liability

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

8. Underwriting and Loadings

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

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

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 100% of Premium excluding applicable Taxes

In case policies are accepted with loadings, waiting period for Pre-Existing Disease Waiting Period (Section 3.1) as well as 2 Year Waiting Period (Section 3.3) shall continue to be applicable.

9. 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

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

10. 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.

11. 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.

12. Policy Disputes

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

13. Portability & Continuity Benefits

Portability means transfer by an Individual health insurance policyholder (including family floater cover) of the credit gained for pre-existing conditions and time bound exclusions if he/ she chooses to switch from one insurer to another.

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

(d) In case the proposed Base Annual 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 Annual Sum Insured under this Policy exceed the total of Base Annual Sum Insured and eligible cumulative bonus under the expiring health insurance policy;

(e) All waiting periods under Sections 3 shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

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

(g) Portability benefit will be offered to the nearest Base Annual 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:

- All Individual health insurance policies issued by General Insurers and Health Insurers including family floater policies
- 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,

- 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
- 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.

14. 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 the 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 Annual 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 Annual Sum Insured shall be allowed up to maximum Base Annual Sum Insured available under the Plan.

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

15. 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.

16. 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.

17. 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.

18. 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) In case of any admissible claim in a Policy year:

- 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.

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

(b) In case the instalment premium is not received within the grace period, the Policy will get cancelled with applicable refund of premium, if any.

19. 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

20. 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.