Lifeline

Your search for high quality health insurance stops here

Your family is the most important part of your lives. You try to plan out the best for them. But life sets its own course. At times, you do face misfortunes like a sudden illness, a serious accident or an unavoidable surgery. To provide them with suitable medical attention in such a scenario, you fall back on your hard earned savings. Is there a better way to keep your savings intact?

Royal Sundaram brings to You Lifeline, a unique health insurance plan, providing most comprehensive health coverage at an affordable price. Lifeline is an individual and family oriented health insurance cover which is simple to buy and easy to understand. In addition to comprehensive health insurance cover to suit your needs, this plan helps you care for your health proactively over time and according to your profile. We are here to build a long term healthy relationship with you and your family.

Key Features of the Policy

Basic Covers:

- Inpatient Care
- Pre Hospitalization Medical Expenses
- Post Hospitalization Medical Expenses
- All Day Care Treatment
- Domiciliary Hospitalization
- Ambulance Cover
- Organ Donor Expenses
- No Claim Bonus
- Re-load of Sum Insured
- AYUSH Treatment
- Vaccination in case of Animal Bite
- Emergency Domestic Evacuation
- Worldwide Emergency Hospitalization (excluding US and Canada)
- International Treatment for 11 specified critical illness (excluding US and Canada)
- Maternity Benefit including New Born Baby Cover and Vaccination for new born baby before the baby completes one year of age
- OPD Treatment including Dental Treatment, Cost of Spectacles and Contact Lenses

Value Added Covers:

- Health Check-up
- Second opinion for 11 critical illness
- Preventive Healthcare & Wellness Benefit and Disease Management

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Optional Covers:

- Hospital Cash
- Top-up plan on annual aggregate deductible basis
- Include US and Canada for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illnesses
- Supreme Plus
- Elite Plus

Supreme Plus:

Under Supreme Plus, following benefits will be offered:

1. Additional facility of app based cabs as a part of Ambulance Cover
2. Refresh of Sum Insured
3. In-patient for Pre-Existing Diseases in case of Life Threatening Conditions- upto Rs. 1 lakh
4. Bariatric Surgery- upto Rs. 50,000
5. Mobility Devices - 5% or Rs. 50,000 whichever is lesser
6. Second Opinion for additional 11 specified Critical Illnesses (Total 22 Critical Illnesses)

Elite Plus:

Under Elite Plus, following benefits will be offered:

1. Additional facility of app based cabs as a part of Ambulance Cover
2. Refresh of Sum Insured
3. International Treatment abroad for 3 additional Critical illnesses (Total 14 specified critical illnesses)
4. In-patient for Pre-Existing Diseases in case of Life Threatening Conditions- upto Rs. 2,00,000
5. Bariatric Surgery- Upto Rs. 2 lakhs
6. Mobility Devices- Upto Rs. 50,000
7. Second Opinion for 11 additional Critical Illnesses (22 specified Critical Illness)
8. In-Vitro Fertilisation(IVF) Treatment- Upto Rs. 2,50,000

Product Benefits – Key Highlights

The policy covers reasonable and customary expenses incurred towards medical treatment taken during the Policy Period for an Illness or an Accident. We cover the following expenses:

Basic Covers

1. In-patient Care: Medical Expenses for:

(i) Medical practitioner's fees, diagnostics tests, medicines, drugs and consumables, nursing charges, treatment charges, operation theatre charges, Room Rent, Intensive Care Unit, Intravenous fluids, blood transfusion, injection administration charges.

(ii) The cost of prosthetics and other devices or equipment if implanted internally during a surgical procedure.

(iii) The following procedures will be covered (whichever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

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

2. **Pre & Post hospitalization Medical Expenses:** Expenses for consultations, investigations and medicines incurred of an Insured person due to an accident or injury or illness incurred immediately prior to hospitalisation or incurred post hospitalisation up to the limits specified under the plan opted by the Insured subject. These are payable for the same illness or treatment as long as we have accepted an In-patient Care claim (as mentioned above) for that treatment or illness. These can be claimed only as reimbursements.

3. **Day Care Treatment**: Medical expenses for day care treatments (including Chemotherapy, Radiotherapy, Hemodialysis, any procedure which needs a period of specialized observation or care after completion of the procedure) where such procedures are undertaken by an insured person as an inpatient in a hospital/day care center for a continuous period of less than 24 hours. Any OPD Treatment undertaken in a hospital will not be covered. Pre & Post hospitalization Medical Expenses are payable for this benefit. All Day Care Treatments are covered.

4. **Ambulance Cover**: Reasonable charges for ambulance expenses (by surface transport only) incurred to transfer the insured person following an Emergency to the nearest Hospital, if we accept the in-patient claim. Our maximum liability for ambulance expenses is limited up to limit specified in Product Benefits Table per event of hospitalization.

5. **Domiciliary Hospitalization:** Medical expenses for treatment taken at home if the treatment continues for an uninterrupted period of 3 days and the condition for which treatment is taken

would otherwise have necessitated hospitalization as long as either (i) the attending medical practitioner confirms that the insured person could not be transferred to a hospital or (ii) you satisfy us that a hospital bed was unavailable. Claims for pre-hospitalization expenses shall be payable, however, post-hospitalisation medical expenses shall not be payable.

6. **Organ Donor Expenses**: Medical expenses for an organ donor's treatment for harvesting of the organ provided that the insured person has been medically advised to undergo an organ transplant and the donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the insured person;

We will not cover:

(a) Pre-hospitalisation or post-hospitalization medical expenses or screening expenses of the donor or any other medical expenses as a result of the harvesting from the donor;
(b) Costs directly or indirectly associated with the acquisition of the donor's organ.

7. **No Claim Bonus (NCB):** If no claim has been made by any insured person, we will increase the base sum insured as per the Plan opted (Classic – 10% of Base Sum Insured, Supreme & Elite – 20% of Base Sum Insured) on each policy year up to a maximum of 50% of base Sum Insured of that policy year for Classic Plan and 100% of base Sum Insured of that policy year for Supreme & Elite Plan, provided the Policy is renewed continuously. You will not earn No Claim Bonus on Policy renewal if any claim is made in expiring Policy Year. However, if there is no claim made in subsequent Policy Year, you will earn No Claim Bonus on renewal as per the Plan. For eg, if you have a Classic Plan and have earned 20% NCB and make a claim in this year, you will not get NCB at the time of renewal. However, in the subsequent year you have not made any claim, you will again earn 10% NCB on renewal

If two or more individual Policies of Lifeline are renewed as Family Floater Policy, then the No Claim Bonus carried to the floater Sum Insured will be the lowest No Claim Bonus available amongst the Insured Persons in that Family unit. For eg, if Husband and Wife have individual cover of Rs.5lakhs each and NCB of 40% and 20% respectively and they decide to renew the policy as Family Floater at the time of renewal, then NCB carried forward to renewed policy will be 20% (lower NCB) for both the insured.

If the Base Sum Insured is increased/decreased, No Claim Bonus will be calculated on the basis of Base Sum Insured of the last completed Policy Year and will be capped to max No Claim Bonus allowed for renewed Plan Base Sum Insured.

If customer has opted for 2 years or 3 years policy, then No Claim Bonus will be added at the end of each policy year subject to no claim being made in policy year.

Illustration:

Customer has opted for 3 years policy period and sum insured of Rs. 5 Lakhs (Supreme Plan) No claim is being made in the first year, hence, No Claim Bonus is added at the end of first year i.e. 1 Lakh (20% of Sum Insured). Second year, no claim being made, hence, No Claim Bonus is added at the end of second year. Sum Insured after a period of two years will be Rs. 7 Lakhs.

8. **Re-load of Sum Insured: –** We will provide Re-load of Sum Insured upto 100% of Base Sum Insured only once in the policy year, if the Base Sum Insured and No Claim Bonus is used partially or completely due to claims made and paid or claims made and accepted as payable for one particular Illness during the Policy Year as per Policy terms and conditions provided that:

   a) It will be applicable only to subsequent claims made by the Insured Person and not against any Illness (including its complications or follow up) for which a claim has been paid or accepted as payable in the current Policy Year.
   b) Any unutilized reinstated sum insured cannot be carried forward to next year.
   c) In case of floater policy, re-load will be available on floater basis.
   d) Re-load of Sum Insured is applicable only for Baseline Cover benefits and not for optional benefits.

9. **Vaccination in case of Animal Bite (in case of Post Bite Treatment) –** We will reimburse the ujhn medical expenses incurred for vaccination including inoculation and immunizations in case of post-bite treatment up to actuals subject to the limit mentioned below. This will be part of overall sum insured. Coverage limit will be as per level:

   i. **Classic –** Upto Rs.2,500/-
   ii. **Supreme –** Upto Rs.5,000/-
   iii. **Elite –** Upto Rs.7,500/-

10. **AYUSH Treatment–** Expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines is covered up to 100% of Sum Insured, during each policy year as specified in the policy schedule

11. **Emergency Domestic Evacuation (Available for Supreme & Elite Plan only) –** We will provide domestic evacuation in case of life threatening emergency condition for treatment of an illness or injury on the advice of treating doctor subject to:

   a. Treating doctor confirms that insured need to be transferred to another hospital having suitable medical technology & equipment for treatment.
   b. Evacuation will be from one medical center to another medical center.
   c. Our maximum liability will be as mentioned below:

i. Classic – Not Available
ii. Supreme – Upto Rs.100,000/-
iii. Elite – Upto Rs.300,000/-

d. Any expenses over and above the limit specified above, customer will have to make the payment to the service provider.
e. This benefit can be availed once by an Insured Person during a Policy Year.
f. This benefit is on per Insured Person basis.

12. Worldwide Emergency Hospitalization (excluding US and Canada) (available for Elite Plan only) – We will cover medical expenses of the insured person incurred outside India as per the limit specified, provided:

a) The treatment is medically necessary and has been certified as an Emergency by a Medical Practitioner and such treatment cannot be postponed until the insured person has returned to India.
b) The medical expenses payable shall be limited to Inpatient Hospitalization only.
c) Each admissible claim will be subject to a deductible of USD 1000.
d) This benefit is available as cashless facility through pre-authorization by Our Service Provider as well as re-imbursement basis through Us. Process for cashless facility through pre-authorization by Our Service Provider is as mentioned below;
   i. In the event of an Emergency, the Insured Person or Network Hospital shall call Our Service Provider immediately, on the helpline number specified in the Insured Person's Schedule of Insurance Certificate, requesting for a pre-authorization for the medical treatment required;
   ii. Our Service Provider will evaluate the request and the eligibility of the Insured Person under the Policy and call for more information or details, if required;
   iii. Our Service Provider will communicate directly to the Hospital whether the request for pre-authorization has been approved or denied;
   iv. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider shall be borne by the Insured Person;
   v. It is agreed and understood that We shall not cover any costs or expenses incurred in relation any persons accompanying the Insured Person during the period of Hospitalization, even if such persons are also Insured Persons.
   vi. Any hospitalization should be intimated to us within 24 hours of hospitalization basis
e) The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. If on the date of discharge, RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.

f) Overall liability will be limited to 50% of Sum Insured upto a max of Rs.20 lakhs.
g) This benefit is available Worldwide excluding US and Canada.
h) Re-load of Sum Insured and Refresh of Sum Insured will not be triggered for this benefit.

13. **International Treatment abroad for specified 11 critical illnesses (excluding US and Canada)- (available for Elite Plan only) –** We will cover medical expenses of the insured person incurred outside India for below mentioned 11 specified critical illnesses:

1. Cancer of Specified Severity
2. First Heart Attack of Specified Severity
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma of Specified Severity
6. Kidney Failure requiring Regular Dialysis
7. Stroke resulting in Permanent Symptoms
8. Major Organ/Bone Marrow Transplant
9. Permanent paralysis of Limbs
10. Motor Neurone Disease with Permanent Symptoms
11. Multiple Sclerosis with Persisting Symptoms

We will pay upto the sum insured, provided:

a. Such claim in India should have been admissible under the Inpatient Care.
b. The medical expenses payable shall be limited to Inpatient Hospitalization & Day Care Hospitalization only.
c. The symptoms of the Critical Illness first occur or manifest itself during the Policy Period and after completion of the 90 days initial waiting period.
d. The Critical Illness is diagnosed by a Medical Practitioner within India during the Policy Period and after completion of the 90 day initial waiting period.
e. Customer should get the pre-authorization from us before going for treatment.
f. All claims will be subject to 20% co-payment.
g. This benefit is available worldwide except US and Canada.
h. The payment of any claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian rupees for payment of claim. If on the date of discharge, RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
i. We will also provide one time return air fare upto a maximum of Rs.3 lakhs, for insured person for whom claim has been accepted. This will be settled on reimbursement basis. This is a part of overall sum insured.
j. Re-load of Sum Insured and Refresh of Sum Insured will not be triggered for this benefit.

k. This benefit is available only as cashless facility through pre-authorization by Our Service Provider. Process for cashless facility through pre-authorization by Our Service Provider is as mentioned below;

i. In the event of the diagnosis of a Specified Illness, the Insured Person should call Our Service Provider immediately and in any event before the commencement of the travel for treatment overseas, on the helpline number specified in the Schedule of Insurance Certificate requesting for a pre-authorization for the treatment;

ii. Our Service Provider will evaluate the request and the eligibility of the Insured Person the Policy and call for more information or details, if required.

iii. Our Service Provider will communicate directly to the Hospital and the Insured Person whether the request for pre-authorization has been approved or denied.

iv. If the pre-authorization request is approved, Our Service Provider will directly settle the claim with the Hospital. Any additional costs or expenses incurred by or on behalf of the Insured Person beyond the limits pre-authorized by the Service Provider or at any Non-Network Hospital shall be borne by the Insured Person.

Value Added Covers

14. Health Checkup: We will cover the cost of health check-up arranged by us through our empanelled service providers as per your plan eligibility defined below:

i. For Classic Plan – every 2nd consecutive renewal; For Supreme & Elite Plan – Available at each renewal. This is available post payment of premium.

Plan	**List of Medical Tests**
Classic	Complete Blood Count, Urine Routine, ESR, Fasting Blood Sugar, ECG, S Cholesterol, SGPT, Creatinine
Supreme	Complete Blood Count, Urine Routine, ESR, HBa1C, Lipid Profile, Kidney Function Test, ECG, Complete physical examination be Physician
Elite	Complete Blood Count, Urine Routine, ESR, HBa1C, Lipid Profile, Stress Test (TMT) or 2D Echo, Kidney Function Test, Complete physical examination be Physician, USG abdomen

Abbreviation of test is provided here:

ESR – Erythrocyte Sedimentation Rate, ECG – Electrocardiogram, S Cholesterol – Serum Cholesterol, SGPT – Serum Glutamic Pyruvate Transaminase, TMT – Tread Mill Test, HbA1C – Glycosylated Haemoglobin Test

This benefit is available to those insured person who have attained the age of 18 years or above on the Policy Period Start Date.

This benefit is provided irrespective of any claim being made in the Policy Year. This benefit is over and above the Base Sum Insured.

15. Second Opinion for critical illnesses (Available for Supreme & Elite Plan only) – We will provide second opinion to the insured person if he is diagnosed with any of the below mentioned 11 critical illnesses:

1. Cancer
2. First Heart Attack
3. Open Chest CABG
4. Open Heart Replacement or Repair of Heart Valves
5. Coma
6. Kidney Failure
7. Stroke
8. Major Organ/Bone Marrow Transplant
9. Permanent paralysis of Limbs
10. Motor Neurone Disease
11. Multiple Sclerosis

This benefit is available only once during the policy year. Benefit is available only for adults.

16. Preventive Healthcare & Wellness and Disease Management

We will provide various preventive healthcare & wellness related activities like health related articles on your registered email ids. Disease Management initiative by us for our existing customers wherein for certain specified Health Risks such as Heart, Kidney, Liver, Cancer, Hypertension, Diabetes etc. our customers will be provided assistance to manage their risk better through preventive check-ups, advise on Nutrition, diet, exercise regime, wearables to monitor various health parameters etc. Any information provided under this will be recommendatory in nature and will not be substitute of doctor consultation.

17. Maternity Benefits (For Elite Plan Only)

Maternity Expenses: This benefit is available only to you or your spouse under Family Floater Policy, only when you and your spouse, are both covered under the same Family Floater Policy. We pay Medical Expenses for the delivery of a child, only after 36 months of continuous coverage since the inception of the first Policy with Us. In case, customer is porting from any other policy providing maternity benefit, the respective waiting period served in that policy will be considered as waiting period waiver in Lifeline policy as per portability guideline. There is a sub-limit on maternity expenses as shown in the Product Benefit Table. Maternity benefits are

paid only twice during the lifetime of the Policy including any of its renewals. However, expenses in respect of harvesting and storage of stem cells are not covered.

New Born Baby: The new born baby will be covered as an insured person from birth. We will cover medical expenses towards the medical treatment of the Insured Person's new born baby while the Insured Person is Hospitalized as an Inpatient for delivery and we have accepted the maternity claim as payable.

Vaccination for New Born Baby: We will cover Reasonable & Customary Charges for vaccination of the new born baby, if we have accepted the maternity claim as payable If the Policy Period ends before the New Born Baby has completed one year, then, We will only cover such vaccinations until the baby completes one year, provided that We have accepted the baby as an Insured Person at the time of renewal of the Policy.

18. **OPD Treatment (Available for Elite Plan Only)** We will cover reasonable & customary charges for Insured Person's medically necessary consultation with a Medical Practitioner, as an OPD Treatment to assess the Insured Person's health condition for any illness. We will also pay for any diagnostic tests prescribed by the medical practitioner and medicines purchased under and supported with a Medical Practitioner's prescription up to the sub-limits shown in the product benefits table.

We will also cover the Reasonable & Customary Charges for Dental Treatment, Cost of Spectacles, Contact Lenses and Hearing Aids once in 2 years with a sublimit of 30% of OPD Treatment sublimit shown in the Product Benefits Table.

Optional Benefits

1. Top-up Plan (on Annual Aggregate Deductibles)

Top-up plan is a modification of existing cover to annual aggregate deductible by which discount premium will be available. You can choose from one of six optional deductibles of Rs 1 lakh, Rs 2 Lakhs, Rs 3 lakhs, Rs. 4 Lakhs, Rs 5 Lakhs and Rs.10Lakhs. You can choose to the take the top up cover under Classic & Supreme Plan.

If a top-up plan (on annual aggregate deductible) is chosen then the insured person shall bear all assessed claim amounts payable under the policy up to the deductible amount, under his policy for any Policy Year. Our liability to make payment under the Policy in respect of any claim made in that Policy Year will only commence once the Deductible has been exhausted.

Any claim amount that is assessed to be payable by Royal Sundaram under this policy during the policy period and is borne by the insured person (even if paid for through another Health Insurance Policy) will be accepted as reason of deductible exhaustion.

Insured Person should submit all the claim documents to us to calculate the exhaustion of deductible on aggregate basis. We will inform the insured person once the deductible amount is exhausted and any claim (assessed to be payable) exceeding the deductible will be paid by us.

Illustration:

Working of Top-up Plan on aggregate annual deductible basis:

Customer has an existing policy with SI of Rs.2lakhs from another company. He opts for a Lifeline Policy for SI of Rs.3lakhs, with annual aggregate Deductible of Rs. 2lakhs

CALCULATIONS		Claim Amount Assessed by Us	Deductible Exhaustion	Balance Deductible	Available Sum Insured in Lifeline policy	Claim amount paid by the other insurance policy or the customer	Claim Amount paid by Us
	At Inception	-	-	Rs 200,000	Rs 300,000	-	-
	Claim 1	Rs 20,000	Rs 20,000	Rs 1,80,000	Rs 300,000	Rs 20,000	0
	Claim 2	Rs 1,90,000	Rs 1,80,000	0	Rs 300,000	Rs 1,80,000	Rs 10,000
	Claim 3	Rs 3,60,000	0	0	Rs 290,000	0	Rs. 2,90,0000

Customer has an option to convert the Top-up Plan to a normal policy at the time of renewal by paying an additional premium. For eg, if a customer had a Top-up Plan with a deductible of Rs.2 lakhs and Sum Insured of Rs.3 lakhs, he was paying 72% of premium (as per multiplicative Factor mentioned in Rate Table) for Rs.3lakhs cover. Now, if customer wants to convert it to a normal policy without any deductible at time of renewal, he will pay the 100% of premium as per Rate Table.

2. Hospital Cash

If the insured person is hospitalized and if We have accepted an inpatient care hospitalization claim under the base plan, We will pay the hospital cash amount as opted by you for each continuous and completed period of 24 hours of hospitalization provided that:

(a) You should have been hospitalized for a minimum period of 48 hours continuously;

(b) We will not make any payment under this optional benefit in respect of an Insured Person for more than 30 days of hospitalization in total under any policy year;

(c) We will not make any payment under this optional benefit for any diagnosis or treatment arising from or related to pregnancy (whether uterine or extra uterine), childbirth including caesarean section, medical termination of pregnancy and/or any treatment related to pre and post natal care of the mother or the new born baby.

The Sum Insured under Hospital Cash is over and above the base Sum Insured. Hospital Cash benefit is not available for hospitalization in case of Supreme Plus and Elite Plus optional covers.

3. Include US and Canada for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illnesses.

You can opt to include US and Canada for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness. This benefit can be opted at the inception of first policy with Us.

4. Supreme Plus

The following benefits shall be offered as a part of Supreme Plus:

1. Additional facility of app based cabs as a part of Ambulance Cover

We will cover charges for app based cabs service incurred towards transportation of an Insured Person at the time of getting admitted to the Hospital or discharge to the Hospital. This benefit is available only on reimbursement basis on the basis of submission of an invoice generated by a digital app based cab service and the invoice should mention details such as date, location of pick-up and drop and time of pick-up and drop. e.g. Ola and Uber. Hand-written paper invoice will not be accepted. The maximum benefit will be restricted up to sub-limit of ambulance cover applicable to your Plan. The benefit is available only for cab ride taken by the Insured Person at the time of Hospital admission or discharge.

2. Refresh of Sum Insured

a. Refresh of Sum Insured is a part of Re-load of Sum Insured. Re-load of Sum Insured is payable only in case of a) Base Sum Insured and No Claim Bonus is completely exhausted. b) same Insured for Illness other than for which claims has already been paid in the same policy year. c) different Insured for the same Illness for which claims has already been paid in the same policy year. The Refresh of Sum Insured shall be available for subsequent claims towards an Illness/Disease/Injury (including complications) for which a claim has been paid or accepted as payable in the current Policy Year for the same Insured Person under Inpatient Care. For triggering Refresh of Sum insured, Insured Person or immediate kin will have to provide his written consent for utilizing Refresh of Sum Insured.

b. Refresh of Sum Insured is available only once in the lifetime of the policy for any one member in a policy.

c. If the Refresh of Sum Insured is partially utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

d. Refresh of Sum Insured is applicable only for Baseline Cover benefits and not for optional benefits.

3. In-patient for Pre-existing Disease in case of Life Threatening Condition

1. We will cover hospitalization expenses resulting from any of the Pre-existing disease which has been specifically disclosed by you at the time of inception of the policy and has been mentioned in the Policy schedule issued to you.
2. This benefit is available only in the event of Life Threatening condition.
3. Certification by the treating Medical Practitioner of such life threatening emergency condition.
4. This benefit is limited to a maximum of Rs. 1,00,000.
5. This benefit is available only once in the Lifetime of the Policy at a policy level.
6. This benefit is available only on reimbursement mode.
7. This benefit can be availed by any one of the member in the policy. Once utilized by any member will not be available to other members in the policy in future.

4. Bariatric Surgery

1. If You are hospitalized on the advice of a Doctor and required you to undergo Bariatric Surgery during the Policy period.
2. This benefit is available to Insured Person aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records and BMI of Insured Person greater than or equal to 35 which is leading to medical complications and bariatric surgery is needed to deal with such complications.
3. This benefit is available only if insured Person has opted for Supreme Plus for a period of 72 months without any break.
4. Policies which are issued with continuity under portability guidelines either from our existing Health Product or any other Non-Health or Standalone Health Insurance Company will have to wait for 72 months from the date of inception of Supreme Plus optional cover.
5. Our maximum liability will be restricted to Rs. 50,000.
6. Bariatric surgery performed for Cosmetic reasons is excluded.
7. This benefit shall not apply where the surgery is performed for:

   I. Reversible endocrine or other disorders that can cause obesity
   II. Current drug or alcohol abuse

III. Uncontrolled, severe psychiatric illness
IV. Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery.

8. Any future complications arising out of bariatric treatment post-surgery will not be covered.
9. At the time of claiming the benefit, Insured Person should be covered under Supreme Plus.

5. Mobility Devices

1. We shall cover expenses incurred by Insured Person towards mobility devices such as walkers, manual wheelchair, crutches, splints, external prosthetics, slings, plasters, etc. which has been advised as a part of treatment to deal with the disability induced by an accident. These expenses can be part of in-patient or post-discharge. This is not payable in case of Pre-hospitalisation, out-patient treatment and any sickness related claims.
2. This benefit is only available if the claim of accidental injury has been admissible by us.
3. Our maximum liability will be restricted to 5% of the Sum Insured or Rs. 50,000 whichever is lesser.

6. Second Opinion for additional 11 specified Critical Illnesses (Total 22 Critical Illnesses)

Following additional 11 Critical Illnesses are covered for Second Opinion:

1. Angioplasty
2. Benign brain Tumor
3. Blindness
4. Deafness
5. End stage lung Failure
6. End stage liver failure
7. Loss of speech
8. Loss of limbs
9. Major head trauma
10. Primary (idiopathic) pulmonary hypertension
11. Third degree burns

5. Elite Plus

The following benefits shall be offered as a part of Elite Plus:

1. Additional facility of app based cabs as a part of Ambulance Cover

We will cover charges for app based cabs service incurred towards transportation of an Insured Person at the time of getting admitted to the Hospital or discharge to the Hospital.

This benefit is available only on reimbursement basis on the basis of submission of an invoice generated by a digital app based cab service and the invoice should mention details such as date, location of pick-up and drop and time of pick-up and drop. e.g. Ola and Uber. Hand-written paper invoice will not be accepted. The maximum benefit will be restricted up to sub-limit of ambulance cover applicable to your Plan. The benefit is available only for cab ride taken by the Insured Person at the time of Hospital admission or discharge.

2. Refresh of Sum Insured

a. Refresh of Sum Insured is a part of Re-load of Sum Insured. Re-load benefit is payable only in case of a) Base Sum Insured and No Claim Bonus is completely exhausted. b) same Insured for Illness other than for which claims has already been paid in the same policy year. c) different Insured for the same Illness for which claims has already been paid in the same policy year. The Refresh of Sum Insured shall be available for subsequent claims towards an Illness/Disease/Injury (including complications) for which a claim has been paid or accepted as payable in the current Policy Year for the same Insured Person under Inpatient Care. For triggering Refresh of Sum insured, Insured Person or immediate kin will have to provide his written consent for utilizing Refresh of Sum Insured.

b. Refresh of Sum Insured can be utilized only once in the lifetime of the policy by any of the Insured members.

c. If the Refresh of Sum Insured is partially utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

d. Refresh of Sum Insured is applicable only for Baseline Cover benefits and not for optional benefits

3. In-patient for Pre-existing Disease in case of Life Threatening Condition

1. We will cover hospitalization expenses resulting from any of the Pre-existing disease which has been specifically disclosed by you at the time of inception of the policy and has been mentioned in the Policy schedule issued to you.
2. This benefit is available only in the event of Life Threatening condition.
3. Certification by the treating Medical Practitioner of such life threatening emergency condition.
4. This benefit is limited to a maximum of Rs. 2,00,000.
5. This benefit is available only once in the Lifetime of the Policy at a policy level.
6. This benefit is available only on reimbursement mode.
7. This benefit can be availed by any one of the member in the policy. Once utilized by any member will not be available to other members in the policy in future.

4. Bariatric Surgery

1. If You are hospitalized on the advice of a Doctor and required you to undergo Bariatric Surgery during the Policy period.
2. This benefit is available to Insured Person aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records and BMI of Insured Person greater than or equal to 35 which is leading to medical complications and bariatric surgery is needed to deal with such complications.
3. This benefit is available only if insured Person has opted for Elite Plus for a period of 48 months without any break.
4. Policies which are issued with continuity under portability guidelines either from our existing Health Product or any other Non-Health or Standalone Health Insurance Company will have to wait for 48 months from the date of inception of Elite Plus optional cover.
5. Our maximum liability will be restricted to Rs. 2,00,000.
6. Bariatric surgery performed for Cosmetic reasons is excluded.
7. This benefit shall not apply where the surgery is performed for:
   i. Reversible endocrine or other disorders that can cause obesity
   ii. Current drug or alcohol abuse
   iii. Uncontrolled, severe psychiatric illness
   iv. Lack of comprehension of risks, benefits, expected outcome, alternatives and lifestyle changes required with bariatric surgery.
8. Any future complications arising out of bariatric treatment post-surgery will not be covered.
9. At the time of claiming the benefit, Insured Person should be covered under Elite Plus.

5. Mobility Devices

1. We shall cover expenses incurred by Insured Person towards mobility devices such as walkers, manual wheelchair, crutches, splints, external prosthetics, slings, plasters, etc. which has been advised as a part of treatment to deal with the disability induced by an accident. These expenses can be part of in-patient or post-discharge. This is not payable in case of Pre-hospitalisation, out-patient treatment and any sickness related claims.
2. This benefit is only available if the claim of accidental injury has been admissible by us.
3. Our maximum liability will be restricted to Rs. 50,000.

6. Second Opinion for additional 11 specified Critical Illnesses (Total 22 Critical Illnesses)

Following additional 11 Critical Illnesses are covered for Second Opinion:

1. Angioplasty
2. Benign brain Tumor
3. Blindness
4. Deafness
5. End stage lung Failure
6. End stage liver failure

7. Loss of speech
8. Loss of limbs
9. Major head trauma
10. Primary (idiopathic) pulmonary hypertension
11. Third degree burns

7. International Treatment abroad for 3 additional Critical illnesses (Total 14 specified critical illnesses)

Following additional 3 Critical Illnesses are covered for International Treatment abroad:

1. End Stage Liver Disease
2. End Stage Lung Disease
3. Third Degree burn

8. In-Vitro Fertilisation(IVF) Treatment

We will reimburse medical expenses incurred on IVF Treatment, where indicated, for sub-fertility subject to:

a. A waiting period of 48 months from the date of inception of the Elite Plus with the Company for the insured person.
b. The maximum cumulative liability in lifetime of the policy of the Company for such treatment shall be limited to Rs.2,50,000/-.
c. For the purpose of claiming under this benefit, in- patient treatment is not mandatory.
d. For claim under this benefit, Insured person should have opted for Elite Plus for a period of 48 months without any break.
e. Re-load and Refresh of Sum Insured Benefit shall not be applicable for this benefit.
f. This Benefit can be used for a maximum of 3 cycles subject to a maximum of Rs. 2,50,000 as a cumulative benefit.
g. To be eligible for this benefit both husband and wife should stay insured continuously without break for a period of 48 months under Elite Plus.
h. This benefit does not cover Surrogacy.
i. This benefit covers intrauterine insemination (IUI), Intra-Cytoplasmic Sperm Injection (ICSI), In-Vitro Fertilisation(IVF).
j. Maximum age of female member should be less than 45 years.
k. To claim under this benefit, we would require certificate and case history from the treating doctor which has necessitated treatment.
l. Available once in lifetime of the policy for a maximum of 3 IVF cycles.
m. Under this benefit, maximum of 3 cycles of the treatment as mentioned above should be utilized in maximum 3 consecutive policy years.
n. At the time of claiming the benefit, Insured Person should be covered under Elite Plus.
o. Any treatment or side effects resulting in hospitalization arising as a consequence to infertility treatment is not payable.

Note: For processing claim under In-Vitro Fertilisation(IVF) Treatment, following additional documents will be required to be submitted:

1. Certificate from treating medical practitioner mentioning the exact diagnosis, case history with treatment advised.
2. All previous consultation papers indicating history and treatment details

Policy Features

1. Age Eligibility

Children: The minimum entry age under this policy is 91 days and maximum is 25 years.

Adult: Minimum entry age is 18 years. There is no limit on maximum entry age in this policy.

2. Individual & Family Combination

The policy can be purchased on an Individual basis or on a Family Floater basis. In case of a family floater policy, one family will share a single sum insured as opted. A floater plan can cover self, spouse and dependent children upto age of 25 years. A floater cover can cover a maximum of 2 adults and 4 dependent children under a single policy.

3. Policy Period Option

Customer can buy the policy for one, two or three continuous years at the option of the Insured. 'One Policy Year' shall mean a period of one year from the date of issuance of the policy.

4. Plan & Sum Insured Options

Customer has the option to choose from a wide range of Sum Insured's available under 3 Plans:

Plan	**Sum Insured**
Classic	Rs.2lakhs, Rs.3lakhs, Rs.4lakhs
Supreme	Rs.5lakhs, Rs. 7.5 lakhs, Rs.10lakhs, Rs.15lakhs, Rs.20lakhs, Rs. 25 lakhs, Rs. 50 Lakhs, Rs, 100 lakhs
Elite	Rs.25lakhs, Rs.30lakhs, Rs.50lakhs, Rs.100lakhs, Rs.150lakhs

Sum Insured is on Annual basis.

5. Premium

The Premium charged on the Policy will depend on the Sum Insured, Policy Tenure, Age, Policy Type, Zone of Cover and Optional Covers opted. Additionally, the health status of the individual will also be considered.

For detailed premium chart please refer Annexure "Rate Chart" attached along with this document.

For the purpose of calculating premium, the country has been divided into 2 Zones.

Zone 1: Delhi/NCR, Mumbai (inc. Thane and Vashi), Bengaluru, Chennai, Pune, Hyderabad, Kolkata and Gujarat.

Zone 2: Rest of India.

A discount of 25% for members in Zone 2 will be applicable. Grid as below:

ZONE	Discount
Zone 1	0%
Zone 2	25%

Premium payment can be made Annual, Half-yearly, Quarterly, Monthly.

6. Loading

The premium can be loaded for optional benefits as opted by customers.

7. Disease Specific Loading/Co-payment

We shall apply a risk loading on the premium payable or Co-payment for certain specific conditions as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Schedule of Insurance Certificate. The maximum risk loading applicable shall not exceed 150% per diagnosis / medical condition and an overall risk loading of 200%. These loadings are applied from the inception of the initial Policy including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured). The maximum risk Co-payment shall not exceed 30% per diagnosis/medical condition and an overall risk co-payment of 30%.

We will inform You about the applicable risk loading and/or applicability of Co-payment through post/courier/email/phone. You shall revert to Us with your written consent and additional premium (if any), within 7 days of the issuance of such counter offer. In case, You neither accept the counter offer nor revert to Us within 7 days, We shall cancel Your application and refund the premium paid within the next 7 days.

8. Discounts

Customer can avail of the following discounts on the premium of their policy.

- Discount on Multiyear policy
    - 7.5% discount for 2 years policy
    - 12% discount for 3 years policy
- 5% discount for Sundaram Group employees & customers purchasing through the direct channel

9. Renewal Features

a) This Policy will automatically terminate at the end of the Policy Period. This Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium. All Renewal application should reach Us on or before the Policy Period End Date.

b) We may in Our sole discretion, revise the Product and Renewal premium payable under the Policy provided that revision to the Renewal premium are in accordance with the IRDAI rules and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification.

c) The premium payable on renewal shall be paid to Us on or before the Policy Period End Date and in any event before the expiry of the Grace Period. For the purpose of this provision, Grace Period means a period of 15 days in case of monthly payments and 30 days in case of quarterly, half-yearly and yearly payments immediately following the Policy Period End Date during which a payment can be made to renew this Policy without loss of continuity benefits such as Waiting Periods and coverage of Pre Existing Diseases. If the premium is paid in instalments, coverage will still be available during the grace period,

d) Renewal of the Policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation or fraud or non-cooperation by You.

e) We reserve the right to carry out underwriting in relation to any alterations like increase/decrease in Sum Insured, change in plan/coverage, addition/deletion of members, addition/deletion of Medical Conditions, request at the time of Renewal of the Policy. Any request for acceptance of changes on renewal will be subject to underwriting. The terms and conditions of the existing Policy will not be altered.

f) This product may be withdrawn by Us after due approval from the IRDAI. In case this product is withdrawn by Us, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDAI. We shall duly intimate You regarding the withdrawal of this product and the options available to You at the time of Renewal of this Policy.

g) In case of floater policies, children attaining 25 years at the time of renewal will be moved out of the floater into an individual cover however all continuity benefits on the policy will remain intact. Cumulative Bonus earned will be suitably passed on the fresh policy of child.

10. Portability Benefit

The insured Person will have the option to port the policy to other insurers as an extant Guidelines related to portability. If such person is presently covered and has been continuously

covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

a) The waiting periods shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.

b) Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

c) For Detailed Guidelines on Portability, kindly refer the below link: -

https://www.royalsundaram.in/health-insurance/health-insurance-portability

11. Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. lf such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefits shall not apply to any other additional increased Sum Insured.
iii. For Detailed Guidelines on Migration, kindly refer the below link:-

https://www.royalsundaram.in/html/files/Modification-guidelines-on-standardization-in-health-insurance-Migration.pdf

12. Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any his/her policies. In all such cases the insurer if chosen by the policy holder 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.
2. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the suns insured under a single policy after, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

4. 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.

13. Premium Payment in Instalment

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of insurance, the following Conditions shall apply (not withstanding any terms contrary elsewhere in the Policy)

1) In case of monthly mode of premium payment, grace period of 15 days is allowed and would be given maximum two times in a policy period. In case of quarterly and half-yearly and yearly mode of premium payment, grace period will be allowed maximum only once for a period of 30 days for payment of the instalment premium due for the policy.
2) If the premium is paid in instalments, coverage will still be available during the grace period.
3) The Benefits provided under — "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
4) No interest will be charged if the instalment premium is not paid on due date.
5) In case of instalment premium due not received within the grace period, the policy will get cancelled.
6) ln the event of a claim, all subsequent premium instalments shall immediately become due and payable.
   The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

14. Income Tax benefit

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act 1961. (Tax benefits are subject to change in the tax laws, please consult your tax advisor for more details).

15. Free Look Period

At the inception of the policy the Insured Person will be allowed a period of 30 days 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. If Insured Person has not made any claim during the free look period, he will be entitled to the following, provided no claim has been settled or lodged for the period the policy has been in force:

a) A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured person and the stamp duty charges or;

b) where the risk has already commenced and the option of return of the policy is exercised, a deduction towards the proportionate risk premium for period on cover or;

c) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

d) Free-look will not be applicable for policies with tenure less than one year.

e) Free-look not applicable in case of renewals.

All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

16. Redressal of grievance

ln case of any grievance the insured person may contact the company through

Website: https://www.royalsundaram.in

Grievance Redressal: https://www.royalsundaram.in/customer-service

You may call us at – 1860 258 0000, 1860 425 0000

Email:

1. Please raise a complaint with us through e mail – care@royalsundaram.in, and we would come back to you with a response in 24 hours.
2. In case you are not satisfied with our response or have not received any response in 24 hours, you may write to manager.care@royalsundaram.in
3. If you feel you are not heard of or have not received any response in 2 business days, you may escalate it to head.cs@royalsundaram.in
4. In case you are not happy with our response or have not received any response in 2 business days, you may approach gro@royalsundaram.in - GRO Contact Number – 7228087400

Sr. Citizen can email us at : seniorcitizengrievances@royalsundaram.in - Senior Citizen Grievance Number - 7228933501 (A separate e-mail id for Senior Citizens has been created for the ease and convenience of Senior citizens)

Fax us at: 044 – 7117 7140

Courier us your complaint at:

Royal Sundaram General Insurance Co. Limited

Vishranthi Melaram Towers,

No.2/319, Rajiv Gandhi Salai (OMR)

Karapakkam, Chennai – 600097

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the Redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Mr. T M Shyamsunder
Grievance Redressal Officer
Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers,

No.2/319, Rajiv Gandhi Salai (OMR)
Karapakkam, Chennai – 600097

For updated details of grievance officer, kindly refer the link http://www.royalsundaram.in

lf Insured person is not satisfied with the Redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for Redressal of grievance as per insurance Ombudsman Rules 2017.

Insurance Ombudsman addresses -https://www.cioins.co.in/ContactUs

Grievance may also be lodged at –

Registration of Complaints in Bima Bharosa by Policyholders:

1. Can directly register complaint in the **Bima Bharosa Portal** https://bimabharosa.irdai.gov.in/
2. Can send the complaint through Email to complaints@irdai.gov.in.
3. Can call Toll Free No. **155255** or **1800 4254 732**.
4. Apart from the above options, if it is felt necessary by the complainant to send the communication in physical form, the same may be sent to IRDAI addressed to:

   General Manager
   Insurance Regulatory and Development Authority of India(IRDAI)
   Policyholder's Protection & Grievance Redressal Department – Grievance Redressal Cell.
   Sy.No.115/1, Financial District, Nanakramguda,
   Gachibowli, Hyderabad – 500 032.

No loading shall apply on renewals based on individual claims experience.

Insurance is the subject matter of solicitation.

17. Cancellation/Termination

The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing.

The Company shall:

a. refund proportionate premium for unexpired policy period, if the term of policy is up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

The Company may cancel the Policy at any time on grounds of misrepresentative, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Waiting Periods and Exclusions:

Claims for the following are not covered:

- **30 Days Initial Waiting Period**: We will not cover any treatment taken during the first 30 days since the commencement of the Policy, unless the treatment needed is a result of an Accident. This waiting period does not apply for any subsequent and continuous renewals of your Policy or Policy is enforced with any other Insurance Company (Non-Life/Health Insurance Company).

- **90 days Initial Waiting Period for Critical Illness :** We will not cover any treatment for critical illness, symptoms of which first occur or manifest itself during the first 90 days since the date of commencement of the policy.

- **Pre-Existing Diseases**: Benefits will not be available for Pre-existing Diseases for Classic Plan and Supreme Plan until 36 months and for Elite Plan until 24 months of continuous coverage have elapsed since the inception of the first Policy with us or Policy is enforced with any other Insurance Company (Non-Life/Health Insurance Company).

- **Specific Waiting Periods:** For all insured persons the 16 conditions listed below will be subject to a waiting period of 24 months and will be covered in the third policy year as long as the insured person has been insured continuously under the Policy without any break:

  • Stones in biliary and urinary systems • Lumps / cysts / nodules / polyps / internal tumours • Gastric and Duodenal Ulcers • Surgery on tonsils / adenoids • Osteoarthrosis / Arthritis / Gout / Rheumatism / Spondylosis / Spondylitis / Intervertebral Disc Prolapse • Cataract • Fissure / Fistula / Haemorrhoids • Hernia / Hydrocele • Chronic Renal Failure or end stage Renal Failure • Sinusitis / Deviated Nasal Septum / Tympanoplasty / Chronic Suppurative Otitis Media • Benign Prostatic Hypertrophy • Knee/Hip Joint replacement • Dilatation and Curettage • Varicose veins • Dysfunctional Uterine Bleeding / Fibroids / Prolapse Uterus / Endometriosis • Hysterectomy for any benign disorder.

- **Personal Waiting Periods:** A special waiting period not exceeding 36 months, may be applied to Individual Insured Persons depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule of Insurance Certificate and will be applied only after receiving Your specific consent.

  Specific Exclusions: Investigation & Evaluation, Rest Cure, rehabilitation and respite care, Obesity/ Weight Control, Change-of-Gender treatments, Cosmetic or plastic Surgery, Hazardous or Adventure sports, Breach of law, Excluded Providers, Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences, Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons, Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure, Refractive Error, Unproven Treatments, Sterility and Infertility, Maternity, Alternative treatment, Ancillary Hospital Charges, Charges for medical papers, Circumcision, Conflict and disaster, Congenital conditions, Convalescence and Rehabilitation, Dental/oral treatment, Drugs and dressings for OPD Treatment or take-home use, Hereditary conditions, Items of personal comfort and convenience, including but not limited to : (A)Telephone, television, diet charges, (unless included in room rent) personal attendant or barber or beauty services, baby food, cosmetics,

  napkins, toiletry items, guest services and similar incidental expenses or services (B) Private nursing/attendant's charges incurred during Pre-hospitalization or Post-hospitalization (C) Drugs or treatment not supported by prescription etc., OPD Treatment, Preventive Care, Self-inflicted injuries, Sexual problems, Sexually transmitted diseases, Sleep disorders, Treatment for Alopecia, Treatment for developmental problems, Treatment received outside India, Artificial life maintenance is not covered from the time Insured Person goes into vegetative state and a point of no recovery to Life, Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense.

- For details of specific exclusions please read the policy terms and conditions or visit www.royalsundaram.in .

- The expenses that are not covered in this policy are placed under List-I of Annexure-1.
- **Moratorium Period:** After completion of five continuous years under this policy no look back would be applied. This period of five years is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of five continuous years would be applicable from the date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.
- Bariatric Surgery- 72 months (Supreme Plus)

48 months (Elite Plus)

- In-Vitro Fertilisation(IVF) Treatment – 48 months
- In case of non-disclosure of a condition, we can incorporate additional waiting period of not exceeding 36 months for the said undisclosed disease or condition from the date the un-disclosed condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.
- Where the non-disclosed condition allows us to continue the coverage by levying extra premium or loading based on the objective criteria laid down in the Board approved underwriting policy, we shall levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, If the un-disclosed condition is surfaced before the expiry of the policy term, we may charge the extra premium or loading retrospectively from the first year of issuance of the policy or renewal, whichever is later.

Claims Procedure

It is imperative to note that Cashless Claims will be settled through TPA and Re-imbursement Claims will be settled by Us.

For admission in Network Hospital (Cashless Claims) (For Domestic Claims only)

Insured Person shall call the TPA helpline and furnish Membership Number, Policy Number and the Name of the Patient within 72 hours before admission to hospital for planned hospitalization and not later than 48 hours of admission in case of emergency hospitalization. The insured shall also provide to the TPA by e-mail or through TPA's web portal, the details of hospitalization like diagnosis, name of hospital, duration of stay in hospital, estimated expenses of hospitalization etc. in the prescribed form available with the Insurance help desk at the Hospital. The Insured shall also provide any additional information or medical record as may be required by the medical panel of the TPA. After establishing the admissibility of the claim under the policy, the TPA shall provide a pre-authorisation to the hospital guaranteeing payment of the hospitalization expenses subject to the sum insured, terms conditions and limitations of the policy. The difference between the amount of pre-authorisation approved and the final hospital bill owing to deductions such as non-payable items, excluded items, policy sub-limits, copay amount, deductible amt etc, shall be borne by the insured.

Details of TPA: as mentioned in your Schedule of Insurance

For admission in Non-Network Hospital or into Network Hospital if cashless facility is not availed (Re-imbursement Claims) (For Domestic Claims as well as Worldwide Emergency Hospitalization)

- **Notice of claim:** Preliminary notice of claim with particulars relating to Policy number, Name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and

address of the attending hospital, should be given to the Insurer within 72 hours before admission incase of planned hospitalization, and not later than 48 hours or before discharge, in case of emergency hospitalization.

- **Submission of claim:** The insured shall submit the claim form along with attending physician's certificate duly filled and signed in all respects with the following claim documents not later than 30 days from the date of discharge.

Mandatory documents

1. Discharge summary (detailed) describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
2. Death summary in case of death of the insured person at the hospital.
3. First consultation papers
4. Doctor's prescriptions confirming diagnosis/advising hospitalization
5. All test reports such as X-rays, ECG, Scan, MRI, Pathology etc, including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought).
6. Hospital Final Bill and advance and final hospital payment receipts, in Original.
7. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.
8. F.I.R/MLC. in the case of accidental injury and English translation of the same, if in vernacular language.
9. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury (in the absence of FIR)
10. Legal heir certificate in the absence of nomination under the policy, in case of death of the proposer. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required.
11. For a) maternity claims, Discharge Summary mentioning LMP, EDD & Gravida b)Cataract claims - IOL sticker c) PTCA claims - Stent sticker. d) Implant sticker for surgeries involving implants
12. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.
13. Complete medical records of past hospitalization/treatment, if any.
14. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital.

15. For OPD claims and Vaccination Animal Bite claims – Bills/Receipts and doctor's prescription advising the same
16. For Emergency Domestic Evacuation
    a) Certification by the treating Medical Practitioner of such life threatening emergency condition and confirming that current Hospital does not have suitable medical equipment & technology for the life threatening condition
    b) Bills/Receipts of transportation agency/ambulance company/air ambulance receipts
17. For Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness – Insured Person/Attendants -passport, Visa, Tickets and Boarding Passes

Documents to be submitted if specifically sought:

1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart). (if available)
2. Copy of extract of Inpatient Register.
3. Attendance records of employer/educational institution.
4. Attending Physician's certificate clarifying
    - reason for hospitalization and duration of hospitalization
    - history of any self-inflicted injury
    - history of alcoholism, smoking
    - history of associated medical conditions, if any
5. Previous master health check-up records/pre-employment medical records, if any.
6. Any other document necessary in support of the claim on case to case basis.

The claim documents should be sent to:

Health Claims Department

Royal Sundaram General Insurance Co. Ltd

Vishranthi Melaram Towers,

No.2/319, Rajiv Gandhi Salai (OMR)

Karapakkam, Chennai - 600097

Payment of Claim

- No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means.

- Insured must give at his expense, all the information asked by Us about the claim and he must help to take legal action against anyone if required.
- If required the Insured / Insured Person must give consent to obtain Medical Report from Medical Practitioner at Our expense.
- If required the Insured or Insured Person must agree to be examined by a medical practitioner of Our choice at Our expense.
- All claims under this Policy shall be payable in Indian Currency. All medical treatments for the purpose of this insurance will have to be taken in India only except for Worldwide Emergency Hospitalization and International Treatment for specified Critical Illness.
- Benefits payable under this policy will be paid within 30 days of the receipt of last necessary document.
- All claims are to be notified to Us within a timeline as per Section 5(b). In case where the delay in intimation is proved to be genuine and for reasons beyond the control of the Insured Person or Nominee specified in the Schedule of Insurance Certificate, We may condone such delay and process the claim. Please note that the waiver of the time limit for notice of claim and submission of claim is at Our evaluation.
- We shall be liable to pay interest at 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed, for sums paid or payable under this Policy, upon acceptance of an offer of settlement by the insured but there is a delay in payment beyond 7 days the date of acceptance.
- At the time of claim settlement, We may insist on KYC documents of the Proposer as per the relevant AML guidelines in force.

Nomination Facility:

You are mandatorily required at the inception of the Policy, to make a nomination for the purpose of payment of claims under this policy, in the event of death.

Disclosure:

All insured persons' personal information collected or held by Royal Sundaram may be used by Royal Sundaram for processing the claims and analysis related to insurance / reinsurance business.

How to Buy Royal Sundaram Policy

Royal Sundaram policy is sold through various channels like telesales team, direct team, individual agents, our website www.royalsundaram.in, licensed brokers and corporate agents.

1. You should go through the product brochure, policy benefits, exclusions etc to thoroughly understand the product before buying.

2. Proposal Form must be filled. You will be required to provide various information (as accurately as possible) such as;

    - Insured's' name, date of birth, and address.
    - As above for all dependants to be covered by the policy.
    - Selection of sum insured & optional covers (if any).
    - Any existing health insurance policy details and claims history, if applicable.
    - Disclosure of any Pre-existing Diseases with details.
    - Medical history report for the proposed insured, if necessary.
    - Height and weight for the proposed insured.
    - Signature and date on application, wherever applicable.
    - Premium payment collected and receipted
    - Selection of Third Party Administrator (TPA)
    - Electronic Insurance Account number

3. If You are required to undergo medicals tests as per the chosen Sum Insured, Age band and BMI, we would arrange the medical check-up's at Our network of diagnostic centres.

4. Based on the above information we will process Your proposal for Insurance and a policy kit containing the Benefit Schedule, Policy Terms and associated documents will be sent to you.

In case we are unable to underwrite Your proposal We will intimate the same to You and refund any premium that has been collected. Upon assessment if there is any change in terms or premium is loaded then We will inform You about any revised terms through a counter offer letter. We will issue the Policy only once you accept the counter offer. Where You do not agree to the counter offer we will cancel your proposal and refund any premium collected.

Pre-policy Medical Check-up requirements:

We will require You to undergo a medical check-up based on Your age and the Sum Insured opted as provided in the grid below or on the basis of Your BMI as per underwriter evaluation. 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, irrespective of Age/ Sum Insured opted. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You. The validity of medical tests would be; for medical tests reports with test result within normal range, the validity is for 6 months from the date of tests done, whereas for medical tests reports with test result not within the normal range, validity is for 3 months from the date of tests done.

Wherever required we may request for additional tests to be conducted based on the declarations on the proposal form and the results of any medical tests that we have received.

Medical Underwriting Grid for all channels (other than Bancassurance Channel – Nationalized, Private and Foreign Banks)

Age/ Sum Insured	Sum Insured up to Rs.10 Lakhs	Sum Insured of Rs.15 Lakhs and Rs.20 Lakhs	Sum Insured of Rs.25 Lakhs & above
Up to 5 years	No Check-up[#]	No Check-up[#]	No Check-up [#]
6 years to 18 years	No Check-up [#]	No Check-up [#]	MER
19 years to 50 years	No Check-up* [#]	Set 1	Set 2
51 years and above	Set 1	Set 2	Set 2

Medical Underwriting Grid (For Bancassurance Channel – Nationalized, Private and Foreign Banks)

Age/ Sum Insured	Sum Insured up to Rs.10 Lakhs	Sum Insured of Rs.15 Lakhs and Rs.20 Lakhs, Rs.25 Lakhs	Sum Insured of Rs.30 Lakhs & above
Up to 5 years	No Check-up[#]	No Check-up[#]	No Check-up [#]
6 years to 18 years	No Check-up [#]	No Check-up [#]	MER
19 years to 50 years	No Check-up* [#]	No Check-up [#]	Set 2
51 years and above	Set 1	Set 2	Set 2

[#] Subject to no adverse medical conditions as disclosed in proposal form.

- Medical test mix:

  - **Set 1:** CBC, ESR, URA, MER, HbA1C, S Cholesterol, ECG, SGPT, S Creatinine.
  - **Set 2:** CBC, ESR, URA, MER, HbA1C, Lipid Profile, TMT or ECG+2D Echo, LFT with GGT, RFT, HBsAg, S Creatinine.

(Abbreviation of test is provided here: CBC – Complete Blood Count, ESR – Erythrocyte Sedimentation Rate, MER – Medical Examination Report, HbA1C – Glycosylated Haemoglobin Test, S Cholestrol – Serum Cholestrol, ECG – Electrocardiogram, SGPT – Serum Glutamic Pyruvate Transaminase, S Creatinine – Serum Creatinine, TMT – Treadmill Test, LFT with GGT –

Liver Function Test, RFT – Renal Function Test, HBsAg – Hepatitis B Surface Antigen), URA-Urine Routine Analysis

- If the BMI of proposed insured is more than or equal to 33, proposal will be subject to medical underwriting. Underwriter might trigger the medical test post evaluation of medical condition of the proposed insured.
- Any additional tests such USG Abdomen and pelvis, MRI, CT Angio to be triggered as per underwriter's discretion.
- No home visits for Lifeline Classic Plan (both individual and family floater) proposals.
- Home visits for Lifeline Supreme & Elite Plan. However, in case of Supreme Plan, customer needs to pay the home visit charges. Home visit charges will be in the range of Rs. 200 to Rs. 400 per Home visit.
- Any waiver of medical tests to be approved by Head – Underwriting and/or Chief Product Officer.

Cost of Pre Policy Medical Check-up (PPMC):

Levels	Proposal Accepted	Proposal Rejected
Classic	Royal Sundaram to bear 50% cost of PPMC	Customer to bear 100% cost of PPMC
Supreme	Royal Sundaram to bear 100% cost of medical examination	Royal Sundaram to bear 100% cost of PPMC
Elite	Royal Sundaram to bear 100% cost of PPMC	Royal Sundaram to bear 100% cost of PPMC

Note: In case of any cancellation by customer or non-acceptance of counter-offer within specified timeline, we will refund the balance premium excluding the cost of Pre-Policy Medical Checkup (PPMC)

What to do next: If you wish to know more about Royal Sundaram's Lifeline Product and/or would like a personal quote, speak to our specially trained sales team or your local agent. They'll take time to fully understand your requirements and help you to select the right plan for you.

Web: www.royalsundaram.in

Disclaimer: This is only a summary of the product features and is for reference purpose only. The details of benefits available shall be as described in the policy document, and will be subject to the policy terms, conditions and exclusions. Please call our customer service if you require any further information or clarification.

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938); 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 life 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 prospectus or the tables of the insurer. Any person making default in complying with the provision of this section shall be punished with fine, which may extend to ten lakhs rupees.

Council for Insurance Ombudsmen

Contact details:
Address:
Council for Insurance Ombudsmen,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

INSURANCE OMBUDSMAN OFFICE LIST

The contact details of **Insurance Ombudsman Office** details are as below:

https://www.cioins.co.in/ContactUs

WHAT IF I EVER NEED TO COMPLAIN?

We hope, of course, that you will never feel the need to complain. Nevertheless, sometimes things do go wrong. When they do, we want to know straight away, so we can put them right as quickly as possible, and take steps to make sure they don't happen again.

In all instances, call our Customer Services at our Chennai office at 1860 258 0000 or e-mail at care@royalsundaram.in or write us to Royal Sundaram General Insurance Co. Limited, Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

Royal Sundaram General Insurance Co. Limited

IRDAI Registration No.102. | CIN: U67200TN2000PLC045611

Annexures:

Annexure 1 –

List-I – Items for which coverage is not available in the policy,
List II — Items that are to be subsumed into Room Charges,
List III — Items that are to be subsumed into Procedure Charges,
List IV — Items that are to be subsumed into costs of treatment

Annexure X – Format to be filled up by the proposer for change in occupation of the Insured

Annexure 2 – Product Benefits Table

Annexure 3 – Rate Tables

Royal Sundaram General Insurance Co. Limited

Corporate Office: Vishranthi Melaram Towers, No. 2/319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097
Registered Office: No. 21, Patullos Road, Chennai - 600002
www.royalsundaram.in

Insurance is the subject matter of solicitation

Unique Identification Number: **RSAHLIP24146V032324**

Annexure I

List I – Items for which coverage is not available in the policy

SI No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES

23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES

49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY

List II — Items that are to be subsumed into Room Charges

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)

2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES

29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III — Items that are to be subsumed into Procedure Charges

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT

15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES

13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure X

Format to be filled up by the proposer for change in occupation of the Insured

Policy No	**Name of the Insured**	**Date of birth/Age**	**Relationship with Proposer**	**City of residence**	**Previous Occupation or Nature of Work**	**New Occupation or Nature of Work**

Place: _____

Date: _____

(DD/MM/YYYY)

Proposer's Signature_____

Name:_____