Royal Sundaram General Insurance Co. Limited
Corp. Office : Vishranthi Melaram Towers,
No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097.
Regd. Office : 21, Patullos Road, Chennai - 600 002

Policy Terms and Conditions

B. PREAMBLE

B.1 PREAMBLE

This Policy is a contract of insurance issued by Royal Sundaram General Insurance Co. Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

B.2 OPERATIVE CLAUSE

Any amount payable under the policy shall be subject to the terms of coverage, exclusions, conditionsand definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured and Cumulative Bonus (if any) specified in the Schedule.

C DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and third gender and references to any statutory enactment includes subsequent changes to the same.

C.1 Standard Definitions

C.1.1 **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

C.1.2 **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policyis conditional upon.

C.1.3 **Day Care Treatment**:

Day care treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hrs because of technological advancement, and
ii. Which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

C.1.4 **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited tothe Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

C.1.5 **Emergency Care:** Emergency care means management for an injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or seriouslong term impairment of the insured person's health.

C.1.6 Hospital

Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and

which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) ofthe said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatientbeds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

C.1.7 **Hospitalisation** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In- patient care' hours except for specified procedures/ treatments, where such admission could be for a period ofless than twenty-four (24) consecutive hours.

C.1.8 **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused byexternal, violent and visible and evident means which is verified and certified by a medical practitioner.

C.1.9 **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hoursfor a covered event.

C.1.10 **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and wherethe level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

C.1.11 **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICUpatient including monitoring devices, critical care nursing and intensivist charges.

C.1.12 **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of anyprescription or follow up prescription.

C.1.13 **Medical Expenses** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of accident on the advice of a medical practitioner, as long as these are no morethan would have been payable if the insured person had not been insured and no more than other hospitals ordoctors in the same locality would have charged for the same medical treatment.

C.1.14 **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state orMedical Council of India or Council for Indian Medicine or for Homeopathy set up by the

Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

C.1.15 **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stayin hospital which

i. is required for the medical management of injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope,duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

C.1.16 **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to providemedical services to an insured by a cashless facility.

C.1.17 **Non- Network Provider** means any hospital that is not part of the network.

C.1.18 **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of therecognized modes of communication.

C.1.19 **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions andfor all waiting periods.

C.1.20 **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall includethe associated medical expenses.

C.1.21 **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of aninjury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

C.1.22 **Grace Period** means specified period of time immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

C.1.23 **Pre-Existing Disease** means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer or

b) For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy or its reinstatement.

Provided that the definition of the pre-existing disease shall not be applicable for Overseas Travel Policies

Cigration

C.1.24 Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

Portability

C.1.25 Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

C.1.26 Specific Waiting Period

Specific waiting period means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

C.2 Specific Definitions

C.2.1 **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

C.2.2 **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without anassociated increase in premium.

C.2.3 **Family:** Family consists of the proposer and any one or more of the family members as mentioned below:

(i) Legally wedded spouse.

(ii) Parents and Parents-in-law.

(iii) Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If thechild above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

C.2.4 **Insured Person** means person(s) named in the schedule of the Policy.

C.2.5 **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insuredperson, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

C.2.6 **Policy period** means period of one policy year for which the Policy is issued.

C.2.7 **Policy Schedule** means the Policy Schedule attached to and forming part of Policy.

C.2.8 **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonusrepresents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person.

D Benefits covered under the policy:

D.1 Base Covers:

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

D.1.1 Death:

The Company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, on death ofthe insured person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of insured person following an accident, if after the payment of accidental death claim, it is found that the insured person has survived the accident, then the policyholder has to refund the payment back to the company in consideration of the obligatory guarantee as provided during the claim.

D.1.2 Permanent Total Disablement:

The company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a) Total and irrecoverable loss of sight of both eyes or
b) Physical separation or loss of use of both hands or feet or
c) Physical separation or loss of use of one hand and one foot or
d) loss of sight of one eye and Physical separation or loss of use of hand or foot
e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

b)

D.1.3 Permanent Partial Disablement:

The company shall pay the following percentage of Sum Insured, specified in the policy schedule, ifthe Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablementshall occur within 12 months of the date of the Accident.

	Loss Covered	Percentage of Sum Insured
1.	Loss of Use/ Physical Separation: One entire hand One entire foot Loss of Sight of one eye Loss of toes – all Great both phalangesGreat – one phalanx Other than great if more than one toe lost	 50% 50% 50% 20% 5% 2% 1%
2.	Loss of Use of both ears	50%
3.	Loss of Use of one ear	20%
4.	Loss of four fingers and thumb of one hand	40%

5.	Loss of four fingers	35%
6.	Loss of thumb - both phalangesone phalanx	 25% 10%
7.	Loss of Index finger -three phalanges two phalangesone phalanx	 10% 8% 4%
8.	Loss of middle finger –three phalanges two phalangesone phalanx	 6% 4% 2%
9.	Loss of ring finger -three phalanges two phalangesone phalanx	 5% 4% 2%
10.	Loss of little finger –three phalanges two phalangesone phalanx	 4% 3% 2%
11.	Loss of metacarpus - first (additional) third, fourth or fifth(additional)	 3% 2%
12.	Any other permanent partial disablement	Percentage as assessed by the independent Medical

Maximum amount payable in respect of multiple nature of disablements shall be restricted to sum insured chosen by the policyholder.

Note:

a) The base sum insured chosen and cumulative bonus, if any, is applicable cumulatively for all the three covers specified under D.1.1, D.1.2 and D.1.3 above i.e, there is a single sum insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.

b) If the accident occurs during the policy period, benefits covered under D.1.1, D.1.2 and D.1.3 aboveare payable, even if death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of policy period, but within 12 months from the dateof accident.

D.2 Optional Covers:

The covers listed below are optional benefits and shall be available to Insured Persons in accordance with the

terms set out in the Policy, if the listed cover is opted.

D.2.1 Temporary Total Disablement:

If the Insured Person sustains an Injury in an Accident during the Policy Period and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable of performing at the time of the Accident (Temporary Total Disablement), the company shall pay the benefit as specified in the policy schedule, till the time the insured person is able to return to work, provided that:

(i) The period of temporary total disablement shall exceed four consecutive weeks from the date of accident, however, the benefit shall be reckoned from the date of accident and shall be payable for the entire duration of disablement.

(ii) the compensation payable under this benefit mentioned under Section D.2.1 shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the Sum Insured.

(iii) The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident.

(iv) The compensation shall be paid by the company at quarterly intervals, after ascertainingthe amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period

(v) During the course of payment under this benefit, the company shall have right to call for a certification from an independent medical practitioner with regard to the continuity of temporary total disability specified under this section.

(vi) The insured shall notify the company immediately on resuming to his occupation/employment. Where it is found that the insured resumed to his occupation/employment without notifying to the company and received the compensation under this cover, the company shall have right to claim the recovery of such benefit paid.

Note: For the purpose of this benefit, “week” is a period of seven consecutive calendar days.

D.2.2 **Hospitalisation Expenses due to Accident:**
The Company shall indemnify medical expenses incurred for hospitalisation arising due to accident during the policy period, up to the limit of 10% of the base sum insured, specified in the policy schedule.

The hospitalisation expenses shall cover the following:

i. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home,

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

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

expenses.

(Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day.)

iv. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.

v. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure carried out to treat the accidental injury covered under the policy.

vi. Expenses incurred on hospitalization due to accident, under AYUSH (as definedin IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

The following other expenses necessitated due to injury shall also be covered under the optional cover specified under Section D.2.2(b):

i. Dental treatment.
ii. Plastic surgery.
iii. All the day care treatments.
iv. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

Note: The expenses that are not covered under the section D.2.2 are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

D.2.3 Education Grant:

Following an admissible claim of the insured person under the policy towards Death or Permanent Total Disability of the insured person, the company shall pay a one-time educational grant of 10% of the Base Sum insured (specified in the policy schedule), per child to all dependent children of the Insured provided that:

a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.

b) Age of the child or children as the case shall not be more than 25 completed years.Note:

i. The benefits payable under each of the optional covers D.2.1 , D.2.2 and D. 2.3 are independentand over and above the base sum insured.

ii. Claim admissibility under the optional covers “Temporary total disablement” and “hospitalization due to accident” is independent of claim admissibility under the base covers.

D.3 Cumulative bonus:

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

Notes:

i. The cumulative bonus is applicable only in respect of base covers referred at Section D.1.1 , D.1.2 and D.1.2 Addition or reduction of cumulative bonus will be done only if claim made under base covers.

ii. The CB shall be added and available individually to the insured persons under the policy, if no claimhas been reported. CB shall reduce only in case of claim from the same Insured Person.

iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

E EXCLUSIONS (applicable to all sections of the policy)

E.1 Specific Exclusions

E.1.1 EXCLUSIONS (applicable to all sections of the policy)

The Company shall not be liable to make any payments under this policy in respect of:

(i) Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalisation of the insured person, directly or indirectly due to War (whether declared or not) andwar like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainmentof all kinds.

(ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person

a. from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;
b. Whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication.
c. Whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.
[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately ownedor chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]
d. Arising or resulting from the Insured Person committing any breach of law with criminal intent.

(ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

(iv) Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:

A. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.

B. Nuclear weapons material

C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

D. Nuclear, chemical and biological terrorism

(v) Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

E.1.2 Exclusions specific to section D.2.2 "Hospitalisation Expenses due to Accident"

The Company shall not be liable to make any payments under this policy in respect of any expenses incurred by the insured person in connection with or in respect of:

i. Investigation & Evaluation (Code- Excl04)
   a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
   b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

ii. 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 (Code- Excl14)
iii. Expenses incurred for treatment of accidental injuries which does not warrant hospitalization.
iv. Any expenses incurred on Domiciliary Hospitalization and OPD treatment.
v. Treatment taken outside the geographical limits of India.
vi. All expenses listed in Annexure-A (List I) of the Policy.

F General Terms and Clauses

F.1 Specific terms and clauses

F.1.1 Disclosure of Information

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

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

F.1.2 Condition Precedent to Admission of Liability

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

F.1.3 Material Change

The Insured Person shall immediately notify the Company in writing of any change in his business or occupation or physical defect or infirmity with which he has become affected since the payment of last preceding premium.

F.1.4 Automatic Termination of Insurance

This policy shall automatically terminate upon the Insured Person's death or payment of 100% Sum Insured. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured personis minor, the

policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship withthe insured person) must be submitted to the company along with the application.

F.1.5 Complete Discharge

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

F.1.6 Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modesspecified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

F.1.7 Territorial Limit

The coverage is worldwide except for the optional cover “Hospitalization expenses due to accident”.

The coverage of optional cover “Hospitalization expenses due to accident”, is limited to medical treatment taken in India only.

F.1.8 Multiple policies (Applicable to covers which offer fixed benefits)

If multiple personal accident policies are issued under the same product or across multiple products in the name of same person issued by us then we shall refund the premium of all other policies except the policy with maximum Sum Insured. However, in case of fraud or misrepresentation, all the policies will be cancelled and premium stands forfeited. If customer has multiple policies with different insurers, on occurrence of the insured event, he can claim from all Insurers under all policies.

F.1.9 Multiple policies (Applicable for Section D.2.2 Hospitalisation Expenses due to Accident)

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/herclaim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies even if the sum insured is not exhausted.Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim thebalance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only have indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

F.1.10 Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaidby all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy: —

(a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

(b) the active concealment of a fact by the Insured Person having knowledge or belief ofthe fact;

(c) any other act fitted to deceive; and

(d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within theknowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

F.1.11 Cancellation

The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shallrefund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Period on Risk	Rate of Premium to be refunded
Up to 1 month	75% of Premium
Up to 3 months	50% of Premium
Up to 6 months	25% of Premium
>6 months	Nil premium

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

The Company may cancel the Policy at any time on grounds of misrepresentation, non- disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium oncancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

F.1.12 Nomination:

The insured person is required at the inception of the policy, to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement (if any)) and in case there isno subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be

treated as full and final discharge of its liability under the policy.

F.1.13 Renewal of the Policy:

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due to renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 15 days in monthly and 30 days in case of quarterly, half- yearly and yearly payments to maintain continuity of benefits without break in policy. If the premium is paid in instalments, coverage will still be available during the grace period.
iv. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
v. If not renewed with in Grace Period after due renewal date, the Policy shall terminate.

No loading shall apply on renewals based on individual claims experience

F.1.14 Possibility of revision of the premium rates:

The company, with prior approval of IRDAI, may revise or modify the premium rates.

F.1.15 Policy Disputes:

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

F.1.16 Arbitration:

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation(Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of the policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suitupon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

F.1.17 Premium Payment in Instalments

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

i. 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.

ii. If the premium is paid in instalments, coverage will still be available during the grace period.

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

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

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

vi. 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

F.1.18 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.

F.1.19 Moratorium

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.

F.1.20 Claims in respect of Multiple Policies

I If multiple personal accident policies are issued under the same product or across multiple products in the name of same person issued by us then we shall refund the premium of all other policies except the policy with maximum Sum Insured. However, in case of fraud or misrepresentation, all the policies will be cancelled and premium stands forfeited. If customer has multiple policies with different insurers, on occurrence of the insured event, he can claim from all Insurers under all policies.

F.1.21 Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, insured person may contact the company through:

i. Website : https://www.royalsundaram.in/claims

ii. Toll Free : 1860 258 0000, 1860 425 0000

iii. E-mail: customer.services@royalsundaram.in

iv. Fax : 91-44-7113 7114

v. Courier :

Royal Sundaram General Insurance Co. LimitedAccident & Health Claims Department
Vishranthi Melaram Towers
No.2/319 , Rajiv Gandhi Salai(OMR)Karapakkam,Chennai - 600097

F.1.22 Grievances

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..

G Other terms and conditions

G.1 CLAIM PROCEDURE

G.1.1 Notification of claim:

i. Intimation about an event or occurrence that may give rise to a claim under this policy must be given within 30 days of its happening.

ii. Claims for insurance benefits must be submitted to the Company not later than one (1) month afterthe completion of the treatment or after transportation of the mortal remains/ burial in the event of Death.

iii. If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency, the company shall be informed within 24 hours of the admissionof the insured person in Hospital.

Note: The Company will examine and relax the time limit mentioned herein above depending upon the merits of the case.

G.1.2 Documents to be submitted**:**

G.1.2.I Basic documents required for All claims

i. Duly completed claim form
ii. Photo Identity Proof of the insured person
iii. Copy of FIR/ Panchnama /Police Inquest Report (wherever these reports are required asper the circumstance of the Accident) duly attested by the concerned Police Station
iv. Copy of Medico Legal Certificate (wherever it is required as per the circumstance of the Accident) duly attested by the concerned Hospital
v. Any other relevant document required by the Company for assessment of the claim

G.1.2.II Documents required in case of Death covered under Section D.1.1

i. Death certificate;
ii. Post Mortem Report (if conducted);
iii. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a validdischarge in

case nomination is not filed by deceased.

iv. Copy of FIR/ Panchnama /Police Inquest Report (wherever these reports are required asper the circumstance of the Accident) duly attested by the concerned Police Station

v. Panchanama / Accident report

vi. Chemical analysis report of viscera / blood sample

vii. Admission / Discharge / Death summary issued by hospital authority

viii. English translation of vernacular documents

G.1.2.III Documents required in case of Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD), covered under Sections D.1.2 and D.1.3

i. Original treating Medical Practitioner's certificate describing the disablement

ii. Original Discharge summary from the Hospital

iii. Disability certificate issued by treating Medical Practitioner

iv. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable.

v. Copy of FIR/MLC/Accident register

G.1.2.IV Documents required in case of Temporary Total Disablement (TTD), covered under Section D.2.1

i. Original treating Medical Practitioner's certificate confirming the disability

ii. Original Discharge summary from the Hospital

iii. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

iv. Leave/Absence Certificate from Employer (If Employed)

v. Medical Practitioner's certificate confirming the Injury and advising rest/ unfit to workfor specified number of days

vi. Fitness Certificate issued by the treating doctor.

vii. Copy of FIR/MLC/Accident register

G.1.2.V Documents required for coverage under Section D.2.2 - Hospitalisation Expenses due to Accident:

i. Discharge Summary from The Hospital

ii. Medical & Investigation reports

iii. Prescriptions, and consultation papers of the treatment

iv. Any other medical, investigation reports, as applicable

G.1.2.VI Documents required for coverage under Section D.2.3 - Education Grant:

i. Proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate.

ii. Photo Identity Proof of Child

iii. Age proof of Child

iv. Bonafide Certificate issued by the educational institution confirming that he/she is a fulltime student of the institution

G.1.3 Claim Settlement

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of lastnecessary document.
ii. In case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder fromthe date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shallinitiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at arate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
v. (Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of theFinancial Year in which claim has fallen due)

G.1.4 Payment of Claim

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

G.2 TABLE OF BENEFITS

Name	Saral Suraksha Bima, Royal Sundaram General Insurance Co. Limited
Product Type	Individual
Category ofC	All the covers are benefit based except the optional cover "HospitalisationExpenses due to Accident" which is indemnity based.
Sum insured	On Individual basis – SI shall apply to each individual family member
Policy Period	1 year
Base covers	i. Death ii. Permanent total disablement iii. Permanent partial disablement
Optional covers	i. Temporary total disablement ii. Hospitalisation Expenses due to Accident iii. Education grant
Cumulative bonus	Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured.

Annexure-A

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

Sl 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 BEDCHARGE)
26	BIRTH CERTIFICATE
2	CERTIFICATE CHARGES

7	
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 medicalpharmaceuticals 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

Sr 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	Flexi 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	Blanket/Warmer 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

Sr 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

Sr 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\Spirit\ 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

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