



ROYAL SUNDARAM GENERAL INSURANCE CO. LIMITED

Registered office: No. 21, Patullos Road, Chennai- 600 002 Corporate Office: Vishranthi Melaram Towers, No. 2/319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai- 600 097

Saral Suraksha Bima, Royal Sundaram General Insurance Co. Limited

An accident does not come knocking at the door. It can happen anytime, anywhere and may result in minor or major injuries leads to death or disability which may hinder one’s day to day activities. These uncertainties may lead to financial crisis and to avoid this we at Royal Sundaram General Insurance Co. Limited has come up with new Product which covers personal accident.

You can secure yourself against Accidental death and disability with our Saral Suraksha Bima, Royal Sundaram General Insurance Co. Limited which covers accidental death, total and partial disabilities as base cover and with other optional benefits.

Key Features of the policy: Base covers:

- a) **Death:** Benefit equal to 100% of Sum Insured shall be payable on death of the 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.
- b) **Permanent Total Disablement:** Benefit equal to 100% of Sum Insured shall be payable 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.
- c) **Permanent Partial Disablement:**
Sum Insured specified below shall be payable if the 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 Disablement shall 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 phalanges Great – 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 phalanges - one 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 or second (additional) third, fourth or fifth (additional)	3% 2%
12	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

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

Note:

- The base sum insured chosen and cumulative bonus, if any is applicable cumulatively for all the three covers specified under (a), (b) and (c) above i.e, there is a single sum insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.
- If the accident occurs during the policy period, benefits covered under (a), (b) and (c) above are 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 date of accident.

Optional Covers:

a) **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), compensation shall be payable, at the rate of 0.2% of the base sum insured per week, till the time the insured person is able to return to work, provided that:

- (i) Such period of temporary total disablement exceeds 4 weeks, however, benefit shall be payable for the entire duration of disablement.
- (ii) The compensation payable under this benefit mentioned under Section (a) of optional cover, 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 payable, shall be paid by the insurer at quarterly intervals, after ascertaining the 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 insurance 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.

b) Hospitalisation Expenses due to Accident:

Hospitalisation expenses arising due to accident (during the policy period) shall be indemnified up to the limit of 10% of base sum insured.

The hospitalisation expenses shall cover the following:

- i. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
- ii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
- iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, cost 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 defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

The following expenses necessitated due to injury shall also be covered under the optional cover specified under Section (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.



c) **Education Grant:**

Following an admissible claim of the insured person under the policy towards Death or Permanent Total Disability of the insured person, a one-time Educational Grant of 10% of the Base Sum insured, per child, shall be payable, 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 (a),(b) and (c) are independent and 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.

Cumulative Bonus (CB):

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. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued. The cumulative bonus is applicable only in respect of base covers only.

No deductibles will be applied.

Policy Features

1. Age Eligibility:

Minimum entry age shall be 18 years and maximum age at entry shall be 70 years for the insured members including principal insured.

Dependent Child / children shall be covered from the age of 3 months to 25 years subject to the definition of ‘Family’ and underwriting policy.

2. Type of Policy:

Individual basis only, when offered as a family cover, the chosen sum insured shall apply to each family member separately.

3. Family means:

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 the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

4. Tenure:

Customer can buy the policy for a tenure of one year only.

5. Sum Insured Options:

Minimum sum insured shall be Rs.2.5lakhs to a maximum sum insured of Rs.5crores.



For Sum Insured from Rs. 2.5 lakhs to Rs. 1 crore (in multiples of Rs. 50,000/-.)
However, for Sum insured greater than Rs.1crore, Sum Insured shall be in multiples of Rs. 50 lakhs.

6. Premium:

The Premium charged on the Policy will depend on the Sum Insured and Occupation.

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

7. Modes of Premium Payment

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

ECS (Auto Debit facility) is also allowed in respect of the above mentioned modes.

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) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of 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 owned or 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.
- (iii) 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.

Exclusions specific to section “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.

CLAIMPROCEDURE

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 after the 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 admission of the insured person in Hospital.

1.2. Documents to be submitted:

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 as per 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

Documents required in case of Death covered under Base cover

- 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 valid discharge in case nomination is not filed by deceased.



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

Documents required in case of Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD), covered under Base cover

- 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

Documents required in case of Temporary Total Disablement (TTD), covered under Optional cover

- 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 work for specified number of days
- vi. Fitness Certificate issued by the treating doctor.
- vii. Copy of FIR/MLC/Accident register

Documents required for coverage under 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

Documents required for coverage under 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

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 last necessary document.

- ii. In case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the Financial Year in which claim has fallen due)

1.4. Payment of Claim

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

2. General Terms and Conditions

2.1. Disclosure of Information

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

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

2.2. Condition Precedent to Admission of Liability

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

2.3. 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.

2.4. 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 person is 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 with the insured person) must be submitted to the company along with the application.

2.5. 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.

2.6. 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 modes specified 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.

2.7. 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.

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

In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar policies.

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

2.10. 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 repaid by 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 doesnot 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 the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

2.11. Cancellation

- i. The Insured may cancel this Policy by giving 15days’ written notice, and in such an event, the Company shall refund 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 respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

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

2.12. 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 is no subsisting nominee, to the legal heirs or legal representatives of



the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

2.13. 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. The cover for the Insured shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under Coverage Death or Permanent Total Disability and no Renewal of contract will be permissible.
- vi. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

No loading shall apply on renewals based on individual claims experience. The insured may also avail an optional cover or opt out of the optional cover at the time of renewal.

2.14. Possibility of revision of the premium rates:

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

2.15. 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.

2.16. 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 herein before 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 suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

2.17. 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 In 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.

2.18. 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.

2.19. Claims in respect of Multiple Policies

If multiple personal accident 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

2.20. 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.



Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, 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:

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.

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

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

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

Grievances

In 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:

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.

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

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

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>

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

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

Grievance may also be lodged at –

Registration of Complaints in Bima Bharosa by Policyholders:

Can directly register complaint in the **Bima Bharosa Portal** <https://bimabharosa.irdai.gov.in/>

Can send the complaint through Email to complaints@irdai.gov.in.

Can call Toll Free No. **155255** or **1800 4254 732**.

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.

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 lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer.



ANY PERSON MAKING DEFAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE PUNISHABLE WITH FINE WHICH MAY EXTEND TO TEN LAKHS RUPEES.

Annexures:

Annexure A –

List I – Items for which coverage is not available under Hospitalisation Expenses due to Accidentcover.

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 1 – Product Benefits Table

Annexure 2 – 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:

Annexure-A

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

S I N o	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



1 5	GUEST SERVICES
1 6	CREPE BANDAGE
1 7	DIAPER OF ANY TYPE
1 8	EYELET COLLAR
1 9	SLINGS
2 0	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
2 1	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
2 2	Television Charges
2 3	SURCHARGES
2 4	ATTENDANT CHARGES
2 5	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
2 6	BIRTH CERTIFICATE
2 7	CERTIFICATE CHARGES
2 8	COURIER CHARGES
2 9	CONVEYANCE CHARGES
3 0	MEDICAL CERTIFICATE
3 1	MEDICAL RECORDS
3 2	PHOTOCOPIES CHARGES
3 3	MORTUARY CHARGES
3 4	WALKING AIDS CHARGES
3 5	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
3 6	SPACER
3 7	SPIROMETRE
3 8	NEBULIZER KIT
3 9	STEAM INHALER
4 0	ARMSLING
4 1	THERMOMETER



4 2	CERVICAL COLLAR
4 3	SPLINT
4 4	DIABETIC FOOT WEAR
4 5	KNEE BRACES (LONG/ SHORT/ HINGED)
4 6	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
4 7	LUMBO SACRAL BELT
4 8	NIMBUS BED OR WATER OR AIR BED CHARGES
4 9	AMBULANCE COLLAR
5 0	AMBULANCE EQUIPMENT
5 1	ABDOMINAL BINDER
5 2	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
5 3	SUGAR FREE Tablets
5 4	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
5 5	ECG ELECTRODES
5 6	GLOVES
5 7	NEBULISATION KIT
5 8	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
5 9	KIDNEY TRAY
6 0	MASK
6 1	OUNCE GLASS
6 2	OXYGEN MASK
6 3	PELVIC TRACTION BELT
6 4	PAN CAN
6 5	TROLLY COVER



6	UROMETER, URINE JUG
6	
6	VASOFIX SAFETY
7	

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

S r N o	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



2 5	Clean Sheet
2 6	Blanket/Warmer Blanket
2 7	Admission Kit
2 8	Diabetic Chart Charges
2 9	Documentation Charges / Administrative Expenses
3 0	Discharge Procedure Charges
3 1	Daily Chart Charges
3 2	Entrance Pass / Visitors Pass Charges
3 3	Expenses Related To Prescription On Discharge
3 4	File Opening Charges
3 5	Incidental Expenses / Misc. Charges (Not Explained)
3 6	Patient Identification Band / Name Tag
3 7	Pulseoxymeter Charges



Prospectus and Sales Literature

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

S r N o .	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
1 0	Arthroscopy And Endoscopy Instruments
1 1	Microscope Cover
1 2	Surgical Blades, Harmonicscalpel,Shaver
1 3	Surgical Drill
1 4	Eye Kit
1 5	Eye Drape
1 6	X-Ray Film
1 7	Boyles Apparatus Charges
1 8	Cotton
1 9	Cotton Bandage
2 0	Surgical Tape
2 1	Apron



Prospectus and Sales Literature

2	Torniquet
2	
2	Orthobundle, Gynaec Bundle
3	



Prospectus and Sales Literature

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

S r N o .	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



Prospectus and Sales Literature

P o l i c y N o	N a m e o f t h e I n s u r e d	D a t e o f b i r t h / A g e	R e l a t i o n s h i p w i t h P r o p o s e r	C i t y o f r e s i d e n c e	P r e v i o u s O c c u p a t i o n o r N a t u r e o f W o r k	N e w O c c u p a t i o n o r N a t u r e o f W o r k

Annexure X

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

Place: _____ Date: _____ Proposer's Signature _____ Name: _____

(DD/MM/YYYY)