Royal Sundaram
General Insurance

Group Health Policy

Prospectus

Royal Sundaram General Insurance Co. Limited

India

Applicability

Group Health Insurance provides cover for a group of people/employees, under a single policy issued in the name of the Employer/Organization/Trade or Professional Association with whom the Group of people covered is associated.

The parties to this Contract of Insurance are the Insurer and the Entity that covers the group of persons, identified as individuals within the entity.

Policy Tenure – One year

Benefits

The Standard Group Health Policy covers the Reasonable and customary medical expenses incurred in India for a consecutive period of not less than 24 hours by the Employees/Members of the Client including their dependants covered under the policy towards treatment of an ailment, sickness, injury or any medical condition subject to a waiting period of 30 days from the date of commencement of the policy.

Non-Standard Group Health policies are tailor-made policies which are client specific providing the following additional covers as required by the client on payment of additional premium.

- ➔ Waiver of Pre-existing Diseases, I year exclusions and 30 days waiting period
- ➔ Maternity cover
- ➔ Day one cover for new borns
- ➔ Hospital Cash benefit
- ➔ Convalescence benefit
- ➔ Out patient treatment
- ➔ Corporate floater
- ➔ Emergency Ambulance expenses
- ➔ Domiciliary Hospitalization expenses
- ➔ Critical Illness cover
- ➔ Terrorism exclusion waiver
- ➔ Out-patient treatment
- ➔ Corporate Floater

Information required :

We seek the following information evaluate the risk.

- Nature of Occupation of the Company
- Profile of the group of employees to be covered
- Group size – Age profile of the group with gender-wise composition under each location with Sum Insured required.
- Past Claims experience and the respective terms of coverage and group size
- Coverage required
- Extensions required, in case Tailor-made Policy is opted for.

- Claims experience

Premium

The Premium is quoted based on the above information provided.

What is Covered

The Policy covers Reasonable and Customary Charges incurred towards Hospitalization for treatment of the disease, illness, medical condition or injury contracted or sustained by the Insured Person during the Period of Insurance stated in the Schedule subject to terms, conditions, limitations and Exclusions mentioned in the Policy.

For a claim to be admitted under this Policy, the Insured Person should be hospitalised as an In-Patient during the Period of Insurance for a minimum period of 24 hours. However this time limit is not applicable to the following specific Day care treatments:

Dialysis, Chemotherapy, Radiotherapy, Eye surgery, Cataract, Lithotripsy (kidney stone removal) Tonsillectomy, D&C, Cardiac Catheterization, Hydrocele Surgery, Hernia repair surgery, Treatments for Fracture and such other Surgical Operation that necessitate Hospitalisation less than 24 hours due to medical/technological advancement / infrastructure facilities.

In the event of any claim becoming admissible under the Policy, the Company will pay to the Insured, the Reasonable and Customary Charges, but not exceeding the Sum Insured mentioned in the Schedule against the Insured person for all claims admitted during the Period of Insurance.

Treatment taken for Cataract is subject to a limit of 30% the Sum Insured or Rs.30000/- whichever is lower during the period of insurance.

Expenses covered under the Policy

1. Room, Boarding Expenses as provided by the Hospital/Nursing Home is subject to a maximum of 1% of the Sum Insured per day and for Intensive Care Unit, 2% of the Sum Insured per day. In case, the insured person is admitted in a room with rent higher than the eligible room rent limit, the total hospitalization claim shall be reduced in proportion of eligible room rent to the actual room rent paid.
2. Nursing Expenses.
3. Surgeon, Anaesthetist, Medical Practitioner, Consultants & Specialist Fees Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Donors medical expenses towards Organ transplant, Cost of Pacemaker, Artificial Limbs,
4. Cost of Organs.
5. Pre-Hospitalisation and Post-Hospitalisation expenses when the claim for hospitalization is admitted under the policy.

The costs that are to be subsumed into the Room Charges are provided in Annexure-I attached to this Policy;

The costs that are to be subsumed into the specific procedure charges are provided in Annexure-II attached to this Policy;
The costs that are to be subsumed into the costs of treatments are provided in Annexure-III attached to this Policy.

EXCLUSIONS (Standard Policy)

The Company shall not be liable under this Policy for any claim in connection with or in respect of:

1. **Pre-Existing Diseases – Code-Excl01:**
   a) Expenses related to the treatment of a Pre-existing disease(PED) and its direct complications until the expiry of 48 months of continuous coverage after the date of inception of the first policy with Insurer.
   b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
   d) Coverage under the policy after expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by the Insurer.

2. **Specified disease/procedure waiting period- Code- Excl02:**
   a) Expenses related to the treatment of the listed conditions shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
   b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
   d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
   e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
   f) List of specific diseases/procedures: Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Fistula in anus, Piles, Sinusitis and related disorders.

3. **30-day waiting period- Code- Excl03:**
   a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. Investigation & Evaluation- Code- Excl04:

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. Rest Cure, rehabilitation and respite care- Code- Excl05:

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. Obesity/ Weight Control:Code- Excl06:

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

7. Change-of-Gendertreatments:Code- Excl07:

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. Cosmetic or plastic Surgery: Code- Excl08:

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the

insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

9. **Hazardous or Adventure sports: Code- Excl09:**
   Expenses related to any treatment necessitated 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.

10. **Breach of law:Code- Excl10:**
    Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

11. **Excluded Providers:Code- Excl11:**
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed by Us in our website / notified to the Insured are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. The list of Excluded Providers are attached herewith. Pl refer to the updated list of Excluded Providers available in our website: https://www.royalsundaram.in/html/files/List-of-Excluded-Hospitals.pdf

12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl12**

13. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

14. 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**

15. **Refractive Error: Code- Excl15:**
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

16. **Unproven Treatments: Code- Excl16:**
    Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. **Sterility and Infertility: Code- Excl17:**
    Expenses related to sterility and infertility. This includes:
    (iv) *Any type of contraception, sterilization*

(ii) *Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI*
(iii) *Gestational Surrogacy*
(iv) *Reversal of sterilization*

18. Maternity: Code Excl18:

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

19. Circumcision unless necessary for treatment of a disease, not excluded hereunder or necessitated due to an accident.

20. The cost of spectacles, contact lenses and hearing aids

21. List of optional items as given in the Annexure-IV attached to this Policy

22. Dental treatment or surgery of any kind unless requiring Hospitalisation.

23. Congenital External Disease or defects or anomalies,

24. Tubectomy, Vasectomy, any treatment related to sterilization.

25. Venereal disease

26. Intentional self injury or attempted suicide.

27. All expenses arising out of any condition directly or indirectly caused by or associated with Human T-Cell Lymphotropic Virus Type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS/HIV.

28. Claims directly or indirectly caused by or arising from or attributable to

29. War, Invasion, Act of Foreign Enemy, War-like Operations (whether war be declared or not)

30. Terrorism (including nuclear, chemical and biological terrorism)

31. Nuclear weapons/materials or Radioactive Contamination.

32. Ionising radiation or contamination by any Nuclear fuel or from any Nuclear waste from burning Nuclear fuel

33. Radioactive, toxic, explosive or other dangerous properties of any explosive nuclear machinery or part of it.

"Nuclear, chemical, biological terrorism" shall mean the use of nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or put the public, or any section of the public, in fear.

"Chemical" agent shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

"Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

34. Any routine or preventative examinations, vaccinations, inoculation or screening.
35. Outpatient treatment charges.
36. Hormone replacement therapy.
37. Use of alcohol, intoxicating drugs and medical conditions resulting therefrom other than impairment of Person's intellectual faculties by usage of drugs, stimulants or depressants prescribed by a Medical Practitioner.
38. Any treatment received outside India.
39. AYUSH treatment.
40. Complication of any surgery, therapy or treatment administered on the Insured Person which is not prescribed or required by a Registered Medical Practitioner/Registered Medical Institution in their professional capacity.

CONDITIONS

1. Claims Procedure

Provided that the due observance and fulfillment of the terms and conditions of this Policy (conditions and all Endorsements hereon are to be read as part of this Policy) shall, so far as they relate to anything to be done or not to be done by the Insured and / or Insured person, be a condition precedent to any liability of the Company under this Policy.
The Claims Procedure is as follows:

- *For opting Cashless Facility: (applicable where the* Insured *has opted for cashless facility and has paid the Third Party Administrator's fees)* - The Insured Person must call the helpline and furnish membership no and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form. The call must be made 72 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 48 hours of admission.

- *Reimbursement Claims* - Preliminary notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us within seven days from the date of hospitalization /injury/ death, failing which admission of claim is at Insurer's discretion.

- Please ensure that the insured/insured person send the claim form duly completed in all respects along with all the following documents within 30 days from the date of discharge from Hospital.

    - Original Bills, Receipt and Discharge certificate / card from the Hospital.
    - Original Cash Memos from Hospital(s)/Chemist(s), supported by the proper prescriptions.
    - Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.
    - Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.
    - Attending Doctor's / Consultant's / Specialist's /
    - Anesthetist's original bill and receipt, and certificate regarding diagnosis.
    - Medical Case History / Summary.
- Insured/Insured Person must give Us at his expense, all the information We ask for about the claim and he must help Us to take legal action against anyone if required.
- If required, the Insured/Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
- If required, the Insured/Insured person must agree to be examined by a medical practitioner of our choice at our expenses.
- Any claim intimated after 90 days from the date of discharge from the Hospital/Nursing Home, shall not be entertained.
- No Claim is admissible beyond 180 days from date of expiry of the policy in respect of hospitalization commencing within the Period of Insurance.

2. Payment of Claim

All claims under this Policy shall be payable in Indian Currency. All medical treatments for the purpose of this insurance will have to be taken in India only.

1. 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.

2. In the 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.

3. 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.

4. 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.

   ("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)
5. At the time of claim settlement, Company may insist on KYC documents of the Insured/Insured Person as per the relevant AML guidelines in force.

3. Transfer

Transferring of interest in this Policy to anyone else is not allowed.

4. Migration

Every Insured Person , including his/her family members covered under this policy shall be provided an option of migration at the time of exit from group or in the event of modification of the group policy (including the revision in premium rates) or withdrawal of the group policy, to an individual health insurance policy or a family floater policy, provided the Insurer has not terminated the Insured Person(S) from being a part of the Group Health Policy due to fraudulent activities or misconduct.

An Insured Person desirous of migrating his/her policy should apply to the Company to migrate the policy along with all members of the family, if any, atleast 30 days before the premium renewal date of his/her existing policy.
Migration from Group Health Policy to Individual Policy will be subject to underwriting and the decision with regard to acceptance of migration shall be conveyed to the Insured Person opting for migration within 15 days from the date of receipt of the proposal for migration or any requirement called for by the Insurer.
Migration shall be applicable to the extent of the sum insured under the group health policy.
Only the unexpired/residual waiting period not exceeding the applicable waiting period of the previous policy with respect to pre-existing diseases and time bound exclusions shall be made applicable on migration under the new policy.
Every Insured Person (including members under family floater policy) covered under an indemnity based individual health insurance policy shall be provided an option of migration at the explicit option exercised by the Insured Person;
a. to an individual health insurance policy or a family floater policy, or;
b. to a group health insurance policy, if the member complies with the norms relating to the health insurance coverage under the concerned group insurance policy.
For detailed guidelines on Migration, kindly refer the link:
https://www.royalsundaram.in/html/files/Modification-guidelines-on-standardization-in-health-insurance-Migration.pdf

5. Portability

Portability is not applicable under Group Health Policy.

6. Inclusion and deletion of Insured persons

a. During the currency of the Policy, additions will be permitted for new joinees and their dependents, newly married spouse, newborn child subject to the age criteria under this policy. The deletions will be permitted for the employees (including their dependents) leaving the organization. No interchange of dependents is allowed under this policy.

b. Inclusion of persons shall be done on collection of additional premium as decided by the company.

c. Refunds in respect of any deletion of Insured Persons shall be made on pro-rata basis from the date of deletion until the expiry date of the Policy provided no claim has been made in respect of that Insured Person.

d. Existing employees and dependents cannot be included during the currency of the Policy period.

7. Cancellation

The Insured may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

Provided no claim has arisen under the within mentioned Policy prior to the receipt of such notice by the Company, the Proposer would be entitled to a return of premium less premium at Company's Short period scales as mentioned below for the period, the Policy had been in force.

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

The Company may cancel the policy at any time on grounds of 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. Such notice shall be deemed sufficiently given, if communicated by e-mail or posted by Registered post and addressed to the Proposer at the address mentioned in the Policy or by any other reliable mode of communication.

8. Short period scales:

For a period not exceeding	1 month	10% of the Annual Premium
-do-	2 months	20% of the Annual Premium
-do-	3 months	30% of the Annual Premium
-do-	4 months	40% of the Annual Premium
-do-	5 months	50% of the Annual Premium

-do-	6 months	60% of the Annual Premium
-do-	7 months	70% of the Annual Premium
-do-	8 months	80% of the Annual Premium
-do-	9 months	90% of the Annual Premium
For a period exceeding	9 months	Full Annual Premium

9. Notice

Every notice and communication to the Company required by this Policy shall be in writing to the office of the Company, through which this insurance is effected. However Initial notification of claim can be made by telephone.

10. 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. "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.

11. Geographical Area:

The cover granted under this insurance is valid only for treatments taken in India.

12. Subrogation

The Insured under this Policy shall at the expense of the Company do and concur in doing, permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing any rights and remedies or obtaining relief or indemnity from other parties to which the Company shall or would become entitled or subrogated, upon the Company paying the benefits provided under this Policy, whether such acts and things shall be or become necessary or required before or after the settlement of claim to the Insured or claimant by the Company.

13. Insurer's rights

We have the right to do the following, in the Insured and /or Insured Person's name at Our expense:

• Take over the defense on settlement of any claim
• Start legal action to get compensation from anyone else
• Start legal action to get back from anyone else for payments that have already been made by Us.

14. Multiple Policies

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 be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

15. Fraud

a. 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 and the premium paid shall be forfeited.

b. Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

c. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- the active concealment of a fact by the insured person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits 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 misstatement of or suppression of material fact are within the knowledge of the insurer.

16. 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.

17. Renewals

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.
vi. The renewal premium shall not be accepted more than 90 days in advance of the due date of the premium payment.

18. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

19. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

20. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

21. Redressal of Grievance

In case of any grievance the insured person may contact Us through
Website: https://www.royalsundaram.in/customer-services/grievance-redressal-procedure
Call Us at: 1860 425 0000
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 :
The Grievance Redressal Unit
Royal Sundaram General Insurance Co. Limited
Vishranthi Melaram Towers
No.2/319 , Rajiv Gandhi Salai(OMR)
Karapakkam,Chennai - 600097
Email ID: grievance.redressal@royalsundaram.in
Web: www.royalsundaram.inc

For updated details of grievance officer, kindly refer the link.: https://www.royalsundaram.in/customer-services/grievance-redressal-procedure

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.
The Insurance Ombudsman's offices are located at Ahmedabad, Bengaluru, Bhubaneshwar, Bhopal, Chandigarh, Chennai, Ernakulam, Guwahati, Jaipur, Kolkata, Lucknow, Noida, Patna, Pune, Hyderabad, Mumbai and Delhi. For detailed grievance redressal procedure and for Contact Details of Insurance Ombudsman, please visit our website www.royalsundaram.in

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms. irda.qov. in/

22. Nomination

The policyholder 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.

23. Arbitration

If any dispute or difference shall arise as to the quantum to be paid under this 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 to difference or, if they cannot agree upon a single Arbitrator within 30 days of any party invoking Arbitration, the same shall be referred to a panel of three Arbitrators, comprising of 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.

It is clearly agreed and understood that no difference or dispute shall be referable to Arbitration as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such Arbitrator/ Arbitrators of the amount of the loss or damage shall be first obtained.

24. Disclaimer

It is also hereby further expressly agreed and declared that if the Company shall disclaim liability to the Insured for any claim hereunder and such claim shall not within 3 calendar months from the date of such disclaimer have been made the subject matter of a suit in a Court of law or pending reference before Ombudsman, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

25. Jurisdiction

The Policy is subject to the laws of India and the jurisdiction of its Courts in Chennai city only.

Prohibition of rebates:

Section 41 of the Insurance Act 1938

No person shall allow or offer to allow, directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published Prospectus or table 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.