ROYAL SUNDARAM GENERAL INSURANCE CO. LIMITED

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Family Plus

Your search for high quality health insurance stops here

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

Royal Sundaram brings to You Family Plus, a unique health insurance plan, providing most comprehensive health coverage at an affordable price. Family Plus is a Family Floater Plan which is designed especially for families and it covers up to 19 relationships. The Plan also offers maternity cover and provide an option to cover families under same policy. Family Plus is health insurance cover which is simple to buy and easy to understand. In addition to comprehensive health insurance cover to suit your needs, this plan helps you care for your health proactively over time and according to your profile. The product offers a unique benefit where each insured member of the family will have an individual sum insured apart from a floater sum insured and reload benefit which any of the family member can consume in case of a major illness. This ensures you are adequately covered at all times. It comes with rich no claim bonus which also helps make your insurance inflation proof by adding 20% additional sum insured for each claim free year. We are here to build a long term healthy relationship with you and your family.

Key Features of the Policy

Basic Covers:

- Inpatient Care
- Pre Hospitalization Medical Expenses
- Post Hospitalization Medical Expenses
- All Day Care Treatment
- Domiciliary Hospitalization
- Ambulance Cover
- Organ Donor Expenses
- No Claim Bonus
- Re-load of Sum Insured
- Ayush Treatment
- Vaccination in case of Animal Bite
- Emergency Domestic Evacuation
- Maternity Benefit including New Born Baby Cover and Vaccination for new born baby before the baby completes one year of age
- Nutritional Allowance for mother post discharge after delivery

Value Added Covers:

- Health Check-up
- Second opinion for 11 critical illness

- Preventive Healthcare & Wellness Benefit

Optional Covers:

- Hospital Cash

Product Benefits – Key Highlights

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

Basic Covers

1. In-patient Care: Medical Expenses for:

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

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

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

a. Uterine Artery Embolization and HIFU

b. Balloon Sinuplasty

c. Deep Brain stimulation

d. Oral chemotherapy

e. Immunotherapy- Monoclonal Antibody to be given as injection

f. Intra vitreal injections

g. Robotic surgeries

h. Stereotactic radio surgeries

i. Bronchical Thermoplasty

j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

k. IONM - (Intra Operative Neuro Monitoring)

l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Note: Medical expenses related to Artificial life maintenance will be covered, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health under any circumstances unless in a vegetative state as certified by the treating medical practitioner.

2. **Pre & Post hospitalization Medical Expenses:** Expenses for consultations, investigations and medicines incurred of an Insured person due to an accident or injury or illness incurred immediately prior to hospitalisation or incurred post hospitalisation up to 60 days and 90 days respectively and part of overall Sum Insured. These are payable for the same illness or treatment as long as we have accepted an In-patient Care claim (as mentioned above) for that treatment or illness. These can be claimed only as reimbursements.

3. **Day Care Treatment**: Medical expenses for day care treatments (including Chemotherapy, Radiotherapy, Hemodialysis, any procedure which needs a period of specialized observation or care after completion of the procedure) where such procedures are undertaken by an insured person as an inpatient in a hospital/day care center for a continuous period of less than 24 hours. Any OPD Treatment undertaken in a hospital will not be covered. Pre & Post hospitalization Medical Expenses are also payable for this benefit. Please refer annexure 4 for indicative list of Day Care Procedures.

4. **Ambulance Cover**: Reasonable charges for ambulance expenses (by surface transport only) incurred to transfer the insured person following an Emergency to the nearest Hospital, if we accept the in-patient claim. Our maximum liability for ambulance expenses is limited up to Rs. 4000 per event of hospitalization.

5. **Domiciliary Hospitalization:** Medical expenses for treatment taken at home if the treatment continues for an uninterrupted period of 3 days and the condition for which treatment is taken would otherwise have necessitated hospitalization as long as either (i) the attending medical practitioner confirms that the insured person could not be transferred to a hospital or (ii) you satisfy us that a hospital bed was unavailable. Claims for pre-hospitalization and Post-hospitalisation Medical expenses shall be payable.

6. **Organ Donor Expenses**: Medical expenses for an organ donor's treatment for harvesting of the organ provided that the insured person has been medically advised to undergo an organ transplant and the donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the insured person;
We will not cover:

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

7. **No Claim Bonus (NCB):** If no claim has been made by any insured person, we will increase the Individual base sum insured by 20% on each policy year up to a maximum of 100% of Individual

base Sum Insured, provided the Policy is renewed continuously. You will not earn No Claim Bonus on Policy renewal if any claim is made by any of the Insured in expiring Policy Year. However, if there is no claim made in subsequent Policy Year, you will earn No Claim Bonus on renewal as per the variant.

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

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

8. **Re-load of Sum Insured: –** We will provide a Re-load equal to 100% of Base Sum Insured of any one Insured Member. Re-load benefit will be applicable as under: a) the Base Sum Insured, No Claim Bonus (if any) and Floater Sum Insured is insufficient as a result of previous claims in that Policy Year; AND

   b) The Re-load Sum Insured shall be activated in following conditions:

   i. Re-load can get activated for same Insured Member in the same Policy year for different illness/injury other than the illness/injury for which claim has already been paid in the current Policy year and/or;

   ii. Re-load can get activated for different Insured Member in the same Policy year

   iii) Re-load benefit once activated for any one of the Insured Member and can be used jointly or severally.

   iv) Re-load once activated for any one of the Insured Member will not get activated again for another Insured Member in the same Policy Year.

   c) If the Re-load Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

   Note: Under Family Plus Product each Insured has to have the same level of Individual Base Sum Insured. Everybody has to select an Individual Base SI and a single Floater SI which will be shared amongst the all Insured members

9. **Vaccination in case of Animal Bite (in case of Post Bite Treatment) –** We will reimburse the medical expenses incurred for vaccination including inoculation and immunizations in case of post-bite treatment up to actuals subject to the limit of Rs. 5,000. This will be part of overall sum insured.

10. **Ayush Treatment–** We will be covering medical expenses for in-patient treatment taken under Ayurveda, Unani, Sidha and Homeopathy provided the treatment has been undergone in a government hospital or in any institute recognized by government and/or accredited by Quality Council of India/National Accreditation Board on Health. Our maximum liability will be limited up to the amount provided in the Product Benefits Table. Outpatient expenses are not payable under this benefit.

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

    a. Treating doctor confirms that insured need to be transferred to another hospital having suitable medical technology & equipment for treatment.
    b. Evacuation will be from one medical center to another medical center.
        i. Our maximum liability in case of Emergency Domestic Evacuation will be Rs.100,000/- and will be part of overall Sum Insured.
    c. Any expenses over and above the limit specified above, customer will have to make the payment to the service provider.
    d. This benefit can be availed once by an Insured Person during a Policy Year.
    e. This benefit is on per Insured Person basis.

Value Added Covers

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

    This benefit can be availed at each renewal.

Annual Health Check-up	**List of Medical Tests**
	Complete Blood Count, Urine Routine, ESR, Fasting Blood Sugar, Lipid Profile, Kidney Function Test, ECG, Complete physical examination by Physician

    Abbreviation of test is provided here:

    ESR – Erythrocyte Sedimentation Rate, ECG – Electrocardiogram, S Cholesterol – Serum Cholesterol, SGPT – Serum Glutamic Pyruvate Transaminase, TMT – Tread Mill Test
    This benefit is available to those insured person who have attained the age of 18 years or above on the Policy Period Start Date.

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

13. **Second Opinion for critical illnesses –** We will provide second opinion to the insured person if he is diagnosed with any of the below mentioned 11 critical illnesses:

    1. Cancer
    2. First Heart Attack
    3. Open Chest CABG

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

This benefit is available only once during the policy year and once during the lifetime of an Insured Person for same Illness. Benefit is available only for adults.

14. Preventive Healthcare & Wellness

We will provide various Preventive Healthcare & Wellness related services that will help the insured person to assess their health status and aid in improving their overall well being. Various Preventive Healthcare & Wellness services include Health related articles, access to various preferred health maintenance network etc.

a. Cost of Services: These wellness benefits are customer friendly and helps in maintaining and accessing health status, information in the form of various health articles on website/email/mobile apps. this will be free of cost to all customers.

b. Periodicity: The intent is to have a continuous engagement with customers on ongoing basis. For example: We will frequently i.e. once in a week atleast upload various health related articles on topics such as Diabetes, Obesity, Diet and Nutrition, exercise etc. (Indicative only).

15. Maternity Benefits

Maternity Expenses: For this benefit, two adult members need to be covered in the policy at the time of first inception under the same Family Floater Policy. We pay Medical Expenses for the delivery of a child, only after 24 months of continuous coverage of mother since the inception of the first Policy with Us. In case, customer is porting from any other policy providing maternity benefit, the respective waiting period served in that policy will be considered as waiting period waiver in Family Plus policy as per portability guideline. Maternity benefits are paid a maximum of Rs. 50,000 per delivery only for two deliveries for each female member covered during the lifetime of the Policy including any of its renewals. However, expenses in respect of harvesting and storage of stem cells are not covered.

Miscarriage will not be payable as a part of Maternity Benefit Claim.

Miscarriage can occur as a result of:
i. Accident

ii. Internal Injury/Sickness/stress

If Miscarriage happens due to an internal injury/sickness/stress, it is not payable. However, it is payable when Miscarriage happens due to an accident.

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

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

Nutrition allowance for mother post discharge

a. We will provide Nutrition allowance for mother post-delivery of the child.

b. This benefit is available in the form a fixed benefit and maximum liability under this is Rs. 10,000 and it is payable after a period of 2 months from the date of discharge of mother after delivery of the child.

c. This benefit is payable only if we accept the claim made under the Maternity Benefit. At the time of settlement of Maternity Claim, we shall issue a post-dated cheque of Rs. 10,000 towards Nutritional allowance.

Optional Benefits

1. Hospital Cash

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

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

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

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

The Sum Insured under Hospital Cash is over and above the base Sum Insured.

Policy Features

1. Age Eligibility

Children: The minimum entry age under this policy is 91 days.

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

2. Individual Sum Insured & Family Floater Sum Insured Combination

The policy can be purchased only by two or more members of the family. In this policy, Insureds will have two types of Sum Insured i.e. Base sum Insured and Floater Sum Insured. A floater plan can cover any(n) number of adult and children under a Policy as per the below mentioned relationships.

1. Self
2. Legally married spouse as long as he or she continues to be married to You
3. Son
4. Daughter-in-law
5. Daughter
6. Father
7. Mother
8. Father-in-law as long as Your spouse continues to be married to You
9. Mother-in-law as long as Your spouse continues to be married to You
10. Grandfather
11. Grandmother
12. Grandson
13. Granddaughter
14. Son-in-law
15. Brother
16. Sister
17. Sister-in-law
18. Brother-in-law
19. Nephew
20. Niece

The intent here is provide coverage to following relations:

- blood relative of proposer,
- blood relative of proposer's spouse,
- spouse of proposer's blood relative
- spouse of proposer's spouse blood relative,

There should be atleast two Insureds member at the time of inception of Policy.

Since availability of both Individual Base Sum Insured and Floater Sum Insured is one of the unique features of Family Plus and hence, as a key policy criteria, customer is required to opt for both Individual Base Sum Insured and Floater Sum Insured. All Insured Members will have same Individual Base Sum Insured and common Floater Sum Insured. This Product cannot be offered on Individual basis and can only be offered to two or more Individuals.

3. Policy Period Option

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

4. Variant & Sum Insured Options

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

Type of Sum Insured	Sum Insured
Base Sum Insured	Rs.2lacs, Rs.3lacs, Rs.5lacs, Rs.10lacs, Rs. 15 Lacs
Floater Sum Insured	Rs.3lacs, Rs.4lacs, Rs.5lacs, Rs.10lacs, Rs. 15 Lacs, Rs.20 Lacs, Rs. 25 Lacs, Rs. 50 Lacs

Sum Insured is on Annual basis.

5. Premium

The Premium charged on the Policy will depend on the Sum Insured, Policy Tenure, Age, No. of Insureds, Zone of Cover and Optional Cover opted. Additionally the health status of the individual will also be considered.

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

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

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

Zone 2: Rest of India.

A discount of 15% for members in Zone 2 will be applicable. Grid as below:

ZONE	Discount
Zone 1	0%
Zone 2	15%

Illustration : Proposer Mr. Singh who is resident of Lucknow (Zone 2) seeks a cover for his parents who are based at Lucknow(Zone 2) and in-laws who are based at New Delhi (Zone 1). The Premium payable shall be as per Zone 2 i.e. after 15% discount of the Zone 1 Premium Amount. However, both Parents and in-laws of Mr. Singh can go for medical treatment anywhere in India in the form of cashless/reimbursement.

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

6. Loading

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

7. Disease Specific Loading/Co-payment

We shall apply a risk loading on the premium payable or Co-payment for certain specific conditions as per underwriting policy (based upon the declarations made in the proposal form and the health

status of the persons proposed for insurance), which shall be mentioned specifically in the Schedule of Insurance Certificate. The maximum risk loading applicable shall not exceed 150% per diagnosis / medical condition and an overall risk loading of 200%. These loadings are applied from the inception of the initial Policy including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured). The maximum risk Co-payment shall not exceed 20% per diagnosis/medical condition and an overall risk co-payment of 20%. We will apply either Disease Specific Loading or Co-payment on your application and will not be applied simultaneously.

We will inform You about the applicable risk loading and/or applicability of Co-payment through post/courier/email/phone. You shall revert to Us with your written consent and additional premium (if any), within 15 days of the issuance of such counter offer. In case, You neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within the next 15 days.

Following loadings or co-payment may be applied on the policy for the medical conditions listed below if they are accepted at the time of underwriting. The loadings are applicable on individual ailments only.

Table I

Note: In case of Table I and Table IA, loading will be applicable at a policy level and co-payment will be applicable at an Insured level for all Claims. Either the loading or co-payment will be applied at a time.

Sr. No.	Condition	Medical test	Medical test result	Duration of condition	Product variant	Loading on base premium	Co-payment for Insured Person
1	Diabetes	HBa1C	Less than or equal to 6.6	NA	All	0.00%	Nil
2	Diabetes	HBa1C	More than 8	NA	All	Decline	Decline
3	Diabetes	HBa1C	More than 6.6 up to 7	Up to 5 years	Family Floater	25.00%	10%
4	Diabetes	HBa1C	More than 7 up to 7.5	Up to 5 years	Family Floater	50.00%	20%
5	Diabetes	HBa1C	More than 7.5 up to 8	Up to 5 years	Family Floater	50.00%	20%
6	Diabetes	HBa1C	More than 6.6 up to 7	More than 5 years up to 10 years	Family Floater	25.00%	10%
7	Diabetes	HBa1C	More than 7 up to 7.5	More than 5 years up to 10 years	Family Floater	50.00%	20%
8	Diabetes	HBa1C	More than 7.5 up to 8	More than 5 years up to 10 years	Family Floater	50.00%	20%
9	Heart Condition	ECG / TMT	Adverse	NA	Family Floater	50.00%	20%
10	Hypertension	Blood Pressure	Above normal up to 140/90	Up to 5 years	Family Floater	10.00%	Nil

11	Hypertension	Blood Pressure	More than 140/90 up to 160/99	More than 5 years up to 10 years	Family Floater	25.00%	10%
12	Hypertension	Blood Pressure	Above normal	More than 10 years	All	Decline	Decline
13	Any Malignant Cancer*	HPE	Confirmatory	NA	All	100%	20%
14	Rheumatoid Arthritis	RA Test	Confirmatory	NA	All	100%	20%

Table 1 A- Underwriting grid of Family Plus for Mental Illness cases

Sr. No.	Duration of Condition	Condition	Co-pay	Loading	Cumulative Sum Insured Restriction**
1	**Up to 5 years with no hospitalisation**	**Mild to Moderate**	**10% on Policy**	**Family Floater- 25%**	**No Restriction**
2	**More than 5 Years with no hospitalisation**	**Moderate to High**	**20% on Policy**	**Family Floater- 50%**	**15 Lakhs**
3	**Hospitalisation due to Mental Illness any time in last 10 years**	**Severe**	**30% on Policy**	**Family Floater- 100%**	**10 Lakhs**

Note: Family Plus has two levels of SI (individual & Family Floater) so restriction will be applied on cumulative sum insured.

*We will consider cases only when the person is cured for cancer and period of remission is > 3 years with no active findings on cancer. The ongoing cancer cases and/or where period of remission is < 3 years will be declined.

Table II

Sr. No.	Condition	Medical test	Medical test result	Duration of condition	Product variant	Loading on base premium	Co-payment for Insured Person
1	Peptic Ulcer Disease	Disclosure and Endoscopy Report	Presence or Old Appearance	Up to 5 years	All	25.00%	10%
2	Ulcerative Colitis	Disclosure and Endoscopy Report	Presence or Old Appearance	Up to 5 years	All	25.00%	20%

3	Crohns Disease	Disclosure and Endoscopy Report	Presence or Old Appearance	Up to 5 years	All	25.00%	20%
4	Breast - Benign Lesions	Disclosure and Mammography	Presence or Old Appearance	Up to 10 years	All	50.00%	20%
5	Breast - Benign Lesions	Disclosure and Mammography	Presence or Old Appearance	Up to 10 years	All	50.00%	20%
6	Pancreatitis – Acute	Serum Amylase and Lipase	Increased	More than 5 years up to 10 years	All	25.00%	10%
7	Pancreatitis - Chronic	Serum Amylase and Lipase	Increased	More than 5 years up to 10 years	All	50.00%	20%
8	Hyperthyroidism	Disclosure and TFT	Increased	More than 5 years up to 10 years	All	50.00%	20%
9	Epilepsy	Disclosure and MRI	Organic or Inorganic	More than 5 years up to 10 years	All	100.00%	10%
10	Stroke#	Disclosure and MRI	Organic or Inorganic	More than 5 years up to 10 years	All	150.00%*	20%
11	Glaucoma	Eye Test	Confirmatory	More than 5 years up to 10 years	All	50.00%	20%
12	Retinal Detachment	Eye Test	Confirmatory	More than 5 years up to 10 years	All	100.00%	20%
13	Asthma	Disclosure and PFT	Confirmatory	More than 5 years up to 10 years	All	50.00%	20%
14	Arthritis	Disclosure	Confirmatory	More than 5 years up to 10 years	All	100.00%	20%

#We will consider cases only when the person is cured for stroke and period of remission is > 3 years with no active findings on stroke. The ongoing stroke cases and/or where period of remission is < 3 years will be declined.

There would be conditions whose claims probability cannot be mitigated by exclusions, such as uncontrolled diabetes and such cases may warrant declinature.

* In case of acceptance of proposal for customers with completed age of 81 years and above having past history of stroke, we shall apply a maximum loading of 100% at the time of inception of the policy subject to satisfying other underwriting requirements.

We shall obtain prior consent of the policyholder before levying any loadings.

8. Discounts

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

- Discount on Multiyear policy
  - 7.5% discount for 2 year policy
  - 12% discount for 3 year policy
- 5% discount for Sundaram Group employees.

9. Renewal Features

a) The Policy will automatically terminate at the end of the Policy Period. The Policy is ordinarily renewable on mutual consent for life, subject to application of Renewal and realization of Renewal premium.

b) The premium payable on Renewal shall be paid to Us on or before the Policy Period end date and in any event before the expiry of the Grace Period. For the purpose of this provision, Grace Period means a period of 45 days in case of one year and 15 days in case of monthly, quarterly and half- yearly payments. Policy would be considered as a fresh policy if there would be break of more than 45 days between the previous policy expiry date and current Policy start date. We however shall not be liable for any claim arising out of an ailment suffered or Hospitalisation commencing or disease/illness/condition contracted during the period between the expiry of previous policy and date of inception of subsequent policy and such disease/Illness/condition shall be treated as a Pre-existing Condition.

c) Renewals will not be denied except on grounds of misrepresentation, fraud, non-disclosure or non-co-operation by You.

d) Where We have discontinued or withdrawn this product/plan You will have the option to renewal under the nearest substitute Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDAI.

e) You shall disclose to Us in writing of any material change in the health condition at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.

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

g) Alterations like increase/ decrease in Sum Insured or Change in Optional Covers, addition/deletion of members, addition/deletion of Medical Condition will be allowed only at

the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. Any request for acceptance of changes on renewal will be subject to underwriting. The terms and conditions of the existing policy will not be altered.

h) Any enhanced Sum Insured during any policy renewals will not be available for an illness, disease, injury already contracted under the preceding Policy Periods. All waiting periods as mentioned below shall apply afresh for this enhanced limit from the effective date of such enhancement.

i) Where an Insured Person is added to this Policy at the time of renewal, all waiting periods will be applicable considering such Policy Year as the first year of Policy with the Company.

j) Applicable Cumulative Bonus shall be accrued on each renewal as per eligibility under the variant opted.

10. Migration:

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

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

ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefits shall not apply to any other additional increased Sum Insured.

11. Portability Benefit

The insured Person will have the option to port the policy to other insurers as an extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

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

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

iii. We should have received Your application for Portability with complete documentation at least 45 days before the expiry of Your present period of insurance.

iv. If the Sum Insured under the previous Policy is higher than the Sum Insured chosen under this Policy, the applicable waiting periods, shall be reduced by the number of months of

continuous coverage under such health insurance policy with the previous insurer to the extent of the Sum Insured and the eligible Cumulative Bonus under the expiring health insurance policy.

v. In case the proposed Sum Insured opted for under Our Policy is more than the insurance cover under the previous policy, then all applicable waiting periods and shall be applicable afresh to the amount by which the Sum Insured under this Policy exceed the total of Sum Insured and eligible Cumulative Bonus under the expiring health insurance policy.

vi. All waiting periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

vii. If You were covered on a floater basis under the expiring Policy and apply for a floater cover under this Policy, then the eligible Cumulative Bonus to be carried forward on this Policy shall also be available on a floater basis.

viii. If You were covered on an individual basis in the expiring Policy then the eligible Cumulative Bonus to be carried forward on this Policy shall be available on an individual basis.

For the purpose of this provision, eligible Cumulative Bonus shall mean the Cumulative Bonus which You or the Insured Person would have been eligible for had the same policy been Renewed with the existing insurance company.

It is further agreed and understood that:

i. Portability benefit will be offered to the extent of sum of previous Sum Insured and accrued Cumulative Bonus (if opted for), and Portability shall not apply to any other additional increased Sum Insured.
ii. We may subject Your proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in Our sole and absolute discretion.
iii. There is no obligation on Us to insure all Insured Persons on the proposed terms, even if You have given Us all documentation.
iv. We should have received the database and claim history from the previous insurance company for Your previous policy.

The Portability provisions will apply to You, if You wish to migrate from this Policy to any other health insurance policy on Renewals.

In case You have opted to switch to any other insurer under portability provisions and the outcome of acceptance of the portability request is awaited from the new insurer on the date of renewal:

i. We may upon Your request extend this Policy for a period of not less than one month at an additional premium to be paid on a pro-rata basis.
ii. If during this extension period a claim has been reported, You shall be required to first pay the full premium so as to make the Policy Period of full 12 calendar months. Our liability for the payment of such claim shall commence only once such premium is received. Alternatively, We may deduct the premium for the balance period and pay the balance claim amount if any and issue the Policy for the remaining period.

12. Income Tax benefit

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

13. Free Look Period

A period of 15 days (30 days for Telesales, Online and Web aggregators) from the date of receipt of the policy document is available to review the terms and conditions of this policy. You have the option of returning the policy stating the reasons for cancellation and We will refund the premium paid by them after deducting the amounts spent on any medical checkup, stamp duty charges and proportionate risk premium for the period on cover. Cancellation will be allowed only if there are no claims reported (paid/outstanding) under the policy. All rights under this policy shall immediately stand extinguished on the free look cancellation of the policy. Free look period is not applicable for renewal case.

14. Cancellation/Termination

In case You are not satisfied with the policy or our services, you can request for a cancellation of the policy by giving 30 days' notice in writing. Premium shall be refunded as per table below if no claim has been registered/ made under the policy and full premium has been received.

Cancellation date upto (x months) from the Policy Period Start Date	**Refund of Premium (basis Policy Period)**		
	1 Year	**2 Year**	**3 Year**
Upto 1 month	75%	87%	91%
Upto 3 months	50%	74%	82%
Upto 6 months	25%	61.5%	73.5%
Upto 12 months	0%	48.5%	64.5%
Upto 15 months	NA	24.5%	47%
Upto 18 months	NA	12%	38.5%
Upto 24 months	NA	0%	30%
Upto 30 months	NA	NA	8%
Beyond 30 months	NA	NA	0%

a. For half- yearly payment mode

Upto 90 days- 50% Refund
Post 90 days- Nil

b. For Quarterly payment mode

Upto 30 days- 50%
After 30 days- Nil

c. For Monthly payment Mode

Cancellation- No refund

The policy can also be terminated by Us if:

a. Any insured person or any person acting on behalf of either has acted in a dishonest and fraudulent manner, under or in relation to this Policy and 100% of the premium shall be retained.
b. You or any insured person has not disclosed any true, complete and all correct facts in relation to the Policy; and/or;
c. Provision for cancellation on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured.

The Policy will be automatically terminated in the following circumstances:

a. Family Floater Policy:
In case of death of all Insured except one Insured, Policy shall be continued till date of next renewal and single surviving Insured shall be migrated to Policy of his/her own choice out of available products with us at the time of next renewal.

Refund:

Refund as per table in Cancellation/Termination section above shall be payable in case of an automatic cancellation of the Policy provided that no claim has been filed under the Policy.

15.Moratorium Period: After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of eight 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 and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

16.In case of non-disclosure of a condition which is other than list of Permanent exclusions, we can incorporate additional waiting period of not exceeding 48 months for the said undisclosed disease or condition from the date the un-disclosed condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.

17.Where the non-disclosed condition allows us to continue the coverage by levying extra premium or

loading based on the objective criteria laid down in the Board approved underwriting policy, we shall levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, If the un-disclosed condition is surfaced before the expiry of the policy term, we may charge the extra premium or loading retrospectively from the first year of issuance of the policy or renewal, whichever is later.

18. Premium Payment in Instalment

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

i. Grace Period of 15 days (in case of monthly mode grace period is allowed and would be available two times and in case of quarterly and half-yearly- grace period will be available only once) would be given to pay the instalment premium due for the policy.
ii. During such grace period, Coverage will not be available from the instalment premium payment due date till die date of' receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "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 lf 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.

Waiting Periods and Exclusions:

Claims for the following are not covered:

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

- **24 months Waiting Period for Maternity Benefits Coverage:** We will not cover Maternity Expenses for Insured Person during the first 24 months since the date of first inception of policy.

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

  There may be an explicit mention of certain Pre Existing Disease conditions in Schedule of Insurance on basis of Your declaration in the Proposal Form and/or discovered by us during the process of Medical Underwriting.

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

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

Permanent Exclusions:
Investigation & Evaluation, Rest Cure, rehabilitation and respite care, Obesity/ Weight Control, Change-of-Gender treatments, Cosmetic or plastic Surgery, Hazardous or Adventure sports, Breach of law, Excluded Providers, Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences, Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons, Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure, Refractive Error, Unproven Treatments, Sterility and Infertility, Alternative treatment, Ancillary Hospital Charges, Charges for medical papers, Circumcision, Conflict and disaster, Congenital conditions, Convalescence and Rehabilitation, Drugs and dressings for OPD Treatment or take-home use, Items of personal comfort and convenience, including but not limited to : (A)Telephone, television, diet charges, (unless included in room rent) personal attendant or barber or beauty services, baby food, cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services (B) Private nursing/attendant's charges incurred during Pre-hospitalization or Post-hospitalization (C) Drugs or treatment not supported by prescription etc., OPD Treatment, Preventive Care, Self-inflicted injuries, Treatment for Alopecia, Treatment received outside India, Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense.

- For details of permanent exclusions please read the policy terms and conditions or visit www.royalsundaram.in .
- Existing Disease which can be permanently Excluded: In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes. The disease which can be excluded under this section are as under:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and

		intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,

		unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

- The expenses that are not covered in this policy are placed under List-I of Annexure-1.

Claims Procedure

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

For admission in Network Hospital (Cashless Claims)

Insured Person shall call the TPA helpline and furnish Membership Number, Policy Number and the Name of the Patient within 72 hours before admission to hospital for planned hospitalization and not later than 48 hours of admission in case of emergency hospitalization. The insured shall also provide to the TPA by fax or e-mail, the details of hospitalization like diagnosis, name of hospital, duration of stay in hospital, estimated expenses of hospitalization etc in the prescribed form available with the Insurance help desk at the Hospital. The Insured shall also provide any additional information or medical record as may be required by the medical panel of the TPA. After establishing the admissibility of the claim under the policy, the TPA shall provide a pre-authorisation to the hospital guaranteeing payment of the hospitalization expenses subject to the sum insured, terms conditions and limitations of the policy.

- **Notice of claim:** Preliminary notice of claim with particulars relating to Policy number, Name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending hospital, should be given to the Insurer within 72 hours before admission incase of planned hospitalization, and not later than 48 hours or before discharge, in case of emergency hospitalization.

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

Mandatory documents (if available)

1. Test reports and prescriptions relating to First / Previous consultations for the same or related illness.
2. Case history / Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
3. Death summary in case of death of the insured person at the hospital.
4. Hospital Receipts / bills / cash memos in Original (including advance and final hospital settlement receipts).
5. All test reports for X-rays, ECG, Scan, MRI, Pathology etc., including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought).
6. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.
7. F.I.R(First Information Report) /MLC. (Medical Legal Certificate) in the case of accidental injury and English translation of the same, if in any other language.

8. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury.

9. Legal heir certificate in the absence of nomination under the policy, in case of death of the proposer. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required by Us.

10. For a) maternity claims, Discharge Summary mentioning Last Menstrual Period (LMP), Estimated Date of Delivery (EDD) & Gravida (a women's status regarding pregnancy) b)Cataract claims – (Intraocular Lens Implant) IOL sticker c) Percutaneous Transluminal Coronary Angioplasty (PTCA) claims - Stent sticker.

11. Copies of health insurance policies held with any other insurer covering the insured persons.

12. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.

13. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital.

14. Additional documents for Emergency Domestic Evacuation.

    a. Certification by the treating Medical Practitioner of such life threatening emergency condition and confirming that current Hospital does not have suitable medical equipment & technology for the life threatening condition.

    b. Bills/Receipts of transportation agency/ambulance company/air ambulance receipts.

Documents to be submitted if specifically sought: (if required)

1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart).

2. Copy of extract of Inpatient Register.

3. Attendance records of employer/educational institution.

4. Complete medical records (including indoor case records and OP records) of past hospitalization/treatment, if any.

5. Attending Physician's certificate clarifying.

    - reason for hospitalization and duration of hospitalization
    - history of any self-inflicted injury
    - history of alcoholism, smoking
    - history of associated medical conditions, if any

6. Previous master health check-up records/pre-employment medical records, if any.

7. Any other document necessary in support of the claim on case to case basis.

Please note that the waiver of the time limit for notice of claim and submission of claim is at Our evaluation.

The claim documents should be sent to:

Health Claims Department

Royal Sundaram General Insurance Co. Limited

Vishranthi Melaram Towers,

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

Karapakkam, Chennai - 600097

Payment of Claim

- No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means.
- Insured must give at his expense, all the information We asks for about the claim and he must help to take legal action against anyone, if required.
- If required the Insured / Insured Person must give consent to obtain Medical Report from Medical Practitioner at Our expense.
- 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.
- Benefits payable under this policy will be paid within 30 days of the receipt of last necessary document.

1. We shall be liable to pay interest at 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed, for sums paid or payable under this Policy, upon acceptance of an offer of settlement by the insured but there is a delay in payment beyond 7 days the date of acceptance.

2. At the time of claim settlement, We may insist on KYC documents of the Proposer as per the relevant AML guidelines in force.

Claim Processing & settlement – reimbursement claims and pre-post hospitalization claims

- **Notice of claim:** Preliminary notice of claim with particulars relating to Policy number, Name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending hospital, should be given to the Insurer within 72 hours before admission incase of

planned hospitalization, and not later than 48 hours or before discharge, in case of emergency hospitalization.

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

- As soon as the claim papers are received for claims on reimbursement basis or pre & post hospitalization claims - Revise the reserve made if any in our books suitably. The Reserve shall be made for the total amount claimed by the insured or the sum insured/limit of liability for the particular ailment as per policy norms. If any add-on benefits like hospital cash, convalescence benefit are available, adequate amount towards the same shall also be reserved.

- Send claim file to TPA (through scanned images) after updation of additional details in the claims system.

- Once processed claim file is received from TPA, settlement or repudiation of the claim is to be done.

- Appropriate entries in the system are to be made by claim handler and claim should be put up for approval with the claim approving authority.

- **Delayed submission:** All claims are to be notified within a timeline as mentioned above. In case where the delay in intimation is proved to be genuine and for reasons beyond the control of the insured, we may condone such delay and process the claim. However, such waiver of the time limit for notice of claim and submission of claim is at the discretion of claims approving authority.

Documents Required

1. Test reports and prescriptions relating to First / Previous consultations for the same or related illness.
2. Case history / Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital.
3. Death summary in case of death of the insured person at the hospital.
4. Hospital Receipts / bills / cash memos in Original (including advance and final hospital settlement receipts).
5. All test reports for X-rays, ECG, Scan, MRI, Pathology etc., including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought).
6. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital.
7. F.I.R/MLC. in the case of accidental injury and English translation of the same, if in any other language.
8. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury.
9. Legal heir certificate in the absence of nomination under the policy, in case of death of the proposer. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required by Us.
10. For a) maternity claims, Discharge Summary mentioning Last Menstural Period (LMP), Estimated Date of Delivery (EDD) & Gravida (a women's status regarding pregnancy) b) Cataract claims – (Intraocular Lens Implant) IOL sticker c) Percutaneous Transluminal Coronary Angioplasty (PTCA) claims - Stent sticker.

11. Copies of health insurance policies held with any other insurer covering the insured persons
12. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.
13. For domiciliary hospitalization claims, a certificate from the attending doctor confirming that the condition of the patient is such that he/she is not in a condition to be removed to a hospital.
14. Duly numbered, signed and seal receipt of the ambulance provider in case of emergency ambulance charges
15. Receipts and corresponding prescription by the doctor for vaccination charges
16. For Emergency Domestic Evacuation
    a) Certification by the treating Medical Practitioner of such life threatening emergency condition and confirming that current Hospital does not have suitable medical equipment & technology for the life threatening condition
    b) Bills/Receipts of transportation agency/ambulance company/air ambulance receipts

Documents to be submitted if specifically sought

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

Nomination Facility:

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

Disclosure:

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

How to Buy Royal Sundaram Policy

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

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

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

    - Insured's' name, date of birth, and contact details (email id, mobile no., address).
    - As above for all dependants to be covered by the policy.
    - Selection of sum insured & optional covers (if any).
    - Any existing health insurance policy details and claims history, if applicable.
    - Disclosure of any Pre-existing Diseases with details.
    - Medical history report for the proposed insured, if necessary.
    - Height and weight for the proposed insured.
    - Signature and date on application, wherever applicable.
    - Premium payment collected and receipted

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

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

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

Pre-policy Medical Check-up requirements:

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

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

Underwriting Grid:

Medical Underwriting Grid for Non Bancassurance Channels: (other than Nationalized, Private and Foreign Banks):

Age/Sum Insured	Cumulative SI upto Rs.10lacs	Cumulative SI above

		Rs.10lacs
Upto 50 years	No Check-up*#	Set1/Set2
51 years and above	Set 1/Set2	Set 1/Set2

Medical Underwriting Grid for Bancassurance Channels (Nationalized, Private and Foreign Banks):

Age/Sum Insured	**Cumulative SI upto Rs.20lacs**	**Cumulative SI above Rs.20lacs**
Upto 60 years	No Check-up*#	Set1/Set2
61 years and above	Set 1/Set2	Set 1/Set2

*Additionally, all Portability cases will be subject to Medical Underwriting.

Cumulative Sum Insured in this context means sum of Individual Base Sum Insured and Floater Sum Insured.

Illustration : If there are five members in a Family Plus and each having an Individual Base Sum Insured of Rs. 5 Lakhs and Floater Sum Insured of Rs. 15 Lakhs. For Underwriting Purpose Cumulative Sum Insured shall be Rs. 20 Lakhs i.e. sum of Individual Base Sum Insured and Floater Sum Insured and accordingly the applicable grid will be referred to.

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

- Medical test mix:

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

Sedimentation Rate, MER – Medical Examination Report, FBS – Fasting Blood Sugar, HbA1C – Glycosylated Haemoglobin Test, S Cholestrol – Serum Cholestrol, ECG – Electrocardiogram, SGPT – Serum Glutamic Pyruvate Transaminase, S Creatinine – Serum Creatinine, TMT – Treadmill Test, LFT with GGT – Liver Function Test, RFT – Renal Function Test, HBsAg – Hepatitis B Surface Antigen), URA- Urine Routine Analysis

- * - If the BMI of proposed insured is more than or equal to 33, proposal will be subject to medical uniderwriting. Underwriter might trigger the medical test post evaluation of medical condition of the proposed insured.
- Any additional tests to be triggered as per underwriter's discretion.
- Home visits can be arranged but customer needs to pay the home visit charges. Home visit charges will be in the range of Rs. 200 to Rs. 400 per Home visit.
- Any waiver of medical tests to be approved by Lead – Underwriting and/or Chief Product Officer.

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

Product	Proposal Accepted/Rejected
Family Plus	Royal Sundaram to bear 100% cost of PPMC

Three potential options will be determined by Royal Sundaram's Underwriter.

- **Low to Medium Risk** - accept application with no condition exclusion(s)
- **Medium to High Risk** – accept application, but special conditions, loading/co-payment and (or) exclusion(s) shall apply.
- **Very High Risk** – decline policy cover. Royal Sundaram may decline policy cover where potential risk cannot be quantified through the use of best knowledge and expertise. Royal Sundarm will consider past medical history, pathological conditions, acquired disease conditions, deformity or disability, terminal conditions, and/or a combination thereof to determine if a risk is uninsurable.

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

Web: www.royalsundaram.in

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

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938); no person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to life or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or the tables of the insurer. Any person making default in complying with the provision of this section shall be punished with fine, which may extend to Ten Lakh rupees.

Annexures:

Annexure 1 –

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

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

Annexure 2 – Product Benefits Table

Annexure 3 – Rate Tables

Annexure 4- Indicative list of Day Care Procedures

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: RSAHLIP22200V032122

Annexure I

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

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

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

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

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

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS

8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG

37	PULSEOXYMETER CHARGES

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

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure X

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

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

Place: _____

Date: _____

(DD/MM/YYYY)

Proposer's Signature_____

Name:_____