1. Part A

Forwarding Letter

<<OwnerName>>
<<Addrs1>>
<<Addrs2>>
<<Addrs3>>
<<Addrs4>>
<<Addrs5>>
<<Postcode>> Telephone No.: << Telno >>

Customer Service Centre
<<CSC Adrs>>

Contract No.	<<contrNo>>
Client Id	<<LA Number>>

Dear << OwnerName >>,

Welcome to Reliance Life Insurance and enjoy a host of value added services. We value your relationship with us and thank you for choosing <<Plan Name>>.

Your policy document comprises of the following documents:

- First Premium Receipt
- Policy Schedule
- Copy of the filled up proposal form
- Benefit Illustration
- Policy Terms & Conditions
- Other relevant documents

We request you to preserve the policy document as it would be required at the time of claim. Within 10 days from receiving this welcome kit, you will also receive a fulfillment kit, comprising of Health Card, a guidebook detailing the process and workflows for claims administration & lodgment and the list of current network hospitals for Cashless hospitalization all over India from our designated third party administrator (TPA). The detail of your TPA is mentioned in the attached Policy schedule. In case you notice any discrepancy or for any policy servicing / claims related queries, please contact us immediately. You can either contact our 24x7 call centre number 30338181 or Toll free number 180030008181 or visit our nearest branch office for further assistance.

As per our records, your contact number is <<Contact no>>

This is a << Frequency>> mode policy, and your premium payment term is 5 years. Your next premium is due on <<Premium Due Date>>.

Please note, we do not offer any free gift or interest free loan facility on any of our policies.

Free look provision: In the event, you are in disagreement with the terms, features and conditions stipulated in the policy document, you may wish to opt out of this plan, by stating the reasons of your disagreement in writing and return the policy to the company within 15 days (30 days if policy is purchased through Distance Marketing channel) of its receipt, for cancellation. You are requested to take appropriate acknowledgement of your request letter and return of policy. In which event, the Company will refund the premium paid subject to a deduction of a proportionate premium for a period of cover less expenses incurred by the Company on your medical examination, if any, and stamp duty charges.

Please examine the policy document carefully. On examination of the Policy, if you notice any mistake, please return the Policy to the Company immediately for correction.

SAMPLE

You may access your account by registering on www.reliancelife.com, and follow a 4 step process:
Step 1: Visit www.reliancelife.com
Step 2: Click on customer tab in the member login area
Step 3: Enter your Client id (mentioned above) and your email id
Step 4: Your password shall be generated and sent to the email id provided in your proposal form.
Login with your client id & password and enter a world of convenience!

The details of your agent/ broker are displayed below. Please note that for direct sale by Reliance Life Insurance Company Limited, kindly contact our 24x7 call centre number 30338181 or Toll free number 180030008181 or visit our nearest branch office for further assistance.

We are delighted to bring to you the convenience of lifeline – your personal online account with Reliance Life. Your Lifeline account provides you a one-window access to any information related to your policy. What's more, it allows you to conduct transactions such as premium payment and a few more account information changes and a lot more at your convenience any time anywhere.

Agency/Broker/Web Aggregator Details
Agent/Broker/Web Aggregator Code: << Agent No >>
Agent/Broker/Web Aggregator Name:<< Agent Name >>
Corporate Insurance Executive Name:
(incase of Corporate Agent)
Principal Officer Name :
(incase of Broker)
Phone No : <<AGTelno>>
Mobile No : <<Agent_Mobno>>
Email ID : <<Agent_email>>

Yours sincerely,

<<Signature>>

Chief Executive Officer

SAMPLE

SAMPLE

A non-linked, non-participating, health insurance plan

1.1. Policy Preamble

Policy Terms and Conditions and Privileges within referred to

This Policy is the evidence of the contract between Reliance Life Insurance Company Limited ('the Company') and the Policyholder referred to below.

Reliance Life Insurance Company Limited (hereinafter called "RLIC") agrees to pay the benefits, as stipulated in the Policy Schedule to the Policyholder on the basis of the statements, proposal, declarations and premium along with taxes as applicable from the Policyholder on the assurance that the Policyholder has agreed to all the Policy terms and conditions referred to in the Reliance Health Total (UIN: 121N105V01) Policy Document. The Benefits shall be paid only when the same are payable as per the stipulations in the Policy Document. The Claimant/ Nominee needs to submit satisfactory proof of title and other applicable documents pertaining to the Policy at the RLIC offices for claiming the benefit.

It is hereby further agreed that this Policy shall be subject to the terms, conditions and privileges in this Policy Document and that the Policy Schedule and every endorsement placed on this Policy by RLIC shall be deemed to be a part of the Policy.

1.2. Policy Schedule – Reliance Health Total

THIS SCHEDULE MUST BE READ WITH THE ACCOMPANYING POLICY DOCUMENT AND IS PART OF THE LIFE INSURANCE CONTRACT

RLIC will pay or provide the benefits specified in the Policy Document in the events and circumstances described there-in but subject to the terms and conditions of this contract.

Personal Details			
Name of the Policyholder: « » Address of Policyholder: « » Client ID of Policyholder: « » Date of Birth of Policyholder: « » Age at entry of Policyholder: « yrs »		Name of Life Insured: « » Client ID of Life Insured: « » Date of Birth of Life Insured: « » Gender of Life Insured: « » Age at entry of Life Insured: « yrs » Age Admitted: «Y/N»	
Contract Details			
Contract no : «Contract number» Date of commencement of policy : « » Date of commencement of risk : « » Policy maturity date : « » Policy Term : 5 years		Premium payment term : 5 years Premium due on : « » Mode of premium payment : « » Annualised Premium (excluding service tax) : Rs. « » Total installment premium (including rider(s) premium, any extra premium & service tax) : Rs « »	
Contract Details of Insured covered under the policy			
Base Plan	**Plan Option**	**Sum Insured (Rs.)**	**Date of Benefit Expiry**
Reliance Health Total	Option « »	«SA»	« »
Rider/s	**Rider Sum Assured (Rs.)**	**Installment premium (Rs.)**	**Date of benefit expiry**
«Rider Name»	« Rider SA»	« »	« »

«Rider Name»	« Rider SA»	« »	« »
«Rider Name»	« Rider SA»	« »	« »

* If any rider is opted for at inception of the policy, the rider terms and conditions will be attached as an annexure and will form part of the Policy Document

Benefits Payable (subject to policy terms and conditions)					
Daily Hospital Cash Benefit: 0.5% of Sum Insured	Rs. « » per day				
Intensive Care Unit Benefit: An additional 100% of DHCB	Rs. « » per day				
Recuperation Benefit (RB) Lump Sum 1.5% of Sum Insured	Rs. « »				
Surgery Cash Benefit (SCB) Lump sum per event: 5% of Sum Insured	Rs. « »				
Major Surgical Benefit (MSB) lump sum per MSB: 100% of Sum Insured	Rs. « »				
Critical Illness (CI) Lump Sum: 100% of Sum Insured	Rs. « »				
Medical Reimbursement Benefit (MRB): Amount payable	During Policy Year				
	1	2	3	4	5
	Nil	Rs. « »	Rs. « »	Rs. « »	Rs. « »

For detailed benefits, please refer to the Policy Terms and conditions.

Nominee Details (under Section 39 of the Insurance Act 1938 as amended by The Insurance Laws (Amendment) Ordinance, 2014) ***(If applicable)***			
Name of the Nominee	Date of Birth	Relationship with the Proposer	Percentage Share
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
« »	« »	« »	« »
		Total	100%

Appointee Details (In case the Nominee is a minor)
Name:
Age: « yrs »

Special Provisions	
«FUP_Code1»	«FUP_Desc1»
«FUP_Code2»	«FUP_Desc2»
«FUP_Code3»	«FUP_Desc3»
	«Benefit_Number»

Third Party Administrator Details		
Name Of TPA	**Address**	**Contact Numbers**
TPA_Name	TPA_addr	TPA_telno

Agency/Broker Details:
Agent/Broker/Web Aggregator Code: « Agent No »
Agent/Broker/Web Aggregator Name :« Agent Name »
Corporate Insurance Executive Name :
(incase of Corporate Agent)
Principal Officer Name :
(incase of Broker)
Agent/Broker's Address:«Agent Addr1»
« Agent Addr2»
« AgentAddr3»
« Agent Addr4»
« Agent Addr5»
« Postcode»
Phone No : « AGTelno » Mobile No : «Agent_Mobno»
Email ID : « Agent_email »

SAMPLE

Date of Policy Issuance:

Place:

Reliance Life Insurance Company Limited

(Signature of Authorized Signatory)

UIN of Reliance Health Total: 121N105V01

On examination of the Policy, if you notice any mistake, please return the Policy to the Company immediately for correction.

Reliance Life Insurance Company Limited (Reg. No. 121)

Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra -400710, India

Corporate Office: 9th floor/ 10th floor, Building No. 2, R-Tech Park, Nirlon Compound, Next to Hub Mall, Behind Oracle Building, Goregaon (East), Mumbai - 400 063

Key Feature Document

Key Benefits

Hospitalization Benefit

The benefits available under the Hospitalization Benefit are as mentioned below:

- **Major Surgical Benefit (MSB)**

In the event of hospitalization for a minimum period of 24 hours for undergoing any one of the listed Major Surgeries a lump sum benefit of 100% of Sum Insured will be payable. For any of the surgeries mentioned in the following list, on payment of one claim, the benefit will terminate for that listed surgery and no further claims will be payable for that surgery or its complication. The list of Major surgeries are given below:

Major Surgeries
1. Hip or Knee joint replacement surgery necessitated due to an accident only
2. Heart valve replacement surgery
3. Excision of tissue of brain with craniotomy
4. Transplantation of Heart
5. Coronary artery bypass surgery
6. Bone marrow transplant
7. Liver transplantation (recipient)
8. Renal transplantation (recipient)
9. Total Excision of Esophagus and Stomach
10. Transplantation of lung

- **Surgical Cash Benefit (SCB)**

In the event of hospitalization for a minimum period of 24 hours for undergoing any valid and Medically Necessary Surgery except the listed major surgeries, a lump sum benefit of 5% of Sum Insured will be payable. Multiple surgeries performed under the same anesthesia will be considered as a single event and be eligible for a lump-sum payment of 5% of Sum Insured only. OPD (Out-patient department) procedures and day care procedures will not be covered under SCB

- **Daily Hospital Cash Benefit (DHCB)**

In the event of hospitalization for Medically Necessary treatment of any illness or injury for a minimum period of 48 hrs, a fixed amount of 0.5% of Sum Insured per day will be payable from the first day of the hospitalization for the duration of hospitalization for a valid claim.

- **Intensive Care Unit (ICU)Benefit**

An additional 100% of DHCB (0.5% of Sum Insured) amount per day is payable for each day of stay in the Intensive Care Unit (ICU) of the insured. This benefit is payable only if the DHCB is payable.

- **Recuperation Benefit (RB)**

A recuperating benefit of 1.5% of Sum Insured is payable for 7 or more days of continuous hospitalization for the same injury or disease, subject to the DHCB being payable at the time of hospitalization. The benefit is payable irrespective of whether

SAMPLE

	the patient is admitted at one or more hospitals during one and the same episode. The benefit is not payable if the patient dies during hospitalization. The RB is payable only once in a policy year.
Critical Illness (CI) Benefit	In the event of a confirmed diagnosis of the Life Insured suffering from one of the Critical Illness Conditions listed in the policy, provided Life Insured survives for 30 days after such diagnosis, and fulfilling all the definition criteria of the relevant condition as specified under Policy Conditions a lump sum benefit of 100% of Sum Insured will be paid. On payment of one CI claim, the benefit will terminate and no further claims will be payable against this benefit, even after the renewal of the policy. The Critical Illnesses covered are listed below: 1. Cancer; 6. Loss of Hearing 2. Heart Attack; 7. Alzheimer's Disease 3. Stroke; 8. Parkinson's Disease 4. Major Burns; 9. Coma 5. Loss of Speech; 10. Terminal Illness
In the above mentioned benefits of the plan, we will pay the defined benefits subject to specified conditions and we will not reimburse medical expenses	
Medical Reimbursement Benefit	Benefits against medical expense bills will be reimbursed up to the limits provided in the table below. The applicable MRB for a policy year would be payable only if all due premiums have been paid for that policy year. During Policy Year – MRB (as % of Annual Premium): 1 – 0 2 – 25% 3 – 50% 4 – 60% 5 – X% For this purpose premium excludes the underwriting extra premiums. X% is dependent on the gender, age at entry and Sum Insured Multiple Option. The values for X are provided in Annexure "B". The applicable MRB for this policy is mentioned in the Policy Schedule.
Death	No benefit is payable on death of insured during the policy term
Maturity Benefit	No benefit is payable on maturity of the policy

Key product conditions

Policy Term (years)	Premium Payment Term (years)
5 Years	5 Years

Plan Options	Benefit comparison	Sum Insured Multiple (as a multiple of Annual Premium)

I	Higher Medical Reimbursement Benefit	6.66667
II	Higher Sum Insured	13.33335

You can choose the Plan Option only at inception of the Policy and it cannot be altered during the term of the Policy. However, at policy renewal after the Policy Term, you may choose to alter the Plan Option, depending on the terms and conditions and plans available at the time of renewal.

SAMPLE

Key Service Features

Nomination	The Life Insured can make multiple nomination for the purpose of payment of benefits in the event of his death, if applicable
Loans	Loan facility is not available under the plan
Riders	For enhanced protection the following riders can be purchased with this plan at a nominal cost: 1. Reliance Accidental Death Benefit and Total and Permanent Disablement Rider (Regular Premium): (UIN:121B002V02) 2. Reliance Major Surgical Benefit Rider : (UIN: 121B014V02) 3. Reliance Critical Conditions (25) Rider : (UIN: 121B012V02)
Change in premium payment mode	The Policyholder may pay regular premiums in yearly and monthly modes. The premium payment mode can be changed on any Policy Anniversary date during the Premium Payment Term
Premium payment	Premium payment can be made by cash, cheque, debit/credit card, ECS, online payment, demand draft, Salary Deduction Scheme (SDS) and direct debit
Customer service number	1800 300 08181 or 022-30338181
Grievance redressal mechanism	Policyholder can contact the Company by sending an email. at rlife.customerservice@relianceada.com or by writing to us at our Registered Office address: Reliance Life Insurance Company Limited, H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra - 400710, India

For detailed benefits, please refer to the Policy terms and conditions.

SAMPLE

Table of Contents

1. Part A ... 1
1.1. Policy Preamble ... 3
1.2. Policy Schedule – Reliance Health Total ... 3
2. Part B ... 12
2.1. Definitions ... 12
2.2. Definitions of Critical Illness ... 17
3. Part C ... 20
3.1. Key Benefits ... 20
3.1.1. Plan Option ... 20
3.1.2. Hospitalization Benefit ... 20
3.1.2.1. Daily Hospital Cash Benefit (DHCB) ... 20
3.1.2.2. Intensive Care Unit Benefit (ICU) ... 20
3.1.2.3. Recuperation Benefit (RB) ... 20
3.1.2.4. Surgical Cash Benefit (SCB) ... 20
3.1.2.5. Major Surgical Benefit (MSB) ... 20
3.1.3. Critical Illness (CI) Benefit ... 21
3.1.4. Medical Reimbursement Benefit (MRB) ... 22
3.1.5. Maturity Benefit ... 22
3.1.6. Death Benefit ... 22
3.2. Sum Insured Limits ... 22
3.3. Policy Limits ... 23
3.4. Other Benefits ... 24
3.4.1. Rider Benefits ... 24
3.5. Premium details ... 24
3.5.1. Payment of premium ... 24
3.5.2. Mode of payment of premium ... 25
3.5.3. Rider premium ... 25
3.5.4. Premium Guarantee ... 25
3.5.5. Employee staff discount ... 25
4. Part D ... 26
4.1. Free look ... 26
4.2. Loans ... 26
4.3. Waiting Period ... 26
4.4. Exclusions ... 27
4.5. Surrender Benefit ... 28
4.6. Discontinuance of payment of premium ... 28
4.6.1. Lapse ... 28
4.6.2. Revival ... 28
4.7. Renewal of Policy (after expiry of the Policy Term of 5 years) ... 29

SAMPLE

4.8. Renewal Discount (after expiry of the Policy Term of 5 years) 29
5. Part E 30
6. Part F....31
6.1. Claims....31
6.1.1. Requirements for Cashless Facility 31
6.2. Requirement for Claims....31
Claims for Medical Reimbursement Benefit....32
6.3. Suicide 33
6.4. Grace period for payment of premium 33
6.5. Tax benefit....33
6.6. Taxes, duties and levies and disclosure of information 33
6.7. Nomination 33
6.8. Assignment 33
6.9. Proof of age 33
6.10. Special provisions....34
6.11. Recovery of additional expenses incurred on account of acts of Policyholders 34
6.12. Mode of payment of benefits....34
6.13. Valid discharge....34
6.14. Limitation of liability....34
6.15. Fraud and Misrepresentation 35
6.16. Loss of Policy Document 35
6.17. Waiver 35
6.18. Electronic transaction 35
6.19. Notice under the Policy 35
6.20. Entire Contract....36
7. Part G....37
7.1. Governing laws and jurisdiction....37
7.2. Primacy of the Policy Document....37
7.3. Grievance Redressal 37
7.4. Procedure for registering complaint with IRDA Grievance Call Centre (IGCC) 37
7.5. Procedure for filing complaint with the Insurance Ombudsman 38
Annexure A: Insurance Ombudsman 40
Annexure B: MRB Rates....43
Annexure C: Section 39, Nomination by policyholder....45
Annexure D: Section 38, Assignment and Transfer of Insurance Policies 47
Annexure E: Section 45, Fraud and Misrepresentation 49

SAMPLE

2. Part B

2.1. Definitions

"Accident" means a sudden, unforeseen and involuntary event caused by external and visible means

"Acute condition" means a medical condition that can be cured by treatment

"Age" means age last birthday; i.e. the age in completed years as on the Commencement Date of the policy

"Annual limit" means the maximum benefit that will be payable in a policy year

"Annualised Premium / Annual Premium" means the due premium contribution as calculated and applicable for a Policy Year. Annualised Premium excludes extra premium, if any.

"Base Plan/ Plan" means Reliance Health Total (UIN: 121N105V01)

"Base Policy / Policy" means this Reliance Health Total, which is the evidence of the contract between Reliance Life Insurance Company Limited ('the Company') and the Policyholder

"Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved

"Chronic condition" means a disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it comes back or is likely to come back.

"Claimant" means either:

a) the person(s) entitled to receive the health cover claim amount, as per applicable clauses, under the Plan. In the event of a death claim, the claimant is the nominee(s), if any, under the Policy, OR
b) In the absence of the nominee, the claimant is the legal heir of the Life Insured, OR
c) In instances where the Policyholder and Life Insured are different, the claimant is the Policyholder, if alive, or nominee(s) under the Policy

"Commencement Date" means the commencement date of this policy as mentioned in the Policy Schedule and means the Policy start date

"Company/Us/We/Our" means Reliance Life Insurance Company Limited (RLIC)

"Congenital Anomaly" refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position including late manifestation of a congenital disease

"Date of Commencement of Policy / Policy Commencement Date" means the start Date of this Policy as mentioned in the Policy Schedule

"Date of Commencement of Risk" means the date as mentioned in the Policy Schedule from which the insurance benefits start under the Policy. The commencement of risk cover on the Life Insured shall depend on the age of the Life Insured on commencement of the Policy

"Day" means a period of a full 24 hours during a period of confinement. The first Day of confinement shall commence at the time of admission to the Hospital and each subsequent Day shall commence 24 hours after the commencement of the previous Day. The minimum period of hospitalization to claim benefits is 48 hours. Thereafter, on the day of discharge, if the insured stays in hospital for more than 12 hours but less than 24 hours that day will also be considered as a "Day" for the eligibility of the benefit under the policy

SAMPLE

“Day Care Treatment or Procedure” Day care treatment refers to medical treatment, and/or surgical procedure

- which is undertaken under General or Local Anesthesia in a hospital care centre in less than 24 hrs because of technological advancement, and
- which would have otherwise required a hospitalization of more than 24 hours.

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

“Day care centre” means any institution established for day care treatment of sickness and / or injuries or a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment
ii. has qualified medical practitioner (s) in charge has a fully equipped operation theatre of its own where surgical procedures are carried out
iii. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel

“Death Benefit” means the amount payable to the claimant on death of the Life Insured during the Policy Term, as agreed at inception of the Policy contract, provided the Policy has not lapsed or terminated

“**Disclosure to information norm**” means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact

“**Due Date**” means the date on which the premium for the next policy year is due for payment as specified in the Policy Schedule

“**Expiry date”** means the date on which the policy completes its fixed term of 5 years from the date of commencement of this policy and as stated in the Policy Schedule

“Event” means hospitalization, admission into ICU, undergoing an event of hospitalization or undergoing a surgery that requires hospitalization or being diagnosed with an insured critical illness as stated

“Grace Period” means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases, Coverage is not available for the period for which no premium is received.

“Health Cover” means the effecting of insurance contracts which provide for sickness benefits or medical, surgical or hospital expense benefits cover, as per the terms of this policy

“Hospital” means any institution established for in-patient care and day care treatment of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

- Has at least 10 Inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in other places;
- Has qualified Nursing Staff under its employment round the clock;
- Has qualified allopathic Medical Practitioner (s) in charge round the clock;
- Has a fully equipped operation theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and will make this record accessible to the Insurance company’s authorized personnel

“**Hospitalization**” means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours

“**Illness**” means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

“In-force status” means a condition during the term of the Policy, wherein the Policyholder has paid all the due premiums under the Policy contract

“Injury” means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner

“Inpatient Care” means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event

“Intensive Care Unit (ICU)” means an identified section, ward or wing of Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards

“Lapse” means a condition wherein the due premiums for the Policy year have not been paid in full within the grace period for the Policy, thereby rendering the Policy unenforceable. No benefits will be payable when the Policy is in Lapse status.

“Lifetime limit” means maximum benefit that will be payable in the lifetime of the Policy even after renewals. If the lifetime limit for a benefit is exhausted, the cover for that benefit will cease and the company will not be liable to pay any claim against that benefit

“Life Insured” means the person, on whose health, this insurance policy has been effected

“Medical Advise” means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription

“Medical Condition” shall mean any Injury, illness or disease which would have caused any ordinary prudent person to seek treatment, diagnosis, care, medical advice or treatment, as covered under this policy

“Medical practitioner” means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The registered practitioner should not be the insured or close family members

“**Medical Expenses”** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment

“Medically Necessary” refers to treatment, tests, medication or stay in hospital or part of a stay in hospital which

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

“Network Provider” means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a Cashless facility

“Non-Network” means any hospital, day care centre or other provider that is not part of the network

“Nominee” means the person or persons appointed under Section 39 of the Insurance Act, 1938, as amended by Insurance Laws (Amendment) Ordinance Act, 2014 by the Policyholder, to receive the admissible benefits, under the Policy

“Notification of Claim” means the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified

“OPD treatment” where Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient

"Physical Injury" means bodily injury caused solely and directly by an Accident (i.e. an event of violent, unexpected external and visible nature)

"Policy Anniversary" means the date of start of every subsequent Policy Year

"Policy Document" means this document, which is the evidence of the contract between Reliance Life Insurance Company Limited ('the Company') and the Policyholder

"Policy Schedule/Schedule" means the Policy Schedule read with the documents attached to the Policy Schedule issued by the company for this policy, together with any amendments to the Policy Schedule which may be issued from time to time

"Policy Year" means a period of twelve (12) consecutive calendar months starting with the Date of Commencement of the Policy as stated in the Policy Schedule and ending at midnight on the day immediately preceding the following anniversary date and each subsequent period of twelve (12) consecutive months thereafter

"Policy Term" means a fixed term of 5 years of Reliance Health Total

"Policyholder/ Policy owner/Proposer/You" means the person specified as such in the Policy Schedule or such other person, who may become the holder of this Policy in respect of the terms and conditions of this contract or by virtue of operation of law. In the event the Proposer is different from the Life Insured, then the Proposer shall be the Policyholder

"Post-hospitalization Medical Expenses" means **e**xpenses incurred immediately after the Insured provided that:

i. Such Medical Expenses are incurred for the same Insured Person's Hospitalisation was required; and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

"Pre-hospitalization Medical Expenses" means expenses incurred immediately before the Insured Person is hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

"**Premium**" means the amount stipulated in the Policy Schedule and paid at regular intervals (yearly/half yearly/ quarterly/ or monthly mode as shall be applicable) by the Policyholder as consideration for acceptance of risk and benefits specified as such in the Policy Document

"Premium payment term" means the period or the term of the Policy contract during which the Policyholder is required to pay the premiums with respect to the Policy, to the Company

"Prevailing rate of interest" means the applicable rate of interest as declared by the Company from time to time that shall be charged to the Policyholder on specified transactions related to the policy, as specified under the Plan, subject to approval of the Regulator, i.e. IRDA .

"**Proposal Form**" means the proposal for this Policy submitted by or on behalf of the Policyholder for the purpose of obtaining this Policy along with any other information or documentation provided to the Company for that purpose prior to inception of this Policy and based upon which this Policy is issued

"Pre-Existing Disease" means any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer

"Reasonable Charges" means the charges for the services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / injury involved

"Regulations" means the laws and regulations as in effect from time to time and applicable to this Policy, including without limitation the regulations and directions issued by the Regulatory Authority from time to time;

"Renewal" means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the-purpose of all waiting periods

SAMPLE

“Revival” means payment of all due premiums that are in arrears to convert a Policy from “Lapse” status into “In force” status

“Regulatory Authority/IRDA” means the Insurance Regulatory and Development Authority of India (IRDA) or such other authority or authorities, as may be designated under the applicable laws and regulations

“Rider” means an optional cover available as an add-on benefit, which can be purchased by you along with the base Plan on payment of additional premium as applicable

“Rider Benefits” means the benefits payable on specified events applicable under the Riders as may be purchased by you

“Rider Premium” means the Premium paid towards the Riders and does not include any taxes and/or levies

“Sum Insured/Base Sum Insured” is the absolute amount of benefit as specified in the attached Policy Schedule

“Surgery” means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner

“TPA” means the third party administrator who is licensed by the Regulatory Authority and is appointed by RLIC for health Services and as specified in the Policy Schedule. The services of the TPA are tenure bound and RLIC may change the TPA, at its discretion as stated in the agreement signed between TPA and the Company

“Unproven/Experimental Treatment” means a treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven

“Waiting Period” means the initial period from the Policy Commencement Date during which the Member is required to wait for the risk cover to commence for specific Illnesses or treatments. Any incidence of Illness/diagnosis/treatment during the Waiting Period will render the Member ineligible, forever, for the Benefit arising out of the same Illness

“We/Our/RLIC/Us/Company/Reliance Life” refers to Reliance Life Insurance Company Limited

“You/Your” means the Policy Owner, Policyholder, Proposer, named in the Policy Schedule or his or her legal heir or personal

SAMPLE

2.2. Definitions of Critical Illness

1. Cancer

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

i. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to:

Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.

ii. Any skin cancer other than invasive malignant melanoma

iii. All tumours of the prostate unless histologically classified as having a Gleason score

greater than 6 or having progressed to at least clinical TNM classification T2N0M0.

iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter

v. Chronic lymphocyctic leukaemia less than RAI stage 3

vi. Microcarcinoma of the bladder

vii. All tumours in the presence of HIV infection.

2. Heart Attack

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

ii. new characteristic electrocardiogram changes

iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of

Troponin I or T

ii. Other acute Coronary Syndromes

iii. Any type of angina pectoris.

3. Stroke

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

4. Major Burns

SAMPLE

Third degree burns covering at least 20% of the surface of the Life Assurer's body. Diagnosis has to be confirmed by a specialist and evidenced by specific results as per the Lund Browder Chart or equivalent burn area calculators.Burns arising due to self infliction are excluded.

5. Loss of Speech

Total and irreversible loss of the ability to speak due to injury or disease of the vocal cords. The condition has to be confirmed and medically documented by a specialist (best by an otorhinolaryngologist) for at least 6 months. Psychogenic loss of speech is excluded from cover.

6. Loss of Hearing

Total, bilateral and irreversible loss of hearing for all sounds as a result of sickness or accident. Medical evidence to be supplied by an otorhinolaryngologist and to include audiometric and sound-threshold testing.

The loss of hearing must not be correctable by aides or surgical procedures

7. Alzheimer's Disease

Unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age 61 that has to be confirmed by a specialist and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT scan, MRI, PET of the brain). The disease must result in a permanent inability to perform independently three or more activities of daily living – bathing (ability to wash in the bath or shower), dressing (ability to put on, take off, secure and unfasten garments), personal hygiene (ability to use the lavatory and to maintain a reasonable level of hygiene), mobility (ability to move indoors on a level surface), continence (ability to manage bowel and bladder functions), eating/drinking (ability to feed oneself, but not to prepare the food) or must result in need of supervision and the permanent presence of care staff due to the disease. These conditions have to be medically documented for at least three months.

Psychiatric illnesses and alcohol related brain damage are excluded.

Coverage for this impairment will cease at age sixty-one (61) or on maturity data/expiry date, whichever is earlier.

The following are excluded:

i. Non organic diseases such as neurosis and psychiatric illnesses and
ii. Alcohol related brain damage
iii. Any other type of irreversible organic disorder/dementia

8. Parkinson's Disease

Unequivocal diagnosis of idiopathic or primary Parkinson's disease (all other forms of Parkinsonism are excluded) before age 61 that has to be confirmed by a specialist. The disease must result in a permanent inability to perform independently three or more activities of daily living – bathing (ability to wash in the bath or shower), dressing (ability to put on, take off, secure and unfasten garments), personal hygiene (ability to use the lavatory and to maintain a reasonable level of hygiene), mobility (ability to move indoors on a level surface), continence (ability to manage bowel and bladder functions), eating/drinking (ability to feed oneself, but not to prepare the food) or must result in a permanent bedridden situation and inability to get up without outside assistance. These conditions have to be medically documented for at least three months.

The following are excluded:

i. Drug-induced or toxic causes of Parkinsonism.
ii. Parkinsonism related to other neurodegenerative disorders
iii. Essential tremor

Coverage for this impairment will cease at age sixty-one (61) or on maturity data/expiry date, whichever is earlier.

SAMPLE

9. Coma

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded

10. Terminal Illness

Terminal Illness is defined as an advanced or rapidly progressing incurable & uncorrectable medical condition, which in the opinion of the treating physician is highly likely to lead to death within the next six months. An independent practicing medical consultant acceptable to the insurance company specializing in the relevant field of medicine also needs to certify with reasonable certainty that the life expectancy of the insured is less than six months at the time of notification. The insured must not be receiving any form of treatment other than palliative medication for symptomatic relief and must not have engaged in any gain full employment for the last 30 days. The insurance company must be notified of the diagnosis within 30 days of the same being made.

Terminal Illness due to AIDS is excluded.

SAMPLE

3. Part C

3.1. Key Benefits

3.1.1. Plan Option

At inception of the Policy, you may choose between the two plan options available under the Policy.

Plan Options	Benefit comparison	Sum Insured Multiple
I	Higher Medical Reimbursement Benefit	6.66667
II	Higher Sum Insured	13.33335

However, due to the effect of rounding, your Sum Insured or premium amount may vary by a few rupees. Please check the Policy Schedule for the exact Sum Insured and annual premium.

Option I is available for all entry ages and Option II is available for entry ages up to age 55 years.

You can choose the Plan Option only at inception of the Policy and it cannot be altered during the term of the Policy. However, at policy renewal after the Policy Term, you may choose to alter the Plan Option, depending on the terms and conditions and plans available at the time of renewal.

3.1.2. Hospitalization Benefit

The benefits available under the Hospitalization Benefit are as described below:

3.1.2.1. Daily Hospital Cash Benefit (DHCB)

In the event of Hospitalization for Medically Necessary treatment of any Illness or Injury for a minimum period of 48 hrs, a fixed amount of 0.5% of Sum Insured per day will be payable from the first day of the hospitalization, subject to not more than 45 such days including ICU in a policy year, for the duration of Hospitalization for a valid claim.

3.1.2.2. Intensive Care Unit Benefit (ICU)

An additional 100% of DHCB (0.5% of Sum Insured) amount per day, subject to not more than 45 such days including DHCB in a policy year, is paid for each day of stay in the Intensive Care Unit (ICU) of the insured. This benefit is payable only if the DHCB is payable.

3.1.2.3. Recuperation Benefit (RB)

A recuperating benefit of 1.5% of Sum Insured is payable for 7 or more days of continuous hospitalization for the same injury or disease. The benefit is payable irrespective of whether the patient is admitted at one or more hospitals during one and the same episode. The benefit is not payable if the patient dies during hospitalization. The RB is payable once in a policy year.

3.1.2.4. Surgical Cash Benefit (SCB)

In the event of hospitalization for a minimum period of 24 hours for undergoing any valid and Medically Necessary surgery except the listed major surgeries in India, a lump sum benefit of 5% of Sum Insured will be payable. In case of multiple surgeries performed under the same anesthesia will be considered as a single event and benefit payout will be capped at maximum eligible limit of 5% of the Sum Insured. The SCB is payable maximum three times in a policy year. OPD (Out-patient department) procedure and day care procedures will not be covered.

3.1.2.5. Major Surgical Benefit (MSB)

In the event of hospitalization for a minimum period of 24 hours for undergoing any one of the listed Major Surgeries a lump sum benefit of 100% of Sum Insured will be payable for any of the surgeries mentioned in the list below. On payment of one claim, the benefit will terminate for that listed surgery and no further claims will be payable for that

SAMPLE

surgery or its complication. Once a claim is accepted for any particular Major Surgery, the benefit will terminate for that particular surgery with no further claims admissible for that surgery or its complications. However, this benefit will continue for the remaining Major Surgeries.

List of major surgeries covered:

1. Hip or Knee joint replacement surgery necessitated due to an accident only
2. Heart valve replacement surgery
3. Excision of tissue of brain with craniotomy
4. Transplantation of Heart
5. Coronary artery bypass surgery
6. Bone marrow transplant
7. Liver transplantation (recipient)
8. Renal transplantation (recipient)
9. Total Excision of Esophagus and Stomach
10. Transplantation of lung

3.1.3. Critical Illness (CI) Benefit

In the event of a confirmed diagnosis of the Life Insured suffering from one of the Critical Illness Conditions listed in the policy, provided the Life Insured survives 30 days after such diagnosis, and fulfilling all the definition criteria of the relevant condition as specified under Policy Conditions a lump sum benefit of 100% of Sum Insured will be paid.

On payment of one CI claim the benefit will terminate and no further claims will be payable against this benefit, even after the renewal of the policy.

Once a CI claim is admitted, no further critical illness claims for the above mentioned 10 illnesses will be payable during the remaining policy term and even after the renewal of the policy.

Following is the list of critical illness (CI) covered under the plan. All other Critical Illnesses other than the ones listed below are excluded from Critical Illnesses (CI) benefits:

1. Cancer
2. Heart Attack
3. Stroke
4. Major Burns
5. Loss of Speech
6. Loss of Hearing
7. Alzheimer's Disease
8. Parkinson's Disease
9. Coma
10. Terminal Illness

For Hospitalization Benefit and Critical Illness Benefit, we will pay the defined benefits subject to specified conditions and will not reimburse actual medical expenses.

3.1.4. Medical Reimbursement Benefit (MRB)

This product provides coverage for Daily Hospitalisation Cash Benefit, ICU Benefit, Recuperation Benefit, Surgical and Major Surgical Benefit. However, if there are some other medical expenses, for medicines and drugs, medical equipments (such as BP machine, thermometers and so on), Out patient (less than 1 day treatment), diagnostic expenses, dental treatment, maternity expenses, spectacles or contact lenses, annual health check-up or Other medical expenses not covered under daily hospitalization cash benefit, the Company will pay the benefit through Medical Reimbursement Benefit (MRB) to the policyholder.

In addition to the above mentioned benefits any claim amount which is not covered under Hospitalisation Cash Benefit, ICU Benefit, Recuperation Benefit, Surgical Cash Benefit and Major Surgical Benefit due to the respective maximum limits applicable would also be covered under MRB subject to the maximum limits provided in the table below.

MRB facility can be availed maximum three times in a Policy year, subject to a minimum of Rs. 1000 for each claim.

This benefit will be payable against medical expense bills* produced without any exclusions & deductions and will be reimbursed up to the limits provided in the table below. The applicable MRB for a policy year would be payable only if the annualised premium has been paid for that policy year. Any unclaimed MRB is not carried forward to the subsequent Policy Year.

During Policy Year	MRB (as a % Annual Premium)
1	0
2	25%
3	50%
4	60%
5	X%

For this purpose premium excludes the underwriting extra premiums.

X% is dependent on the gender, age at entry and Sum Insured Option. The values for X are provided in Annexure "B".

For online channel, MRB in fifth policy year will be (X% + 25%).

The applicable MRB for this policy is as mentioned in the Policy Schedule.

*Medical expense bill refers to expense bill against any medicine/drugs/equipments/treatment/advice which is medically necessary.

3.1.5. Maturity Benefit

No benefit is payable on maturity of the policy.

3.1.6. Death Benefit

No benefit is payable on death of the life insured during the Policy Term.

3.2. Sum Insured Limits

Below mentioned table shows the Sum Insured options available in the policy:

SAMPLE

Minimum	**Maximum**
Rs. 66,667 Sum Insured is a multiple of Annual Premium. The following Sum Insured Multiples are available under this Plan: • Option I: 6.66667 • Option II:13.33335 Example: For Annual Premium of Rs. 10,000, eligible Sum Insured shall be as under: - Option I: 6.66667 x 10,000 = Rs. 66,667 - Option II: 13.33335 x 10,000 = Rs. 1,33,334 For this purpose premium excludes the underwriting extra premiums.	**Rs. 6,66,667** Sum Insured is a multiple of Annual Premium. The following Sum Insured Multiples are available under this Plan: • Option I : 6.66667 • Option II :13.33335 Example: For Annual Premium of Rs. 50,000, eligible Sum Insured shall be as under: - Option I: 6.66667 x 50,000 = Rs. 3,33,334 - Option II: 13.33335 x 50,000 = Rs. 6,66,668 For this purpose premium excludes the underwriting extra premiums.

- Sum Insured applicable under this policy is as stated in the attached Policy Schedule

3.3. Policy Limits

The following policy limits shall apply during a Policy Year and during lifetime of this policy:

Benefit Type	Annual Limit	Lifetime Limit
HCB	45 x DHCB per policy year (including the ICU benefit)	8 times maximum annual limit
RB	Once per policy year	8 times maximum annual limit
SCB	Thrice per policy year	8 times maximum annual limit
MSB	Once per policy year	5 times maximum annual limit
CI	Once per policy during the policy's lifetime	Once per policy during the policy's lifetime
HCB + RB + SCB	100 x DHCB amount per policy year for all hospitalization benefits (excluding MSB)	Not Applicable
MRB	As specified under section 3.1.3 for each policy year, during the Policy Term	Not Applicable

3.4. Other Benefits

3.4.1. Rider Benefits

To safeguard yourself and your family members against certain unfortunate events, we offer the following riders with this plan at a nominal cost.

1. **Reliance Major Surgical Benefit Rider** (UIN: 121B014V02)**:** Provides a lump sum amount to cover surgical expenses from a list of 33 surgeries including open heart surgery, kidney transplant, cornea transplantation, transplant of lungs and many more.
2. **Reliance Critical Conditions (25) Rider** (UIN: 121B012V02): Provides a lump sum amount to take care of 25 critical conditions including cancer, heart attack, paralysis, major organ transplant and many more.
3. **Reliance Accidental Death Benefit and Total and Permanent Disablement Rider (Regular Premium)** (UIN: 121B002V02)**:** Provides an additional death/disability benefit if death/disability occurs directly as a result of an accident. Also, the waiver of premium benefit under the rider continues in the plan in case of disability.

Rider benefits can be selected on commencement of the policy or on any policy anniversary during the Premium Payment Term. The rider Policy Term will be less than or equal to the Policy Term of the Base Plan if taken at the outset, or will be less than or equal to the outstanding base Policy Term if taken subsequently at the policy anniversary of the Base Plan, subject to the rider Policy Term options available.

The Sum Assured under the rider shall not be higher than the Sum Insured under the Base Plan. When the Base Plan is lapsed, surrendered or forfeited, the rider attached to the Base Plan will also terminate immediately.

For more details on the rider benefits, features, terms and conditions, please refer to the rider terms and conditions carefully or contact your insurance advisors.

3.5. Premium details

3.5.1. Payment of premium

The Policyholder is required to pay premiums regularly for the entire premium payment term as per the mode of premium specified in the Policy Schedule.

Premiums shall be deemed to have been paid only when received at the Company's offices which are authorized by the Company to accept payment of Premiums. The official receipt issued by the Company is the only valid evidence of payment of Premiums.

In case a valid claim arises under the policy during the grace period but before payment of the due premium, the Company will still admit the claim.

Any unpaid premium for the policy year will become due and payable immediately. In the event, the said unpaid premium is not received by the Company, the Company will deduct the said unpaid premium, while settling such a claim.

Collection of advance premium shall be allowed within the same financial year for the premium due in that financial year. However, where the premium due in one financial year is being collected in advance in earlier financial year, we may collect the same for a maximum period of 3 months in advance of the due date of the premium.

SAMPLE

3.5.2. Mode of payment of premium

The Policyholder is required to pay the Regular Premium under the plan as per the mode of premium specified in the Policy Schedule.

The Policyholder can pay the regular premiums in yearly and monthly mode. The yearly premium may be paid by cash, cheque, debit/credit card, online payment and demand draft. Monthly mode is allowed only through Electronic Clearing System (ECS) or through Direct Debit.

The Policyholder may request to change the mode and frequency of payment of regular premiums on any Policy Anniversary date during the Premium Payment Term but not at other times. The Company, at its sole discretion, may agree to accept the payment of the Premium in any mode (yearly / monthly) as requested by Policyholder. The amended Schedule notifying the changed installment Premium shall be issued to the Policyholder.

If the monthly mode is chosen at the time of issuance, first two months premium will be collected at the time of issuance of the policy.

Alteration in premium frequency is allowed only on policy anniversaries subject to minimum premium limits mentioned below by giving written notice to the Company at least 30 days before the policy anniversary.

Premium Payment Mode	**Minimum Premium Payable (Rs.)**
Yearly	10,000
Monthly	834

3.5.3. Rider premium

Riders will be available, on payment of additional premium over and above the base premium provided conditions on riders (entry age, Policy Term, Premium Payment Term, Sum Assured) are satisfied. Rider premium should be paid on the due date or within the grace period. The mode of rider premium payment shall be same as the mode of premium payment under the Base Plan. The rider premium payment term will be either equal to or lower than the premium payment term of the Base Plan. The sum of rider premiums should not exceed 100% of the premiums paid under the Base Plan.

3.5.4. Premium Guarantee

The premium rates for the plan, once applied for any policy, shall be guaranteed for the first five years of the policy. After the five years period, the Company may change the premium rates which shall remain guaranteed for the subsequent Policy Term of the renewed policy.

3.5.5. Employee staff discount

No commissions are payable on policies purchased by Reliance Life Insurance Company Limited staff and staff of other Anil Dhirubhai Ambani Group companies, where the discount of 5% applies on the premiums every year. However, if the person ceases to be an employee of Reliance Life Insurance Company Limited or any other company of the Reliance Anil Dhirubhai Ambani Group, the premium rates without discount may be applicable from the date the person ceases to be an employee of the Reliance Group company.

SAMPLE

4. Part D

4.1. Free look

In the event you disagree with any of the terms and conditions of the Policy, you may return the Policy to the Company within 15 days (applicable for all distribution channels, except for Distance Marketing* channel, which will have 30 days) of its receipt for cancellation, stating your objections, in which case, you shall be entitled to a refund of the premiums paid, subject only to a deduction of the proportionate risk premium for the period on cover and the expenses incurred by the insurer on medical examination of the Life Insured and stamp duty charges.

*Distance Marketing includes every activity of solicitation (including lead generation) and sale of insurance products through the following modes:

i. Voice mode, which includes telephone-calling
ii. Short Messaging Services (SMS)
iii. Electronic mode which includes e-mail, internet and interactive television (DTH)
iv. Physical mode, which includes direct postal mail and newspaper & magazine inserts and
v. Solicitation through any means of communication other than in person

4.2. Loans

Loan facility is not available under this Policy.

4.3. Waiting Period

The Company shall not be liable to make any payment if claims are made due to;

1) Any treatment of illness/ailment/disease diagnosed or hospitalization taking place during the first 90 days of the policy commencement date or date of revival.

2) Any hospitalization for treatment of any of the following diseases or surgeries or procedures and any complications arising out of them within 1 year of the policy commencement date or date of revival

   a. Hernia Repair
   b. Corrective procedure for gall stones
   c. Corrective procedure for kidney or urinary tract stones
   d. Disectomy, laminectomy
   e. Hemi / Partial thyroidectomy
   f. Corrective procedure for anal fistula or anal fissure
   g. Removal of uterus, fallopian tubes and/or ovaries, except for malignancy
   h. Corrective procedure for fibroids, uterine prolapse, or dysfunctional uterine bleeding
   i. Corrective procedures for haemorrhoids
   j. Cataract & Joint replacement surgeries

   Note: The waiting periods are not applicable if the claims are as a result of an accident

3) The 1 year waiting period as mentioned above will not be applicable for the Critical illness Benefit. The 1 year waiting period includes the 90 days waiting period mentioned above.

SAMPLE

4.4. Exclusions

1. Medical Reimbursement Benefit (MRB) claims are excluded from 4.4.2 mentioned below. MRB claims are admissible up to the limits as specified under the Policy Schedule, subject to terms under and conditions mentioned under section 3.1.4.
2. We will not pay any claim towards the Life Insured directly or indirectly for health related illnesses under Hospitalization Benefit and Critical Illness Benefit, caused by or arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy. All other conditions other than ones listed below are eligible for claim under the plan, subject to policy conditions.

i. Pre existing Condition :

"Pre-existing Condition" means any condition, whether diagnosed or not, ailment or injury or related condition(s) for which Insured had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first Policy issued by the Insurer. We will cover pre-existing diseases after an initial waiting period of 4 years. For a renewed policy, no such waiting period will be applicable.

ii. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), terrorism, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

iii. Insured person committing or attempting to commit a criminal or illegal act with criminal intent, or intentional self injury or attempted suicide while sane or insane

iv. Any Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing.

v. The abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies, or accidental physical injury which may be suffered after consumption of intoxicating substances , liquors or drugs except those prescribed by a Doctor as part of treatment.

vi. Obesity or morbid obesity and any weight control program, regardless of whether the same is caused directly or indirectly by a medical condition.

vii. Psychiatric, mental disorders (including mental health treatments and study and treatment of sleep apnoea; congenital internal or external diseases, defects or anomalies, including defects present from birth, genetic disorders; stem cell implantation or surgery, or growth hormone therapy.

viii. AIDS, HIV related complications or any sexually transmitted disease.

ix. Pregnancy child birth (including voluntary termination) and their complications, abortions, medical termination of pregnancy, infertility or sex change operation, sterilization, contraception, miscarriage except in ectopic pregnancy.

x. Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services.

xi. Dental treatment and surgery of any kind, unless requiring Hospitalization caused by traumatic injury. The exclusion would include dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics and treatment of similar cosmetic nature.

xii. Expenses for donor screening.

SAMPLE

xiii. Treatment for Nasal septum deviation and nasal concha resection; circumcisions unless necessitated by an accident, laser treatment for correction of eye due to refractive error, aesthetic or change of life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance or carried out in childhood or at any other times driven by cultural habits, fashion or the like or any procedures which improve physical appearance, cosmetic or plastic surgery unless necessitated by accident.

xiv. Any unproven treatment /procedure /pharmacological regimen not recognized by Indian medical council.

xv. Convalescence cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, home for the aged, long-term nursing care or custodial care.

xvi. Any non allopathic treatment.

xvii. All preventive care, vaccination including inoculation and immunisations, any physical, psychiatric or psychological examinations or testing during these examinations.

xviii. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who is a member of an Insured Person's family.

xix. Hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness.

xx. Stay in hospital for non-medical reasons, where no active regular treatment is given by a Doctor and wherein the length of stay in the hospital is beyond the medically necessary hospitalization for the specific Illness or Injury

xxi. Any exclusion mentioned in the policy terms and conditions or the breach of any specific condition mentioned in the policy terms and conditions

xxii. Death within 30 days of confirmed diagnosis of Critical Illness (CI)

xxiii. This Policy covers medical treatment taken within India only.

4.5. Surrender Benefit

No Surrender value is payable under the policy.

4.6. Discontinuance of payment of premium

If the Policyholder discontinues the payment of premiums, the policy will be treated as lapsed after the end of the grace period

4.6.1. Lapse

The policy will lapse if the due premiums are not paid within the grace period. The Company will not be liable to make any payments if claims are made due to any treatment of illness/ailment/disease diagnosed or hospitalization taking place during the period the policy was in lapse status.

If the lapsed policy is not revived within 2 years of the due date of the first unpaid premium then the policy will be terminated.

4.6.2. Revival

A policy in lapsed condition can be revived within two years from the due date of first unpaid regular premium, but before the date of maturity of the Base Plan. The Base Plan along with rider benefits can be revived by paying the arrears of premiums along with the applicable interest. The revival of the policy and riders, if any, will be subject to Company's Board approved underwriting policy, i.e. the Life Assured may have to undergo medical test, etc. if so required.

SAMPLE

The current rate of interest applicable for revival is 9% and the Company reserves the right to revise the applicable interest rate from time to time depending on the economic environment, experience and other factors, subject to approval of the Regulator, i.e. IRDA.

On revival, the policy will be eligible for its complete benefits as per the original contract.

4.7. Renewal of Policy (after expiry of the Policy Term of 5 years)

- The Policyholder has the option to renew the policy within 30 days after the expiry of the previous Policy Term at the premium rates, terms and conditions, and plans prevailing at the time of renewal of the policy. Coverage ceases on the expiry of the previous Policy Term and coverage is not available for the period for which no premium is received. Company can offer the same plan or a similar plan with revised premium rates and terms and conditions as per the experience and prevailing standard practice at the time of renewals after approval from the IRDA.
- Company will intimate the Policyholders by sending a notice for such revision in premium rates and the terms and conditions at least three months prior to the date of renewals of the cover.
- If the Sum Insured chosen at the time of renewal is equal to the Sum Insured chosen on commencement of the previous policy term, the policy shall be renewed without underwriting.
- If the Sum Insured chosen at the time of renewal is higher than the Sum Insured chosen on commencement of the previous policy, the renewal of the policy would be subject to the Life Insured satisfying the financial and medical underwriting requirements of the company. The Company shall have the right to refuse any increase in Sum Insured in policy on renewal.
- On renewal under the same or a similar plan, the waiting period would not be applicable.
- On renewal, in case Sum Insured has increased, all waiting periods would apply on the sum insured difference between the revised and old Sum Insured.

4.8. Renewal Discount (after expiry of the Policy Term of 5 years)

On renewal, no discount will be given on premiums payable during the renewed Policy Term.

SAMPLE

5. Part E

Not applicable as this is not a unit linked insurance policy.

SAMPLE

6. Part F

6.1. Claims

i. The Company shall make any payment under this Policy, only if and subject to the terms and conditions stipulated in this document, the company has been provided with the documentation and information as asked for from time to time and the company or the TPA has requested the Policyholder to establish the circumstances of the claim, its quantum or Company's liability for it, and if the Insured Person has complied with his obligations under this Policy.

ii. In case of death of the Life Insured and provided there is a valid health claim, the Company will pay the benefit amount to the Claimant when it is satisfied of the identity of the Insured Person, Age of the Insured Person, the Insured Person is dead and all relevant provisions of the Policy have been met.

iii. Third Party Administrator (TPA):

The Policyholder may contact our authorized TPA to avail the Cashless facility or to claim health related benefits. TPA details are available on our website and in the fulfillment kit received by you.

6.1.1. Requirements for Cashless Facility

i. The Policyholder has the option to avail Cashless facility in network hospitals as specified by the company / Third Party Administrator (TPA).

ii. In case of a planned hospitalization of a member, the Policyholder has to take pre-authorization from the Third Party Administrator (TPA) or from the company prior to taking admission at any network medical hospital and in case of emergency hospitalization, the Policyholder has to notify to the TPA or to the company in writing within 24 hours of the hospitalization of the member.

iii. The Policyholder will be provided with a identity card with a unique membership number by the TPA/company which will entitle him/her to avail Cashless hospitalization services to the extent the medical expenses are reimbursable as per the terms and conditions, upon hospitalization in specified network hospitals in India subject to pre-authorization or approval either from the company or from the TPA.

iv. However, if the Policyholder does not wish to avail Cashless facility or the member is hospitalized in any hospital other than the specified network hospitals or Cashless facility has been disapproved by the company/TPA, the Policyholder has to notify the company in writing, within 7 days of the hospitalization of the member. The company will reimburse the medical expenses as per the benefit mentioned under Section "Hospitalisation Benefit (Section 3.1.2)"

v. Cashless facility is not available for availing Medical Reimbursement Benefit (MRB)

6.2. Requirement for Claims

<u>Claims for Hospitalization Benefit or Critical Illness Benefit</u>

In the event of claim for Hospitalization Benefit or Critical Illness Benefit, the person to whom the benefits are payable shall endeavour to intimate the Company in writing of the claim and provide the following documents to the Company within 24 hours for Cashless facility in network hospitals and 7 days for payouts where the Cashless facility is not opted for by the Policyholder or the Life Insured is hospitalized in any hospital other than the specified network hospitals or Cashless facility has been disapproved by the Company/TPA (This limit is not applicable to MRB claims), of the claim arising to enable the company to process the claim in a speedy manner; provided the Company may accept/process the claim on merits of the case even beyond the period of 30 days, provided:

i. The reasons for delay are due to unavoidable circumstances beyond the control of the Claimant and

SAMPLE

ii. The submission of documents in respect of the said delays is evidenced to the satisfaction of the Company.

iii. A genuine claim with valid reasons for delayed notification even beyond the stipulated period would be considered. The valid reasons would be as follows:

a. If the policyholder is admitted & remains in unconscious state during the hospitalization

b. If the policyholder is not in state of mind/position to notify and his/her family members are unaware about the policy details.

c. If there were any changes to the TPA arrangement and notification was sent to TPA not authorised/empanelled at the time of notification.

d. If the policyholder/insured member lost his/her identity card.

e. If the policyholder/insured member is unaware about the policy details

iv. The company may ask for:

a. Proof of age of the Primary insured if his or her age is not already admitted in the records of the company,

b. KYC documents of the claimant as per AML Guidelines. (Address Proof & Idendity Proof)

c. ECS Mandate form/ Cancelled cheque leaf of the claimant

d. Copy of the First Information Report filed with the concerned police station (FIR)

e. Original bills with detailed breakup of charges (including but not limited to pharmacy purchase bill, consultation bill, and diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.

f. Original payment receipts

g. Discharge card

h. Doctor's certificate

i. Prescriptions, diagnostic reports and such other document as may be called for by company and/ or Third Party Administrator (TPA) relevant for stated treatment.

j. Any information or clarification or documents which are asked by the company or the TPA directly from network or non-network hospital

Notwithstanding anything contained in the Clause mentioned above, depending upon the cause or nature of the claim, the Company reserves the right to call for other and/or additional documents or information, including documents/information concerning the title of the person claiming Benefits under this Policy, to the satisfaction of the Company, for processing the claim. If the documents called for are not submitted or not given, then valid reasons for not providing the same in a letter within the time mentioned in the letter.

<u>Claims for Medical Reimbursement Benefit</u>

To claim the MRB amount, you may avail of this facility maximum three times in a Policy year, subject to minimum Rs. 1000 for each claim.

We have an authorized TPA for processing and paying your reimbursement claims. You may follow below mentioned simple steps to claim the reimbursement amount:

a. Fill up the "Health Claim Form" available on our or the TPA's website or collect physical form from the TPA

b. Mentioned type of claim i.e. Medical Reimbursement Benefit

c. Attach required documents as mentioned in the policy document along with original medical bills

d. Submit the duly completed "Health claim Form" with required documents to our authorized TPA

e. Mention your bank account details

SAMPLE

v. The Policy covers medical treatment taken wholly within India and payments under this Policy shall only be made in Indian Rupees within India.

vi. The Company shall not pay any benefits until the Company's requirements have been met to the Company's satisfaction

6.3. Suicide

The Company will not pay any claims for Self affected injuries or conditions (attempted suicide) and or the treatment directly or indirectly arising from alcoholism or drug abuse and any Illness or Physical Injury which may be suffered after consumption of intoxication liquors or drugs except those prescribed by a Doctor as part of treatment.

6.4. Grace period for payment of premium

There is a grace period of 30 days (15 days for monthly mode) from the due date of first unpaid premium. In case of a claim arising due to death during the grace period, the claim amount will be paid to the claimant after deducting the due unpaid premium for that policy year.

6.5. Tax benefit

Premiums paid under the Base Policy and Rider(s) opted for, if any, are eligible for tax exemptions, subject to applicable tax laws and conditions. Income tax benefits under this plan and rider benefits, if opted for shall be as per the prevailing Income Tax Laws and are subject to amendments and interpretation from time to time. The Policyholder is recommended to consult a tax advisor.

6.6. Taxes, duties and levies and disclosure of information

a. In the event where RLIC is obliged to disclose information concerning to the Policy and Benefits or account to the revenue authorities or other regulatory authorities for any taxes, duties, levies or imposts including without limitation any sale, use, value added, service or other taxes, as may be imposed now or in future by any authority (collectively “Taxes”) applicable to this Policy or the Benefits payable under this Policy, RLIC shall be entitled to disclose such information / deduct such Taxes / pay any amount under the polices and deposit the amount so deducted or directed, with the appropriate governmental or regulatory authorities without informing the policyholder, if so directed by the authority.

b. It shall be the responsibility of the Policyholder to satisfy himself and ensure that the payment of the Additional Premium does not adversely affect his entitlement or claim for tax benefits, if any, available or admissible under this Policy.

6.7. Nomination

Nomination should be in accordance with provisions of Section 39 of the Insurance Act 1938, as amended from time to time.

[A Leaflet containing the simplified version of the provisions of Section 39 is enclosed in annexure – C for reference]

6.8. Assignment

Assignment should be in accordance with provisions of Section 38 of the Insurance Act 1938, as amended from time to time.

[A Leaflet containing the simplified version of the provisions of Section 38 is enclosed in annexure – D for reference]

Assignment will not be permitted if the policy is issued under Married Women’s Property Act, 1874.

6.9. Proof of age

The age of the Life Assured has been admitted on the basis of the declaration made by the Policyholder/ Life Assured in the Proposal and/or in any statement based on which this Policy has been issued.

SAMPLE

- If the age of the Life Assured as on the Policy Commencement Date is found to be higher than the maximum, or lower than the minimum, entry age that was permissible under this plan then the Company shall cancel the policy immediately and shall refund all premiums paid.
- If the age of the Life Assured is found to be different from that declared but within the age limits of the plan of this Policy then:
  - In case the correct age is found to be lower, the Company shall refund the difference in premiums without interest or increase the benefits which would have been due as per the correct age
  - In case the correct age is found to be higher, the Company shall intimate the Policyholder to pay the difference in premiums along with the applicable interest from inception or shall reduce the Policy benefits which would have been due as per the correct age

6.10. Special provisions

Any special provisions subject to which this Policy has been entered into, whether endorsed in the Policy or in any separate instrument shall be deemed to be part of the Policy and shall have effect accordingly.

This product is approved by the Insurance Regulatory and Development Authority (IRDA) and this policy is subject to:

- The Insurance Act, 1938, as amended by the IRDA Act, 1999.
- Amendments, modifications (including re-enactment) as may be made from time to time, and
- Other such relevant Regulations, Rules, Laws, Guidelines, Circulars, Enactments etc as may be introduced by Life Insurance Council, IRDA, GBIC, any other regulatory body with jurisdiction there under from time to time.

We reserve the right to require submission of such documents and proof at all life stages of the Policy as may be necessary to meet the requirements under Anti- money Laundering/Know Your Customer norms and as may be laid down by IRDA and other regulators from time to time.

6.11. Recovery of additional expenses incurred on account of acts of Policyholders

RLIC also reserves the right to recover "cheque bounce charges" or "electronic debit bounce charges", incurred by it from the Policyholders, on account of dishonour of cheque issued or bounce of electronic debit towards premium payment, by Policyholders. The Company may recover these additional costs by requisitioning additional payments from the Policyholders.

6.12. Mode of payment of benefits

All benefits (claims/ maturity payments/ any other sum due to the Policyholders or nominees or assignees) under this policy shall be remitted only through Electronic Clearing System (ECS), National Electronic Fund Transfer (NEFT), Real Time Gross Settlement (RTGS), Interbank Mobile Payment Service (IMPS), Automated Clearing House (ACH) or any other electronic mode as permitted by Reserve Bank of India.

All Benefits under this Policy shall be payable in the manner and currency allowed / permitted under the Regulations. All amounts payable either to or by the Company and shall be payable in Indian currency.

6.13. Valid discharge

Any discharge given by the person to whom the benefits are payable, or by any person authorized by the person to whom the benefits are payable, in writing, in respect of the benefits payable under this Policy shall constitute a valid discharge to RLIC in respect of such payment. The Company’s liability under the Policy shall be discharged by such payment and the Company shall not be required to see the application of the monies so paid.

6.14. Limitation of liability

The maximum liability of the Company under this Policy shall not, in any circumstances, exceed the aggregate amount of the relevant Benefits payable hereunder.

SAMPLE

6.15. Fraud and Misrepresentation

Fraud and Misrepresentation would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938 as amended from time to time. (Please refer to the simplified version of the provisions of Section 45 mentioned in Annexure E for reference)

6.16. Loss of Policy Document

If the Policy Document is lost or misplaced, Policyholder should submit to us a written request stating the fact and the reason for the loss. The Company reserves the right to undertake such investigations into and call for such evidence of the loss or destruction of the Policy Document at the expense of the Policyholder as it considers necessary before issuing a copy of the Policy Document. If we are satisfied that the Plan document is lost or destroyed, then, we will issue a duplicate Policy Document duly endorsed to show that it is issued following the loss or destruction of the original Policy Document. Upon the issue of the duplicate policy Document, the original Policy Document immediately and automatically ceases to have any validity. The Company may charge a fee, subject to a maximum of Rs. 200, for the issuance of a duplicate Policy Document.

The Policyholder agrees to indemnify us and hold us free and harmless from any costs, expenses, claims, awards, misuse or judgments arising out of or in relation to the original Policy Document. The Company may also require the Policyholder to issue a newspaper declaration for the same. The cost for the same will be borne by the Policyholder.

6.17. Waiver

Failure or neglect by either party to enforce at anytime the provisions of this Policy shall not be construed or be deemed to be waiver of either party's right herein nor in anyway affect the validity of the whole or any part of this Policy nor prejudice either party's right to take subsequent action.

6.18. Electronic transaction

The Policyholder shall adhere to and comply with all such terms and conditions as prescribed by RLIC from time to time and hereby agree and confirm that all transactions effected by or through facilities for effecting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of RLIC, for and in respect of the Policy or its terms, or RLIC's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with RLIC's terms and conditions for such facilities, as may be prescribed from time to time.

6.19. Notice under the Policy

Any of the notices required to be issued in terms of this Policy may be issued, either by issuing individual notices to the Policyholder, including by electronic mail**,** SMS, telephonic conversation and/or facsimile, or by issuing a general notice, including, by publishing such notices in the newspapers and/or on the Company's website.

i. In case of the Proposer

As per the details specified by the Policyholder in the Proposal Form/Change of address intimation submitted by him, notices and instructions are sent through various modes such as electronic mail and/or facsimile, or by issuing a general notice, including by publishing such notices in newspapers and/or on RLIC's website.

ii. In case of the Company

To Reliance Life Customer Service

Address: Reliance Life Insurance Company Limited, H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra 400710, India

Reliance Life representatives may be contacted between 10 AM.- 5 PM, Monday to Friday on Customer Care number 1800 300 08181 (Toll free) or 30338181 (local call charges apply).

Email: rlife.customerservice@relianceada.com

6.20. Entire Contract

This Policy comprises the terms and conditions set forth in this Policy document, Policy Schedule, and the endorsements, if any, made on or applicable to this Policy, which shall form an integral part and the entire contract, evidenced by this Policy. The liability of RLIC is at all times subject to the terms and conditions of this Policy and the endorsements made from time to time.

The Provision of this policy cannot be changed or varied by anyone (including an insurance advisor) except by a policy endorsement signed by an officer of the Company authorized for the purpose. This Policy Document constitutes the complete contract of insurance.

The Policy is issued on the basis of the Proposal and Declaration from the Proposer and on the express understanding that the said Proposal and Declaration and any statements made or referred to therein shall be part and parcel of this Policy.

SAMPLE

7. Part G

7.1. Governing laws and jurisdiction

This Policy shall be governed by and interpreted in accordance with the laws of India. All actions, suits and proceedings under this Policy shall be subject to the exclusive jurisdiction of the courts of law within whose territorial jurisdiction the registered office of the Company is situated.

7.2. Primacy of the Policy Document

In the event of any inconsistency or conflict between the terms and conditions contained in the Policy Document and the terms and conditions contained in any other document such as marketing material or sales brochure, the terms and conditions contained in the Policy Document shall prevail over all other terms and conditions contained in various other documents

7.3. Grievance Redressal

Step 1: If you are dissatisfied with any of our services, please feel free to contact us –

Step 1.1: 24 hours contact centre: 30338181 (Local call charges apply) & 1800 300 08181(Toll free) or Email: rlife.customerservice@relianceada.com **OR**

Step 1.2: Contact the Customer Service Executive at your nearest branch (this is a link for branch location details) of the Company **OR**

Step 1.3: Write to: Reliance Life Customer Care

Reliance Life Insurance Company Limited

H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra 400710. India

If your complaint is unresolved for more than 10 days,

Step 2: Please contact our Branch Manager, who is also the Local Grievance Redressal Officer at your nearest branch.

If you are unhappy with the solution offered,

Step 3: Write to Head of Customer Care at rlife.headcustomercare@relianceada.com or at the address mentioned above.

If you are still not happy with the solution offered,

Step 4: Write to our Grievance Redressal Officer, Head of Legal & Compliance at rlife.gro@relianceada.com or at the address mentioned above.

If the issues remain unresolved; a further reference may be made to the Insurance Ombudsman in terms of Rule 12 & 13 of the Redressal of Public Grievance Rules, 1998.

7.4. Procedure for registering complaint with IRDA Grievance Call Centre (IGCC)

If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority (IRDA) of India on the following contact details:

IRDA Grievance Call Centre (IGCC) TOLL FREE NO: 155255
Email ID: complaints@IRDA.gov.in

You can also register your complaint online at http://www.igms.IRDA.gov.in/

Address for communication for complaints by fax/paper:

SAMPLE

Consumer Affairs Department
Insurance Regulatory and Development Authority
9th floor, United India Towers, Basheerbagh
Hyderabad – 500 029, Andhra Pradesh
Fax No: 91- 40 – 6678 9768

7.5. Procedure for filing complaint with the Insurance Ombudsman

While we expect to satisfactorily resolve your grievances, you may also at any time approach the Insurance Ombudsman. The Insurance Ombudsman may receive and consider any complaints under Rule 12 & 13 of the Redressal of Public Grievance Rules, 1998; which relates to any partial or total repudiation of claims by RLIC, any dispute in regard to premium paid or payable in terms of the Policy, any dispute on the legal construction of the policies insofar as such disputes relates to claims; delay in settlement of claims and non-issue of any insurance document to customers after receipt of premium. On the above grounds, any person may himself or through his legal heirs make a complaint in writing to the Insurance Ombudsman within whose jurisdiction the RLIC branch is located. The complaint shall be in writing duly signed by the complainant or through his legal heirs and shall state clearly the name and address of the complainant, the name of the branch, the fact giving rise to complaint supported by documents, if any, the nature and extent of the loss caused to the complainant and the relief sought from the Ombudsman.

However as per Provision of Rule 13(3) of the Redressal of Public Grievance Rules, 1998 the complaint to the Ombudsman can be made:

i. Only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer or complainant has not received any reply within 30 days from the date of complaint or the complainant is not satisfied with the reply given to him by the Company
ii. The complaint has been filed within one year from the date of rejection by the Company
iii. If it is not simultaneously under any litigation

The detailed list of the Ombudsmen is provided in Annexure A of this Policy Document.

About Reliance Life Insurance Company Limited

Reliance Life Insurance Company Limited is a licensed life insurance company registered with the Insurance Regulatory & Development Authority (IRDA) of India Registration No. 121. Reliance Life Insurance Company Limited offers you products that fulfill your savings and protection needs. Our aim is to emerge as a transnational Life Insurer of global scale and standard.

CIN: U66010MH2001PLC167089

Insurance is the subject matter of the solicitation.

Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra -400710, India

Corporate Office: 9th floor/ 10th floor, Building No. 2, R-Tech Park, Nirlon Compound, Next to Hub Mall, Behind Oracle Building, Goregaon (East), Mumbai - 400 063

For more information or any grievance,

1. Call us at our 24 x 7 Call Centre number - 30338181(Local call charges apply) or our Toll Free Number 1800 300 08181
2. Fax number +91-22-30002222
3. Visit us at www.reliancelife.com or
4. Email us at: rlife.customerservice@relianceada.com

UIN for Reliance Health Total: 121N105V01

SAMPLE

BEWARE OF SPURIOUS PHONE CALLS AND FICTITIOUS/FRAUDULENT OFFERS

IRDA clarifies to public that

• IRDA or its officials do not involve in activities like sale of any kind of insurance or financial products nor invest premiums.

• IRDA does not announce any bonus. Public receiving such phone calls are requested to lodge a police complaint along with details of phone call, number.

SAMPLE

Annexure A: Insurance Ombudsman

The detailed list of the Insurance Ombudsman is mentioned below for reference.

Address of Ombudsman:

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Office of the Insurance Ombudsman 2nd Floor, Ambica House Near. C.U.Shah College 5, Navyug Colony, Ashram Road **AHMEDABAD – 380 014** Tel. 079-27546840 Fax:079-27546142 E-mail: ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL	Office of the Insurance Ombudsman Janak Vihar Complex, 2nd Floor Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL - 462023** Tel. 0755-2569201/02 Fax:0755-2769203 E-mail: bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman 62, Forest Park **BHUBANESHWAR – 751 009** Tel. 0674-2596455 Fax - 0674-2596429 E-mail: ioobbsr@dataone.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman S.C.O. No.101, 102 & 103, 2nd Floor, Batra Building Sector 17-D , **CHANDIGARH – 160 017** Tel.: 0172-2706468 Fax: 0172-2708274 E-mail: ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Office of the Insurance Ombudsman Fatima Akhtar Court , 4th Floor, 453 (old 312) Anna Salai, Teynampet, **CHENNAI – 600 018** Tel. 044-24333668/5284 Fax: 044-24333664	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)

SAMPLE

	Email:chennaiinsuranceombudsman@gmail.com	
NEW DELHI	Office of the Insurance Ombudsman 2/2 A, Universal Insurance Bldg. Asaf Ali Road **NEW DELHI – 110 002** Tel.011-23239633 Fax: 011-23230858 E-mail: iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Office of the Insurance Ombudsman Jeevan Nivesh, 5th Floor Nr. Panbazar Overbridge , S.S. Road **GUWAHATI – 781 001** Tel. : 0361-2132204/5 Fax: 0361-2732937 E-mail: ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Office of the Insurance Ombudsman 6-2-46 , 1 st floor, Moin Court Lane, Opp. Saleem Function Palace, A.C.Guards, Lakdi-Ka-Pool **HYDERABAD – 500 004** Tel. 040-65504123 Fax: 040-23376599 E-mail: insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
KOCHI	Office of the Insurance Ombudsman 2nd Floor, CC 27/2603, Pulinat Building Opp. Cochin Shipyard, M.G. Road , **ERNAKULAM – 682 015** Tel: 0484-2358759 Fax: 0484-2359336 E-mail: iokochi@asianetindia.com	Kerala , UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
KOLKATA	Office of the Insurance Ombudsman 4th Floor, Hindusthan Bldg. Annexe, 4, C.R. Avenue, Kolkatta-700 072. Tel: 033 22124346/(40); Fax 033 22124341; Email: iombsbpa@bsnl.in	West Bengal, Bihar, Jharkhand and UT of Andaman & Nicobar Islands, Sikkim

SAMPLE

LUCKNOW	Office of the Insurance Ombudsman Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Road. Hazratganj, **LUCKNOW – 226 001** Tel.: 0522-2231331 Fax: 0522-2231310 E-mail: insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI	Office of the Insurance Ombudsman, Jeevan Seva Annexe, 3rd Floor, S.V.Road, Santacruz(W), **MUMBAI – 400 054** Tel: 022-26106928; Fax: 022-26106052; E-mail: ombudsmanmumbai@gmail.com	Maharashtra , Goa

SAMPLE

Annexure B: MRB Rates

MRB Rates as a percentage of Annual Premium				
	Male		Female	
Age/SA	Sum Insured Option I	Sum Insured Option II	Sum Insured Option I	Sum Insured Option II
18	240%	225%	240%	230%
19	240%	225%	240%	225%
20	240%	225%	240%	225%
21	240%	225%	240%	225%
22	240%	225%	240%	225%
23	240%	220%	235%	220%
24	235%	220%	235%	220%
25	235%	220%	235%	220%
26	235%	220%	235%	215%
27	235%	220%	235%	215%
28	235%	215%	235%	215%
29	235%	215%	230%	210%
30	235%	215%	230%	210%
31	235%	215%	230%	205%
32	235%	210%	230%	205%
33	230%	210%	225%	200%
34	230%	210%	225%	195%
35	230%	205%	225%	195%
36	230%	205%	220%	190%
37	230%	200%	220%	185%
38	225%	200%	220%	180%
39	225%	195%	215%	175%
40	220%	190%	210%	170%
41	220%	185%	210%	165%
42	215%	180%	205%	160%
43	215%	175%	200%	150%
44	210%	165%	200%	140%
45	205%	160%	195%	135%
46	200%	150%	190%	125%
47	195%	140%	185%	115%
48	190%	130%	180%	105%

49	185%	115%	175%	90%
50	180%	105%	170%	80%
51	175%	90%	160%	70%
52	165%	75%	155%	55%
53	160%	60%	150%	40%
54	150%	40%	140%	20%
55	140%	20%	135%	5%
56	130%	NA	125%	NA
57	120%	NA	115%	NA
58	105%	NA	105%	NA
59	95%	NA	90%	NA
60	80%	NA	80%	NA
61	70%	NA	70%	NA
62	60%	NA	60%	NA
63	45%	NA	50%	NA
64	35%	NA	40%	NA
65	25%	NA	30%	NA

Annexure C: Section 39, Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Ordinance dtd 26.12.2014. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.
2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
3. Nomination can be made at any time before the maturity of the policy.
4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.
5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.
6. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.
7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.
9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.
11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.
12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).
13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them

    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

SAMPLE

14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Ordinance, 2014 (i.e 26.12.2014).
16. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.
17. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Ordinance) 2014, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Ordinance, 2014 and only a simplified version prepared for general information. Policy Holders are advised to refer to Original Ordinance Gazette Notification dated December 26, 2014 for complete and accurate details.]

SAMPLE

Annexure D: Section 38, Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Ordinance dated 26.12.2014. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.
2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.
6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.
9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
    a. not bonafide or
    b. not in the interest of the policyholder or
    c. not in public interest or
    d. is for the purpose of trading of the insurance policy.
10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment
11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.
12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.
13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR
    b. where the transfer or assignment is made upon condition that
        i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
        ii. the insured surviving the term of the policy

SAMPLE

Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
    a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
    b. may institute any proceedings in relation to the policy
    c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings
15. Any rights and remedies of an assignee or transferee of a life insurance policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Ordinance, 2014 shall not be affected by this section.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Ordinance, 2014 and only a simplified version prepared for general information. Policy Holders are advised to refer to Original Ordinance Gazette Notification dated December 26, 2014 for complete and accurate details.]

SAMPLE

Annexure E: **Section 45 – Policy shall not be called in question on the ground of mis-statement after three years**

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended by Insurance Laws (Amendment) Ordinance dated 26.12.2014 are as follows:

1. No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 yrs from
    a. the date of issuance of policy or
    b. the date of commencement of risk or
    c. the date of revival of policy or
    d. the date of rider to the policy,

    whichever is later.
2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
    a. the date of issuance of policy or
    b. the date of commencement of risk or
    c. the date of revival of policy or
    d. the date of rider to the policy,

    whichever is later.

    For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.
3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
    a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
    b. The active concealment of a fact by the insured having knowledge or belief of the fact;
    c. Any other act fitted to deceive; and
    d. Any such act or omission as the law specifically declares to be fraudulent.
4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.
6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.
7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured,

SAMPLE

within a period of 90 days from the date of repudiation. However, the payment will be as per IRDA directions /Regulations / Circulars issued from time to time.

8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.
9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Ordinance, 2014 and only a simplified version prepared for general information. Policy Holders are advised to refer to Original Ordinance Gazette Notification dated December 26, 2014 for complete and accurate details.

SAMPLE