RELIANCE
Life Insurance

Reliance Easy Care Fixed Benefit Plan

A healthcare policy that keeps your savings intact

PROTECTION against the unexpected

Reliance Easy Care Fixed Benefit Plan

A non-linked individual health benefit plan

Why should you buy a Health Insurance Policy?

In this fast paced life of ours, we invest all our energies into work. The sedentary life style reaps dividend in the form of health ailments and stress. The little gems of pleasure that come our way often prove to be detrimental – junk food, fast driving, reaching for the stars...In the race for moving ahead diabetes, accidents and heart attacks become our companions. Our beautiful world starts crumbling as fear and insecurity stems large on us and our family members.

Adequate health Insurance cover would protect us from indebtedness and impoverishment resulting out of rising medical expenses and also provide us peace of mind and security during a crisis arising out of a medical emergency.

Why Reliance Life Insurance should be your first choice?

We offer you innovative health insurance plans that not only protect you from unexpected financial burden but care for you as a friend in need in your difficult times. Apart from the exclusive features of health plans, we also provide a basket of unique and specialized services which differentiates us in the field of empathy and care.

Who can buy this plan?

- To buy this plan you should be 18 to 65 years of age when this insurance cover starts.
- Your occupation and health condition may restrict your available options. This will be determined when your application is being considered

Why do you need Reliance Easy Care Fixed Benefit Plan?

We bring in a special way to take care of your agonies where you can emphatically say – "All is Well". Life is beautiful and RLIC wants to reiterate it with you with Reliance Easy Care Fixed Benefit Plan which takes care of all your worries – from accidents to health ailments. You can now sleep peacefully at night while we take care of your worries.

What Reliance Easy Care Fixed Benefit Plan brings for you?

This comprehensive health plan offers you fixed payment for the daily hospitalization expenses, lump sum payment towards cost of multiple surgeries, benefit for 10 major surgeries, listed 10 major critical illness conditions & the cost of recovery from illness depending on the option chosen and fulfillment of certain criteria.

What makes the Reliance Easy Care Fixed Benefit Plan unique?

- This plan is simple and affordable
- This plan guarantees what it promises
- Payment of a fixed amount per day towards hospitalization expenses for the days you are in hospital for treatment*
- Additional 100% of hospital cash benefit for each day of stay in case of ICU treatment
- Covers medically necessary surgeries in event of hospitalization for minimum 24 hours*
- Lump sum benefit for 10 major listed surgeries
- Guaranteed renewability upto 99 years of age#
- Coverage for confirmed diagnosis of 10 critical illness conditions
- Recuperation benefit for 7 or more days of hospitalization, irrespective of shift between hospitals*
- Guaranteed fixed rate of premium for 5 years
- Income Tax benefit are applicable for health insurance premium paid u/s 80D of Income Tax Act, 1961
- 5% discount on renewal paid after completion of 5 years policy term

- Cashless facility over 4000 hospital across the country
- Multiple options of coverage to choose from option I to V.
- Option of paying single premium for fixed term of 5 years at an attractive rate
- Regular Premium can be paid monthly and annually
- A no claim bonus in the form of increase in Sum Assured by 5% of the base Sum Assured is provided for every claim free year. The maximum increase over the base Sum Assured will be capped at 20%.

#The existing policyholder of this product shall be allowed to renew the policy till the age of 99 years under guaranteed renewability option. However maximum entry age for new policyholder is 65 years and policy term is fixed of 5 years.

How does this plan work?

This is a regular/single premium, non-participating, non-linked health benefit plan based on individual life. The plan has a fixed policy term of 5 years. If you are between 18 to 65 years of age you can buy this plan.

This plan is offered to both, male & female with different premium rates. The policyholder has the option to avail Cashless service at network hospitals as specified by the Company/ TPA in addition to reimbursement facility.

Plan Benefits

The plan covers reasonable and customary medical expenses towards hospitalisation during the policy term for illness, surgery, injury contracted or sustained by the policy holder subject to terms, conditions, limitations, waiting period and exclusions as described below:

1. **Daily Hospital Cash Benefit (DHCB):** In the event of Hospitalization for Medically Necessary treatment of any Illness including critical illnesses or Injury for a minimum period of 48 hrs a fixed amount of 1% of Sum Assured per day will be payable from the first day for the duration of Hospitalization for a valid claim.

   Let us take an example of Mr Rahul who bought a Reliance Life Easy Care Fixed Benefit Plan with Option II on 14.05.2009. He was admitted in a hospital on 19.08.2011 at 10 A.M with cerebral malaria (malignant) and was initially admitted in ICU for 3 days. Later he was shifted to general ward and

was discharged on 26-08-2011 at 11 A.M. Thus, Rahul is eligible to receive Rs 14000 (i.e.Rs.2000 X 7 days) as Hospital Cash Benefit.

2. **Intensive Care Unit (ICU) benefit:** An additional 100% of DHCB amount (1% of Sum Assured) per day 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.

   E.g. Rahul is entitled to receive ₹ 2000 daily as ICU benefit for 3 days i.e. ₹ 6000/-in addition to Daily Hospital Cash Benefit.

3. **Recuperation Benefit (RB):** A recuperating benefit equal to 3% of Sum Assured 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 the patient is admitted to 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.

   Thus Rahul is eligible to receive ₹ 6000 RB as a lump sum benefit (since hospitalization was for 7 days).

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 below mentioned major Surgeries in MSB, in India, a lump sum benefit equal to 10% of Sum Assured will be paid.

   Multiple surgeries performed under the same anesthesia will be considered as a single event and benefit pay-out will be capped. OPD procedures are not covered.

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 guaranteed amount equal to 100% of Sum Assured will be paid.

   Multiple surgeries performed under the same anesthesia will be considered as a single event and benefit pay-out will be capped.

   For any of the surgeries in the following list, on payment of one claim, the benefit will terminate for that listed surgery and no further claims will be payable against that surgery.

Following is the list of major surgeries covered under the plan. All other surgeries other than the ones listed below are excluded from the MSB benefits.

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

6. **Critical Illness (CI):** In the event of a confirmed diagnosis of any one of the listed critical illness a onetime fixed amount equal to 100% of Sum Assured will be paid and the benefit will cease to continue for lifetime.

   Following is the list of Critical Illnesses covered under the plan. All other Critical Illnesses other than the ones listed below are excluded from Critical Illness (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

Policy Limits

Plan Benefits and Limits						
Benefits Available (in INR per day)	Daily Hospital Cash Benefit (DHCB) Per day	ICU Benefit Per day	Recuperation Benefit (RB) Lump Sum	Surgical Cash Benefit (SCB) Lump sum per event	Lump sum Major Surgical Benefit (MSB) lump sum per MSB	Critical Illness (CI) Lump Sum
	1% of Sum Assured	+100% DHCB	3% of Sum Assured	10% of Sum Assured	100% of Sum Assured	100% of Sum Assured
Option I	1000	+100% DHCB	3000	10000	100000	100000
Option II	2000	+100% DHCB	6000	20000	200000	200000
Option III	3000	+100% DHCB	9000	30000	300000	300000
Option IV	4000	+100% DHCB	12000	40000	400000	400000
Option V	5000	+100% DHCB	15000	50000	500000	500000
*Annual (Policy) Limits:	45 x DHCB per policy year (including the ICU benefit) for DHCB Only once per policy year for RB Three events of hospitalization per policy year for SCB Only once per policy year for MSB Only once per policy for CI 100 x DHCB amount per policy year for all hospitalisation benefits					
**Lifetime (Policy) Limit	5 times maximum annual limit for MSB 8 times maximum annual limit for HCB, RB, SCB and 1 times maximum annual limit for CI					

Sum Assured (SA) under Plan Options I, II, III, IV and V is ₹ 100,000, ₹ 200,000, ₹ 300,000, ₹ 400,000 and ₹ 500,000 respectively.

*Annual limit is the maximum benefit that will be payable in a policy year.

**Lifetime limit is the 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. Once the CI benefit ceases a reduced premium without CI Benefits will be charged as per issue age from next policy anniversary.

The annual limit will increase in line with the no claim bonus. The lifetime limit is as defined at policy inception plus the no claims bonuses (in absolute amounts) earned till date.

For example: For a policy of 1,00,000 Base Sum Assured, the annual limit for MSB benefit is 1,00,000 and Lifetime limit is 5,00,000. After three claim free years, Sum Assured becomes ₹ 1,15,000 (Base SA plus no claim bonus for 3 years) and annual limit for MSB will be 1,15,000 (100% of Accumulated Sum Assured) and lifetime limit will be 5,15,000 (Base lifetime limit plus no claim bonus for 3 years)

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 prevailing at the time of renewal of the policy. Coverage ceases on the expiry of the previous policy term and no cover exists during this period of 30 days.
- Company can revise the premium rates and terms and conditions as per the experience of the plan and prevailing standard practice at the time of renewals after approval from IRDA.
- Company will intimate the policyholders by sending a notice for such revision in premium rates and the terms and condition at least three months prior to the date of renewals of the cover.
- If the Plan Option chosen after renewal is higher (not because of No Claim Bonus) than the Plan Option chosen on commencement of the previous policy, the renewal of policy would be subject to the Insured satisfying the financial and medical underwriting requirements of the company. The company shall have the right to refuse the increase (other than No Claim Bonus benefits) in Plan Option on renewal.
- On renewal, the waiting period would be reduced by the number of continuous years the member has been insured with company under this plan or any other plan of the company of similar nature. The number of continuous years will include the 30 days period given for the renewal of the policy.

Renewal Discount (after expiry of the policy term of 5 years)

Irrespective of any claims paid previously, If you renew your policy after the term of 5 years we will give you a discount of 5% on premiums payable.

Alteration of Premium Payment Frequency

The premium payment frequency may be changed at any policy anniversary

Option to change the Plan options

The Plan option chosen at the commencement of the policy can be changed on any renewal of the policy (where renewal occurs after the end of each policy term of 5 years) subject to underwriting, if required by the company.

Sample Benefit Illustration

The following table shows annualised premium without service tax and benefits, for Plan option I

	Regular Premium		Single Premium							
Age (Yrs)/ Gender	Male	Female	Male	Female	DHCB per day	ICU Benefit Per day	(RB) Lump Sum	(SCB) Lump sum per event	Lump sum (MSB)	(CI) Lump Sum
18	1,470	1,420	4,830	4,680	1% of SA	+100% DHCB	3% of SA	10% of SA	100% of SA	100% of SA
35	1,830	2,040	6,320	7,220						
45	2,590	2,990	9,580	11,210						

Higher Sum Assured Rebate

You will get a discount as per the table given below if you buy plan options with higher sum assured:

Higher Sum Assured rebate	Rebate as a percentage of Tabular Premium				
	Age Group (in Years)				
Plan Option	18-25	26-35	36-45	46-60	>=61
1	0%	0%	0%	0%	0%
2	20%	17%	11%	4%	3%
3	26%	22%	14%	5%	4%
4	30%	25%	16%	6%	5%
5	32%	26%	17%	6%	5%

If you don't claim

If you don't claim we will increase your Sum Assured by 5% of the base Sum Assured for every claim free year. Maximum increase over the base sum assured is 20%.

In case of a claim we will reduce your Sum Assured in the following year by 5% of the base Sum Assured. In any case your Sum Assured will not go below base Sum Assured under your chosen plan option.

The annual limit will increase in line with the no claim bonus. The lifetime limit is as defined at policy inception plus the no claims bonuses (in absolute amounts) earned till date.

For example: For a policy of 1,00,000 Base Sum Assured, the annual limit for MSB benefit is 1,00,000 and Lifetime limit is 5,00,000. After three claim free years, Sum Assured becomes 1, 15,000 (Base SA plus no claim bonus for 3 years) and annual limit for MSB will be 1,15,000 (100% of Accumulated Sum Assured) and lifetime limit will be 5,15,000 (Base lifetime limit plus no claim bonus for 3 years)

What the plan does not cover?

We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, 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.

- **Pre existing Diseases:**

  "Pre-existing Disease" 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. It would also mean any direct or indirect complications arising out of pre-existing conditions, whether known or unknown to the Insured. The pre-existing diseases are not covered under this plan. Pre existing diseases are also not covered at the time of guaranteed renewability at the end of each subsequent policy term of 5 years.

- 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

- Hospitalization and/or treatment within the waiting period and hospitalization and/or treatment following the diagnosis within the waiting period;
- Insured Person committing or attempting to commit a criminal or illegal act, or intentional self injury or attempted suicide while sane or insane
- 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
- 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.
- Obesity or morbid obesity and any weight control program, regardless of whether the same is caused directly or indirectly by a medical condition.
- Psychiatric, mental disorders (including mental health treatments and study and treatment of sleep apnoea), depression, dementia or rest cures or general debility or exhaustion ("run-down condition"); congenital internal or external diseases, defects or anomalies, including defects present from birth, genetic disorders; stem cell implantation or surgery, or growth hormone therapy
- AIDS, HIV related complications or any sexually transmitted disease.
- 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.
- 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
- 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

- Expenses for donor screening
- 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.
- Any unproven treatment /procedure /pharmacological regimen not recognized by Indian medical council.
- Convalescence cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, home for the aged, long-term nursing care or custodial care
- Any non allopathic treatment
- All preventive care, vaccination including inoculation and immunisations, any physical, psychiatric or psychological examinations or testing during these examinations;
- 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 shares the same residence as an Insured Person or who is a member of an Insured Person's family
- Hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness
- Any treatment or part of a treatment that is not of a reasonable and customary cost, not medically necessary; non-prescription drugs or treatments. Any elective surgery /treatment or hospitalization which is not medically necessary and/or not in accordance with the diagnosis for which hospitalization was warranted, and hospitalization primarily for diagnostic and general health check up with no active regular treatment during the hospitalization period (which otherwise could not be given on an outpatient basis) by a specialist medical practitioner.
  "Reasonable and customary medical expenses" means expenses that an Insured Person has

necessarily and actually incurred for medical treatment during the Policy Period on the advice of a Medical Practitioner due to Illness or Accident occurring during the Policy Period, 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.

- Any exclusion mentioned in the policy terms and conditions or the breach of any specific condition mentioned in the policy terms and conditions.
- Length of stay in hospital beyond reasonable and customary length of stay.
- Death within 30 days of confirmed diagnosis of critical illness (CI).
- This Policy only covers medical treatment taken within India only.

Grace period

The grace period will be 30 days from the due date for payment of regular premiums. under annual modes and 15 days from the due date for payment of regular premiums under monthly mode. If premium is not received within the grace period then the policy will lapse.

Nomination

Nomination will be allowed as per Section 39 of the Insurance Act, 1938.

Assignment

Assignment is not allowed under this plan.

Free Look Period

In the event, you disagree with any of the terms and conditions of this policy, you may cancel this policy by returning it to the Company within 15 days of receiving it for all distribution channels except for Distance Marketing* channel, which will have 30 days of receiving it subject to stating his / her objections. The Company will refund the Premiums paid by you less a deduction for the proportionate risk premium for the time that the Company has provided cover up to the date of cancellation and for

the expenses incurred by the Company on medical examination 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.

Lapse & Revival (Reinstatement)

A policy, which has lapsed for non-payment of premium within the days of grace, may be revived subject to the following conditions

- The policy can be revived within 90 days from the due date of first unpaid premium, by paying the arrears of premiums with interest at the prevailing rate of interest. The current rate of interest is 9.0% p.a. This will be subject to satisfactory medical and financial underwriting. Good Health Declaration form to be filled in and in case of adverse findings, revival would not be allowed.
- If the lapsed policy is not revived within 90 days of the due date of the first unpaid premium then the policy will be terminated.
- The company will not be liable to make any payments if claims are made due to any treatment of illness/ ailment/disease diagnosed or hospitalisation taking place during the period when the policy is lapsed.
- There shall be a waiting period of 30 days from the revival date in respect of any Insured person where the revival occurs more than 60 days after the first unpaid premium. Also, the exclusions applicable at the inception of the Policy shall once again become applicable. Only claims in respect of injuries caused by accidents will be payable.
- No additional waiting period will be applicable for any revival within 60 days of the due date of the first unpaid premium.

- The Policyholder furnishes, at his own expense, satisfactory evidence of health of the Life Insured as required by the Company.
- The revival of the policy may be on terms different from those applicable to the policy before it lapsed.
- The revival will take effect only on its being specifically communicated by the Company to the Life Insured or the applicant.

Waiting Period

- A waiting period of 90 days from the date of commencement of the policy is applicable for all benefits payable under this cover

  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
- Hernia Repair
- Corrective procedure for gall stones
- Corrective procedure for kidney or urinary tract stones
- Disectomy, laminectomy
- Hemi / Partial thyroidectomy
- Corrective procedure for anal fistula or anal fissure
- Removal of uterus, fallopian tubes and/or ovaries, except for malignancy
- Corrective procedure for fibroids, uterine prolapse, or dysfunctional uterine bleeding
- Corrective procedures for haemorrhoids
- Cataract & Joint replacement surgeries

Note:

- The waiting periods are not applicable if the claims are as a result of an accident
- The 1 year waiting period will not be applicable for the Critical illness Benefit

Claim information & role of the TPA

The policyholder has the option to avail cash less service facility in network hospitals as specified by the company / Third Party Administrator (TPA).

In case of a planned hospitalisation 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 hospitalisation, the policyholder has to notify to the TPA or to the company in writing within 24 hours of the hospitalisation of the member.

The policyholder will be provided with a photo identity card with a unique membership number by the TPA/company which will entitle him/her to avail cash less hospitalisation services to the extent the medical expenses are reimbursable as per the hospitalisation benefit under section 7.1, upon hospitalization in specified network hospitals in India subject to pre-authorization or approval either from the company or from the TPA.

However if the policyholder does not wish to avail cash less facility or the member is hospitalised in any hospital other than the specified network hospitals or cash less facility has been disapproved by the company/TPA, the policyholder has to notify the company in writing, within 7 days of the hospitalisation of the member. The company will reimburse the medical expenses.

Claims delayed by more than 7 days from the occurrence of the insured event will be verified and the company may accept/process the claim on merits of the case even beyond the period of 7 days provided:

i) The reason for delay are due to in unavoidable circumstances beyond the control of the claimant, and
ii) The submission of document in respect of the said delays is evidenced to the satisfaction of the company

Critical Illness definitions

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.

   Excluded are:

   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.
   - Any skin cancer other than invasive malignant melanoma
   - Papillary micro - carcinoma of the thyroid less than 1cm in diameter
   - Chronic lymphocytic leukaemia less than RAI stage 3

- 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.
- Microcarcinoma of the bladder
- 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:
   - Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
   - Other acute Coronary Syndromes
   - 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:** 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

   - Non organic diseases such as neurosis and psychiatric illnesses and
   - Alcohol related brain damage
   - 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.

Exclusions:

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

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

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

Other important definitions

1. **Hospitalization:** If the life insured is hospitalized for Medically Necessary treatment of any Illness or

Injury for a minimum period of 48 hrs then the benefit will be payable from the first day for the duration of Hospitalization.

2. **Day:** "Day" in Hospital 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.

3. **Hospital:** "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 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 all other places;
   - Has fully qualified nursing staff under its employment round the clock;
   - Has fully 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; and
   - Maintains daily records of patients and will make these accessible to Insurance company's authorized personnel .

4. **Intensive Care Unit:** "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.

5. **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.

6. **Medically Necessary:** "Medically Necessary" refers 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

7. **Pre-Existing Condition:** "Pre-Existing Condition" means a condition (illness or bodily injury) for which, prior to the effective date of the policy:
   - the life insured had signs or symptoms, or
   - medical advice or treatment was recommended by or received from a physician, or
   - the life insured had undergone medical tests or investigations, or
   - is a direct or indirect outcome or complication of treatment rendered for the said condition which was prior to the effective date of the policy

Tax Benefits

Currently premium paid for health insurance is eligible for benefits under section 80(D) of income tax act, 1961, Subject to conditions. Service tax and education cess will be charged extra as per applicable rates. Tax laws are subject to amendments from time to time and interpretation. You are advised to consult your tax adviser.

About Us

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.

Reliance Life Insurance Company Limited is an associate of Reliance Capital, under Reliance Group. Reliance Capital is one of India's leading private sector financial services companies, and ranks among the top 3 private sector financial services and banking companies, in terms of net worth. Reliance Capital has interests in asset management and mutual funds, stock broking, life and general insurance, proprietary investments, private equity and other activities in financial services.

Reliance Group also has presence in Communications, Energy, Natural Resources, Media, Entertainment, Healthcare and Infrastructure.

Nippon Life Insurance, also called Nissay, holds 26% stake in Reliance Life Insurance Company Limited.

Nippon Life Insurance is Japan's largest private life insurer with revenues of ₹ 346,834 crore (US$ 80 Billion) and profits of over ₹ 12,199 crore (US$ 3 billion). The Company has over 14 million policies in Japan, offers a wide range of products, including individual and group life and annuity policies through various distribution channels and mainly uses face-to-face sales channel for its traditional insurance products. The company primarily operated in Japan, North America, Europe and Asia and is headquartered in Osaka, Japan. It is ranked 81st in the Global Fortune 500 firms in 2011.

Reliance Life Insurance is a licensed life insurance company registered with Insurance Regulatory & Development Authority (IRDA) Registration No. 121.

Section 41 of the Insurance Act, 1938 states: Prohibition of rebates

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

Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.

2) Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to five hundred rupees.

Section 45 of the Insurance Act, 1938 states: Policy not to be called in question on ground of mis-statement after two years

No policy of life insurance effected before the commencement of this Act shall after the expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this Act shall, after the expiry calf two years from the date on which it was effected be called in question by an insurer on the ground that statement made in the proposal or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy-holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose:

Provided that nothing in this section shall prevent the insurer from calling 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 that the age of the life insured was incorrectly stated in the proposal.

Note: *Insurance is the subject matter of solicitation. This product brochure is indicative of the terms and conditions, warranties and exceptions in the insurance policy giving only the salient features of the plan. For further details please refer to the policy document and detailed benefit illustration before concluding the sale. In the event of conflict, if any, between the terms and conditions contained in this brochure and those contained in the policy document, the terms and conditions contained in the policy document shall prevail. For further details on all the conditions, exclusions related to* ***Reliance Easy Care Fixed Benefit Plan*** *please contact our insurance advisors.*

Tax laws are subject to change, consulting a tax expert is advisable.

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RELIANCE
Life Insurance

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 & 10th Floor, Bldg. No. 2, R-Tech Park, Nirlon Compound, Next to Hub Mall, Behind Oracle Bldg, Goregaon (East), Mumbai, Maharashtra 400063.

- Customer Care Number: **1800 300 08181** & **3033 8181**
- Email: **rlife.customerservice@relianceada.com**
- Website: **www.reliancelife.com**

UIN for Reliance Easy Care Fixed Benefit Plan: 121N093V02
Insurance is the subject matter of the solicitation.

- Income Tax Benefits under the income tax laws of 1961 are subject to amendments and interpretation
- Kindly consult a tax expert
- Kindly review the offer documents carefully before investing
- *Conditions apply

ISO 9001:2008
CERTIFIED COMPANY