Reliance Easy Care Fixed Benefit Plan

Policy Term and Conditions and Privileges within referred to

Reliance Easy Care Fixed Benefit Plan (UIN: 121N093V02)

This Policy comprises the terms and conditions set forth in this Policy document, the 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 the Company is at all times subject to the terms and conditions of this Policy and the endorsements made from time to time. In the event of any inconsistency between the terms and conditions set forth in this Policy document, the terms and conditions set forth in this Policy shall prevail.

This contract is entered into between Reliance Life Insurance Company Limited (the "Company") and the Policyholder named in the Schedule to this Policy (the "Policy Schedule") and sets forth the terms and conditions governing this Policy. 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. If any of the details furnished to the Company are incorrect or incomplete, then the policy will be void. The Benefits shall be paid only when the same are payable as per the stipulations in the policy document kit. 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 declared that this Policy of Health Insurance shall be subject to the terms, conditions and privileges in this Policy Document kit and that the Policy schedule and every endorsement placed on the Policy by RLIC shall be deemed to be a part of the Policy.

Plan description

Reliance Easy Care Fixed Benefit Plan is a five year single / regular premium, non-participating, non-linked individual health benefit product, providing fixed benefits on the insured undergoing an event of hospitalization or undergoing a surgery that requires hospitalization or being diagnosed with an insured critical illness as stated. Insured can choose the amount of cover in the multiples of the minimum Base Sum Assured of Rs. 1,00,000 i.e. option I subject to maximum Base Sum Assured of Rs. 5,00,000 i.e. option V.

Premium shall be based on the age, gender and the plan option selected.

Terms and Conditions

1. Definitions and Interpretation:

1.1. **Definitions:** In this policy document, the words and phrases listed below shall have the meaning assigned to them wherever they appear, unless the context otherwise requires:

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

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

1.1.3. **"Age"** means completed years as on the Commencement Date.

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

1.1.5. **"Basic Plan /Policy/ The Plan"** means Reliance Easy Care Fixed Benefit Plan (UIN: 121N093V02)

1.1.6. **"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

1.1.7. **"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.

1.1.8. **"Claimant"** means either:

a) the Policyholder in the event of a health cover claim, as per applicable clauses under this plan, OR

b) the person who is 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 under the Policy. In the absence of the nominee, the claimant is the legal heir of the Life Insured. In instances where the Policyholder and Life Insured are different, the claimant is the Policyholder, if alive

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

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

1.1.11. **"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

1.1.12. **"Critical Illness (CI) benefit"** means a lump sum payment of the entire Sum Assured to the insured, in case of diagnosis of one of the illnesses mentioned under "List of Critical Illness covered" in this policy and fulfilling all the criteria mentioned under "Critical Illness definitions" in this policy

1.1.13. **"Congenital"** 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.

1.1.14. **"Date of Commencement of Risk"** means the date as mentioned in the Schedule provided to You from which the insurance cover starts under the policy.

1.1.15. **"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.

1.1.16. **"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

1.1.17. **"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

1.1.18. **"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

1.1.19. **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, then 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.

1.1.20. **"Doctor"/ "Medical Practitioner"** is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice allopathic medicine within its jurisdiction; and is acting within the scope and jurisdiction of his/her license. The treating Doctor should not be the Insured person himself or not related to the Insured Person by blood or marriage.

1.1.21. **"Due Date"** means the date on which the premium for the next policy year is due for payment as specified in the Schedule.

1.1.22. **"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 schedule. However the policy can be renewed after the expiry and you will be allowed to renew the policy till the maturity age of 99 years under guaranteed renewability option.

1.1.23. **"Event"** means hospitalization or undergoing an insured surgery that requires hospitalization or being diagnosed with an insured critical illness as stated.

1.1.24. **"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.

1.1.25. **"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

1.1.26. **"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

1.1.27. **"Hospitalisation"** 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

1.1.28. **"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

1.1.29. **"Inpatient"** means treatment for which the Insured Person has to stay in a Hospital/Nursing Home for more than 48 hours for a covered event

1.1.30. **"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

1.1.31. **"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

1.1.32. **"Inpatient Care"** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event

1.1.33. **"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

1.1.34. **"Lapse"** means a condition wherein the due premiums for the first 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

1.1.35. **"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.

1.1.36. **"Life Insured"** means the person, on whose health, this insurance policy has been effected.

1.1.37. **"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

1.1.38. **"Medical Advise"** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription

1.1.39. **"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

1.1.40. **"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

1.1.41. **"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.

1.1.42. **"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

1.1.43. **"Major Surgery Benefit (MSB)"** means a lump sum benefit of 100% of Sum Assured paid in the event of Hospitalization for a minimum period of 24 hours of hospitalization for undergoing any one of the 10 listed Major Surgeries

1.1.44. **"Network Hospitals"** means and includes all such Hospitals/Nursing Home, day care centers or other providers that the Insurance company / TPA have mutually agreed with, to provide services like cashless access to policy holders. The list is available with the Insurer / TPA and subject amendment from time to time.

1.1.45. **"Nominee"** means any persons nominated by the Policyholder under Section 39 of the Insurance Act, 1938, by the Policyholder, to receive the admissible benefits, in the event of death of the Life Insured

1.1.46. **"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

1.1.47. **"Non-Network"** means any hospital, day care centre or other provider that is not part of the network

1.1.48. **"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

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

1.1.50. **"Policy Anniversary"** means the date of start of every subsequent Policy Year..

1.1.51. **"Policy Commencement Date"** means the start Date of this Policy as mentioned in the Schedule.

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

1.1.53. **"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

1.1.54. **"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.

1.1.55. **"Policy Term"** means a fixed term of 5 policy years of Reliance Easy Care Fixed Benefit Plan starting from the Date of Commencement of the Policy.

1.1.56. **"Policyholder, Policy owner or Proposer"** 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

1.1.57. **"Post-hospitalization Medical Expenses"** means expenses incurred immediately after the Insured provided that:

- Such Medical Expenses are incurred for the same Insured Person's Hospitalisation was required; and

- The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

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

- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

- The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

1.1.59. **"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

1.1.60. **"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.

1.1.61. **"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. 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.

1.1.62. **"Primary insured"** means the adult individual other than the dependent parents and parent in law(s) with age higher than the age of the spouse.

1.1.63. **"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.

1.1.64. **"Recuperation Benefit (RB)"** means fixed amount of 3% of Sum Assured 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 only once in a policy year.

1.1.65. **"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;

1.1.66. **"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

1.1.67. **"Revival"** means payment of all due premiums that are in arrears to convert a Policy from "Lapse" status into "In force" status

1.1.68. **"Regulatory Authority"** means the Insurance Regulatory and Development Authority (IRDA) or such other authority or authorities, as shall be designated under the applicable laws and regulations

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

1.1.70. **"Sum Assured"** is the absolute amount of benefit as specified in the attached Policy Schedule

1.1.71. **"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

1.1.72. **"Surgery Cash Benefit(SCB)"** means a lump sum benefit of 10% of Sum Assured paid In the event of Hospitalization for a minimum period of 24 hours for undergoing any valid and Medically Necessary Surgery in India and actually undergoing that Surgery.

1.1.73. **"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 a TPA are tenure bound and RLIC may change the TPA, at its discretion as stated in the agreement signed between TPA and the Company

1.1.74. **"Unproven/Experimental Treatment"** means a treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven

1.1.75. **"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

1.1.76. **"We/Our/RLIC/Us/Company/Reliance Life"** refers to Reliance Life Insurance Company Limited

1.1.77. **"You/Your"**, means the Policy Owner, Policyholder, Proposer, named in the Policy Schedule or his or her legal heir or personal

2. Critical Illness definitions:

2.1 **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.

II. 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.

2.2 **Heart Attack:** 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.

II. 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.

2.3 **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.

2.4 **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.

2.5 **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.

2.6 **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

2.7 **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

2.8 **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:

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

2.9 **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.

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

2.10 **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

3. Interpretation

3.1 This Policy is divided into numbered clauses for ease of reference and reading. Except as stated, these divisions and the corresponding clause headings do not limit the Policy or its interpretation in any way. Words of one gender shall include the other gender and the singular shall include the plural and vice versa, unless the context otherwise requires

3.2 This Policy comprises of the terms and conditions set forth in this Policy document, the Policy Schedule and the Annexes referred to herein, which shall form an integral part of this Policy

3.3. **Plan Benefits:** The benefits available under this product are as described below:

3.3.1 **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 1% of Sum Assured per day will be payable from the first day of the hospitalization for the duration of Hospitalization for a valid claim.

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

3.3.3. **Recuperation Benefit (RB):** A recuperating benefit of 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 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.

3.3.4 **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 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 at maximum eligible limit. OPD (Out-patient department) procedure will not be covered.

3.3.5 **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 Assured will be paid. 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.

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

All other surgeries other than the ones listed above are excluded from the MSB benefits.

3.3.6 **Critical Illness (CI):** In the event of a confirmed diagnosis of the life assured suffering from one of the Critical Illness Conditions listed in the policy and fulfilling all the definition criteria of the relevant condition as specified under Policy Conditions a lump sum benefit of 100% of Sum Assured will be paid.

The CI benefit is payable on confirmed diagnosis of the life assured suffering from one of the Insured Critical Illness Conditions and fulfilling all the definition criteria of the relevant condition as specified under Policy Conditions. 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.

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

*The detailed definitions of these conditions are listed under section 2 in this document

Note: The policy will pay multiple benefits. This Sum Assured may increase by No Claim Bonus for every claim free year as described in the section 8 of this document

4. Plan Limits

4.1 **Benefit 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**	**Surgery 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 days 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 • One CI claim during the policy's lifetime • 100 x DHCB amount per policy year for all hospitalization benefits					
**Lifetime (Policy) Limit	• 5 times maximum annual limit for MSB • 8 times maximum annual limit for DHCB, RB, SCB and • 1 times maximum annual limit for CI					

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

4.2 **Sum Assured Limits:** Below mentioned table shows the Base Sum Assured options available in the policy:

Option	Base Sum Assured
I	Rs. 100,000
II	Rs. 200,000
III	Rs. 300,000
IV	Rs. 400,000
V	Rs. 500,000

5. Premium

5.1 **Mode of Premium payment:** The Policyholder is required to pay the Regular or Single Premium under the plan as per the mode of premium specified in the policy schedule.

5.2 **Frequency of Premium Payment:** The Policyholder can pay the regular premiums in yearly and monthly mode. The annual/single premium may be paid by cash, cheque, debit/credit card, online payment, demand draft, however monthly mode is permitted only through salary deduction scheme (SDS), Electronic Clearing System (ECS) or through direct debit. The regular premiums are paid in yearly and Monthly (only through ECS and Direct debit) mode.

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

5.3 **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 five years period, the Company may change 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 the Regulatory Authority.in the event the policyholder opts to continue the policy.

6. 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 conditions 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 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

7. Renewal Discount (after expiry of the policy term of 5 years): On renewal, a discount of 5% will be given on premiums payable during the renewed Policy Term, irrespective of any claim paid previously

8. No Claim Bonus: 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%. In case of a claim, the accumulated no claim bonus will reduce by 5% of base Sum Assured in the following year subject to a minimum of 0%. The base Sum Assured is the Sum Assured according to the chosen plan option as defined in item 5.2 above.

Example : For one claim free year there will be a increase of 5% of Base Sum Assured in the previous year accumulated Sum Assured which implies the increase in the benefits as mentioned below for the first claim free year:

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**	**Surgery Cash Benefit (SCB) Lump sum per event**	**Lump sum Major Surgical Benefit (MSB) lump sum per MSB**	**Critical Illness (CI) Lump Sum**
Option I	1050	+100%DHCB	3150	10500	105000	105000
Option II	2100	+100%DHCB	6300	21000	210000	210000
Option III	3150	+100%DHCB	9450	31500	315000	315000
Option IV	4200	+100%DHCB	12360	42000	420000	420000
Option V	5250	+100%DHCB	15750	52500	525000	525000

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).

9. Exclusion:

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.

i. Pre existing Diseases Exclusion:

"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. 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.

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. Hospitalization and/or treatment within the waiting period and hospitalization and/or treatment following the diagnosis within the waiting period;

iv. Insured Person committing or attempting to commit a criminal or illegal act, or intentional self injury or attempted suicide while sane or insane

v. 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

vi. 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.

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

viii. 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

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

x. 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.

xi. 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

xii. 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

xiii. Expenses for donor screening

xiv. 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.

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

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

xvii. Any non allopathic treatment

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

xix. 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

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

xxi. 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.

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

xxiii. Length of stay in hospital beyond reasonable and customary length of stay.

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

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

10. Sub-standard lives

Substandard lives with medical conditions or other impairments will be charged appropriate extra in accordance with underwriting norms.

11.Policy Loan Provisions

No loan will be available.

12. Grace period for non-forfeiture provisions:

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

13. Nomination and Assignment:

Nomination will be allowed as per Section 39 of the Insurance Act, 1938. Assignment is not allowed under this plan. The Policyholder, may, at any time during the currency of this Policy, may make a nomination for the purpose of payment of benefits under this policy in the event of his/her death. Where the Nominee is a minor, the Policyholder may also appoint a person to receive the money during the minority of the Nominee. Nomination may be made by an endorsement on the Policy and by communicating the same in writing to the Company. Any change of nomination, which may be effected before the termination of the Policy shall also be communicated to the Company. In registering a nomination, the Company does not accept any responsibility or express any opinion as to its validity or legal effect.

Assignment is not allowed under this plan.

14. Revival / Reinstatements

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

i. 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.

ii. 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.

iii. 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.

iv. 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.

v. No additional waiting period will be applicable for any revival within 60 days of the due date of the first unpaid premium.

vi. The Policyholder furnishes, at his own expense, satisfactory evidence of health of the Life Insured as required by the Company.

vii. The revival of the policy may be on terms different from those applicable to the policy before it lapsed.

viii. The revival will take effect only on its being specifically communicated by the Company to the Life Insured or the applicant.

15. Waiting Period

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

i. 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.

ii. 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

1 Hernia Repair

2 Corrective procedure for gall stones

3 Corrective procedure for kidney or urinary tract stones

4 Disectomy, laminectomy

5 Hemi / Partial thyroidectomy

6 Corrective procedure for anal fistula or anal fissure

7 Removal of uterus, fallopian tubes and/or ovaries, except for malignancy

8 Corrective procedure for fibroids, uterine prolapse, or dysfunctional uterine bleeding

9 Corrective procedures for haemorrhoids

10 Cataract & Joint replacement surgeries

Note:

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

2 The 1 year waiting period under 15.ii will not be applicable for the Critical illness Benefit

16. Death Benefit

No death benefit will be payable under this policy.

17. Maturity/Surrender benefit

No maturity surrender benefit will be payable under this policy.

18. Suicide Exclusion

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.

19. Alteration of Premium Payment Frequency.

The premium payment frequency may be changed at any policy anniversary

20. Option to Change the Plan Option

The Plan Option i.e. I, II, III, IV and V 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.

21. Examination:

The Company reserves the right to examine the Member by an authorized Doctor appointed by the Company as per underwriting guidelines prior to the commencement of the risk or subsequent renewal, or to verify a claim, as the case may be.

22. Claims Payment:

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 policy holder 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 the event of the death of the policy holder, the company shall make payment to the Nominee as named in the Proposal form or as intimated to RLIC by you.

iii. Cashless Service:

• 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 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.

• 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 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.

• However if the policyholder does not wish to avail cash less facility or the member is hospitalized 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 hospitalization of the member. The company will reimburse the medical expenses as per the benefit mentioned under Section "Intensive Care Unit (ICU) Benefit" above.

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

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

vi. Where there is a delay on part of insurer in processing a claim for a reason other than proper identification of the payee, the insurer shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is received by the insurer.

23. Requirement for Claims:

In the event of claim for benefit arising under this policy, the person to whom the benefits are payable shall endeavor to intimate the Company in writing of the claim and provide the following documents to the Company within 24 hours for cashless and 7 days for reimbursement, 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 above mentioned period, provided:

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

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

The company may ask for:

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

2. KYC documents of the claimant as per AML Guidelines. (Address Proof & Identity Proof)

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

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

5. 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.

6. Original payment receipts

7. Discharge card

8. Doctor's certificate

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

10. 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 is not submitted or not given the valid reasons for not providing the same in letter within time mentioned in the letter then Company shall draw an adverse inference of you not being ethical and in view of your actions the Company may refuse to honor the claim either until you submit the requisite documents sought or repudiate the claim itself.

24. Fraud / Misrepresentation / Concealment:

i. Forfeiture:

1 In issuing this Policy, the Company has relied on, and may rely on, accuracy and completeness of the information provided by the Policyholder / Primary insured and any other declarations or statements made or as may be made hereafter, by the Policyholder/ Primary insured. Subject to the provisions of the applicable Regulations including Section 45 of the Insurance Act, 1938, in the event any such information, declaration or statement is found to be false or incorrect or any material information is found to be withheld or misrepresented, the Policy shall be cancelled immediately refunding the premiums paid after deducting all applicable charges and expenses incurred at the discretion of the Company,, and the Company shall cease to be liable for any Benefits under this Policy.

2 Further the company shall not be liable to make any payment under this policy in respect of any claim, if such claim be in any manner intentionally or recklessly or otherwise misrepresented or concealed or non-disclosure of material facts or making false statements or submitting false bills whether by the member or institution/ organization on his behalf. Such action shall render this policy null and void and all claims under this policy will be forfeited. Company may take suitable legal action against the member/ institution/ organization as per law.

ii. Age of Admission:

1 The age of the Member(s) has been admitted on the basis of the declaration made by the Policyholder / Member(s) in the Proposal and/or in any statement based on which this Policy has been issued. If the age of the Member is found to be different from that declared, the Company may, adjust the Premiums and/or the Benefits under this Policy and/or recover the applicable balance amounts, if any, as it deems fit. This Policy shall however become void from commencement, if the age of the Member at the Policy Commencement Date is found to be higher than the maximum or lower than the minimum entry age that was permissible under the plan of this Policy at the time of its issue and the amounts received under this Policy shall be liable to be forfeited, at the option of the Company.

25. Revision or Modification:

Any revision or modification in a policy document which is approved by the Insurance Regulatory and Development Authority (IRDA) shall be notified to policyholders at least three months prior to the date when such revision or modification comes into effect, along with the reasons for such revision or modification, in particular the reason for an increase in premium and quantum of such increase.

The Provision of this policy cannot be changed or varied 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. This Policy Document cannot be changed or varied by any one (including an insurance advisor) except by a Policy endorsement in writing signed by an officer of the Company authorized for this purpose.

26. Withdrawal of this plan

The company may decide to withdraw this plan subject to prior approval by the Insurance Regulatory and Development Authority (IRDA) that shall be notified to policyholders at least three months prior to the actual date of the withdrawal. Policyholders shall respond to such notice within a given timeframe, failing which the policy will stand withdrawn from the subsequent renewal date and policyholders may be given an option to subscribe to other health insurance plan, if any, available with the company.

27. Loss of the Policy Documentation:

i. If the Policy Document is lost or destroyed, then at the request of the Policyholder, the Company, if satisfied that the Policy Document has been lost or destroyed, will issue a copy Policy Document duly endorsed to show that it is issued following the loss or destruction of the original Policy Document. The Company reserves the right to make 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. The Company may charge a fee for the issuance of a copy of the Policy Document.

ii. Upon the issuance of a copy Policy Document the original Policy Document will cease to have any legal effect

iii. It is hereby understood and agreed that the Policyholder will protect the Company and hold the Company harmless against any claims, costs, expenses, awards or judgments arising out of or howsoever connected with the original Policy Document or arising out of the issuance of a copy of the Policy Document.

28. Taxes, duties and levies and disclosure of information

i. This Policy and the Benefits payable under this Policy shall be subject to the Regulations, including taxation laws in effect from time to time. All 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") on the Premiums and other sums payable to the Company or the Company's obligations under the Policy or the Benefits payable under the Policy or in any way relating to this Policy, shall be borne and paid by the Policyholder or the Person to whom Benefits are payable, as the case may be. The Premium and other sums payable under or in relation to the Policy do not include the Taxes. If, however, the applicable law imposes such Taxes on the Company, then the Company shall have the right to recover the same from the Policyholder or the Person to whom Benefits are payable.

ii. The persons receiving the Benefits shall be solely liable for complying with all the applicable provisions of the Regulations, including taxation laws, and payment of all applicable Taxes. Except as otherwise required by law, the Company shall not be responsible for any Tax liability arising in relation to this Policy or the Benefits payable in terms of this Policy. In any case where the Company is obliged to account to the revenue authorities for any Taxes applicable to this Policy or the Benefits payable under this Policy, the Company shall be entitled to deduct such Taxes from any sum payable under this Policy, and deposit the amount so deducted with the appropriate governmental or regulatory authorities.

iii. In any case where the Company is obliged to disclose to the revenue or other regulatory authorities any information concerning the Policy, including information concerning the Premium and the Benefits under this Policy, the Company shall be entitled to disclose the required information to the appropriate governmental or regulatory authorities.

iv. Service Tax: The service Tax will be levied on the yearly premium as stated on the schedule. The level of this charge will be as per the rate of Service Tax declared by the Government from time to time. The current rate of service tax on risk premium is 12.36% (Service tax of 12% along with education cess of 3%). The service tax levy is required to be borne by the policyholder.

29. Governing Law 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.

No action in law or equity shall be brought against the Company to enforce any claim under this Policy, unless the Policyholder has filed with the Company a claim together with all the required documents, in accordance with the requirements of this Policy and complied with the requirements of the Company, at least 60 days prior to the institution of such action.

30. Incontestability:

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.

31. Forfeiture in certain events:

In issuing this Policy, the Company has relied on, and may rely on the accuracy and completeness of the information

provided by the Policyholder and any other declarations or statements made, or as may be made hereafter, by the Policyholder. Subject to the provisions of the applicable regulations including Section 45 of the Insurance Act, 1938, in the event any such information, declaration or statement is found to be false or incorrect or any material information is found to be withheld or misrepresented, the Policy shall be cancelled immediately refunding the premiums paid after deducting all applicable charges and expenses incurred at the discretion of the Company,, and the Company shall cease to be liable for any Benefits under this Policy.

32. Electronic Transaction:

The Policyholder shall adhere to and comply with all such terms and conditions as prescribed by the Company 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, teleservice 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 the Company, for and in respect of the Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

33. Free Look:

The policyholder 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 Free look period. The Company will refund the premiums paid by the policyholder, less a deduction for the proportionate premium for the time that the Company has provided cover up to the date of cancellation and for the following expenses incurred by the Company:

a) Proportionate mortality cover charges incurred to cover the Policyholder from the date of commencement of Risk till the date of Free Look cancellation.

b) Medical examination of the Policyholder, if any

c) Stamp Charges and expenditure, if any, incurred in the above regard

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

a) Voice mode, which includes telephone-calling

b) Short Messaging services (SMS)

c) Electronic mode which includes e-mail, internet and interactive television (DTH)

d) Physical mode which includes direct postal mail and newspaper & magazine inserts; and

e) Solicitation through any means of communication other than in person.

34.Information about the Policyholder:

As and when Reliance Life Insurance Company Ltd may be called upon, under the law, to furnish information on its Policyholders to the government authorities, the Company will be legally bound to disclose such information in its possession, as required.

35.Currency:

All Benefits and other sums under this Policy shall be payable in India and in Indian Currency.

36. Notice/ Communication / Instruction:

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

The Company is required to serve the notice on the Policyholder as per the details specified by the Policyholder in the Proposal Form. In the event of a change of address, an intimation should be submitted by the Policyholder to the Company which should then be duly acknowledged by the Company where after the notice / Communication / instruction should be served as per the changed details given by the Policyholder. Any notice / communication and / or instruction shall be deemed "served" Seven (7) days after posting of the same or immediately upon receipt of acknowledgement of communication by hand delivery or immediately by e-mail or immediately upon hosting of the same on the website of the Company.

In the event Policyholder wishes to serve a notice on the Company, then the Policyholder is required to serve the notice in writing on "Reliance Life Customer Service" on the following address:

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 10am- 5pm, Monday to Friday on Customer Care number 1800 300 08181 (Toll free) or 30338181 (local call charges apply).

Email: rlife.customerservice@relianceada.com

Note: In case You have any complaint/grievance, You may approach the Grievance Redressal / Ombudsman (as per the areas of jurisdiction) whose address is as under:

37. 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.

38. Procedure for filing complaint with the Insurance Ombudsman:

While we expect to satisfactorily resolve your grievances, you 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 in-so-far 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 B of this Policy Document.

The Policyholder's attention is invited to Sections 41 and 45 of the Insurance Act, 1938, which are reproduced below for reference:

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 of 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.

About Reliance Life Insurance

Reliance Life Insurance Company Limited is a licensed life insurance company registered with the Insurance Regulatory & Development Authority (IRDA) 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.

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

Insurance is the subject matter of the solicitation

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

Registered Office: Reliance Life Insurance Company Limited, 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 call us at our 24*7 Call centre number- 3033 8181 (Local call charges apply) or our Toll Free Number 1800 300 08181 or email us at: rlife.customerservice@relianceada.com

Visit us at www.reliancelife.com.

UIN for Reliance Easy Care Fixed Benefit Plan: 121N093V02

Annexure A: Insurance Ombudsman

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

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, BHOPAL 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 Email:chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry
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
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