Reliance Care For You Advantage

A non-linked, non-par, health insurance reimbursement plan

Policy Conditions & Privileges within referred to

The Reliance Care For You Advantage Plan (non-linked, non-participating, regular premium, Hospitalization benefit plan, UIN: 121N089V02) as evidenced by this Policy document ("Policy") is an agreement 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 form part and parcel of this Policy.

1. Definitions and Interpretation:

1.1. **Definitions:** In this Policy, unless the context requires otherwise, the following words and expressions shall have the meaning ascribed to them respectively herein below;

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

"Admissible Hospital Expenses" means the Medical Expenses incurred by You for the In-Patient treatment subject to the admissibility limit as per policy guide lines."Age" means completed years as on the Commencement Date.

"Plan" means Reliance Care For You Advantage Plan

"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

"Co-payment" means cost sharing arrangement under this Health Insurance policy that requires the Policyholder to bear a specified percentage of the admissible costs. A co -payment is applicable on a claim and does not impact the sum Insured.

"Commencement Date" means the Commencement Date of this policy as mentioned in the policy schedule.

"Congenital anomaly/Birth Defect" 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.

(i) **"External Congenital anomaly"** refers to a condition which is present since birth, in the visible and accessible parts of the body and which is abnormal with reference to form/structure /position / function.

(ii) **"Internal Congenital anomaly"** refers to a condition which is present in the inaccessible part of the body since birth, cannot be seen from outside and is abnormal with reference to form /structure / position / function.

"Contribution" is essentially the right of-an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion

"Bonus" shall mean any increase in the sum assured granted by the insurer without an associated increase in premium.

"Date of Commencement of the Risk" is a date as indicated in the Policy Schedule

"Day Care Treatment or Procedure" means the medical treatment, and/or surgical procedure which is: undertaken under General or Local Anesthesia in a hospital/clan care centre in less than 24 hrs because of technological advancement, and which would have otherwise required a hospitalization of more than 24hours. The Eligible Medical Expenses to be reimbursed under this benefit shall consist of cost of Day Care Treatment for listed Day Care Procedures as given in Annexure I. The Company reserves the right to modify the list of Day Care Procedures from time to time, subject to the Regulatory Authority's approval and the Policyholder shall be informed of the same. However, treatment normally taken on an outpatient basis including procedures carried out in General Practice clinics, is not included in the scope of this definition.

"Day care centre" means any institution established for day care treatment of sickness and / or injuries or a medical set -up within a hospital aid 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:-has qualified nursing staff under its employment - has qualified medical practitioner (s) in charge has a fully equipped operation theatre of its own where surgical procedures are carried out- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel

"Doctor/Medical Practitioner" is a person who holds a 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 registered medical practitioner should not be the Insured person himself or not related to the Insured Person by blood or marriage.

"Dependent Child" means a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income

"Dependent Member" means the Member(s) listed in the Schedule other than Primary insured.

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

"Due Date" means the date on which the premium for the next policy year becomes due for payment. The same shall be specified in the Schedule.

"Expiry date" means the date on which the policy completes its term of 12 years from the date of commencement of this policy and as stated in the schedule.

"Family/Members" means the persons including Self, Spouse, Children, parents of self and/or spouse who are entitled for the benefits under this policy as per the terms & conditions of this policy. All the Insured covered under the policy will be referred as Members.

"Floater Benefit" means the Sum Insured as specified for a particular Insured and the Members of his/her family as covered under the policy, is available for any or all the Members of his/her family for one or more claims during the tenure of the policy.

"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.

"Hospital" means any institution established in India for inpatient care and day care treatment of sickness and or injuries and which has been registered as a Hospital/Nursing Home with the local authorities wherever applicable, offers allopathic treatment only 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.

"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.

"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

"Illness" means a physical condition marked by pathological deviation from the normal health state.

"Inpatient Care" means treatment for which the Insured Members has to stay in a Hospital/Nursing Home for more than 24 hours for a covered event

"Intensive Care unit" 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.

"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.

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

"Medically necessary" treatment is defined as any 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.

"Medical Practitioner" A 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 medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license

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

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

"Network Hospitals" 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.

"Nominee/s" is/are the person named by you in the proposal form as the nominee/s shall be the person to whom the benefits (if applicable) shall be paid under this policy, in the event of Proposer's death. Such nomination only indicates the person, who is authorized to receive the amount of benefit on the payment of which, we will receive a valid discharge of our labiality under the policy. Change in nomination, if any, may be made by you at any time during the term of the policy and the same must be registered with us. The nominee's right arises only in the event of the death of the policy holder.

"Non - Network Hospitals" means any Hospitals/Nursing Home, day care center and other provider that is not part of the network recognized by the company.

"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.

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

"Policy Anniversary" means the date of end of every policy year.

"Policy Document/s" includes the Welcome Letter, First Premium Receipt, the Policy Schedule, copy of the Proposal Form, Policy Terms & Conditions including Annexures thereto...

"Policy Month" means a period of thirty (30) consecutive calendar days starting with the Date of Commencement of the Policy as stated in the Policy Schedule and each subsequent period of thirty (30) consecutive calendar days thereafter;

"Policy Schedule" means the policy schedule issued by the Company, together with any amendments to the schedule which shall be issued from time to time;

"Policy Year" means a period of twelve (12) consecutive 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;

"Policyholder", **"Policy owner"** or **"Proposer"** means the person specified as such in the Policy Schedule. This Policy as per the terms and conditions of this contract or by virtue of operation of law;

"Premium" means the premium payable by the Policyholder at regular intervals in the amounts and at the frequency specified in the Schedule.

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

"Pre-existing Condition" means any medical condition or complication directly or indirectly arising from it which, existed before the commencement of the Policy Period (even if it is unknown to you), or for which care, treatment or advice was sought, recommended by or received from a doctor. The exclusion shall cease to apply if the member has maintained the Policy with the company for a continuous period of a full 4 years without break from the date of the first Policy with the company.

"Pre hospitalization Medical Expenses" Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

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

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

"Post-hospitalization Medical Expenses" Medical Expenses incurred immediately after the Insured provided that:

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

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

"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.

"Qualified Nurse" Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

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

"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;

"Renewal Date" means the date till midnight on which this Policy is renewed and as specified in the Policy Schedule

"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

"Room Rent" shall mean the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses. Deductible is a cost sharing requirement that provides that We will not be liable for the amount of covered Medical Expenses, as specifically mentioned in the Policy Schedule, which has to be borne by You for each and every Claim during the Policy Period before it becomes payable by Us under the Policy. This is to clarify that a deductible does lot reduce the sum insured

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

"Sum Insured" means the amount specified in the Schedule being the maximum liability RLIC will reimburse for Medical Expenses during the policy year and in relation to a Family Floater represents the maximum liability for any and all claims made by the Insured member(s) during the policy year. The sum insured will be an aggregate benefit limit from which all claim settlements will be deducted and under no circumstances will the combined claims of all lives listed under this policy exceed the Sum Insured

"Surgery" or surgical procedure means manual and / or operative procedure (s) required for treatment of an Illness or Surgery, 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 Medical Practitioner

"TPA" means the third party administrator who for the time being is licensed by the Regulatory Authority and is appointed by RLIC for health Services and as specified in the schedule. The services of the TPA are tenure bound and RLIC may change the TPA, at its discretion.

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

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

"We", **"Our"**, **"RLIC"**, **"Us"** or **"Company" "Reliance Life"** refers to Reliance Life Insurance Company Limited.

"You/Your", **"Individual"**,**"Insured"** means the policy owner, policyholder, principal Insured named in the schedule or his

or her legal or personal representative.

2. Interpretation:

2.1 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.

2.2 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. Grant of Benefits, Plan Structure and Free look

3.1 Grant of Benefits: Subject to the provisions and fulfillment of the conditions of this Policy, the Company agrees to pay to the Person to whom the Benefits are payable, the Benefits on the happening of the events in respect of which such person shall have furnished proof of happening of the event to the satisfaction of the Company, whereupon the Benefits are expressed to be payable.

3.2 Plan Structure: Your policy is a non-linked, non-participating, regular premium, Hospitalization benefit plan offering specific health related benefits. The plan is offered to an Individual or a family consisting of primary insured and/or spouse and/or children and/or Parents of self and/or Spouse.

3.3 Free Look: The policy owner 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 policy owner 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 date of Free Look Cancellation

b) Medical examination of the Life Assured if any,

c) Stamp Charges and

d) 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:

(i) Voice mode, which includes telephone-calling:

(ii) Short Messaging services (SMS):

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

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

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

4. Benefits:

Policy covers reasonable and customary medical expenses incurred towards hospitalization during the policy term for the disease, illness, medical condition or injury contracted or sustained by the member(s) subject to terms, conditions, limitations and Exclusions as mentioned below:

4.1 In a policy year, the total liability of the company under this policy is limited to the Sum Insured, without making any reference to what the company has reimbursed or are liable to reimburse for the claims made in the previous policy year.

4.2 If the Insured needs to be hospitalised as an in-patient with the advice of a registered allopathic doctor during the policy term because of an illness or accidental physical injury, for more than 24 continuous hours, the company will, subject to waiting period, exclusions and other applicable clauses, reimburse the expenses to the policyholder incurred in the manner as described below:

4.2.1 If Hospitalisation is due to one of the following illnesses/procedures/ailments/group of illnesses, then the company shall reimburse 95% of the medical expenses if the treatment is taken in Net Work Hospital or 90% of the medical expenses treatment is taken in Non Net Work Hospital, subject to a maximum reimbursement limit per member in a policy year, as described in the table below.

Illnesses/procedures/ailments/group of illnesses	The lower of:	
	% of sum insured	Lump sum in Rs.
Cataract	12%	25,000
Knee replacement	50%	150,000
Hip replacement	50%	175,000
Ectopic Pregnancy	Not Applicable	30,000
ACL Tear (Anterior Cruciate Ligament Tear)	Not Applicable	25,000

4.2.2 We will pay 95% (if treatment is taken in Net Work Hospitals) or 90% (if treatment is taken in Non Net Work Hospitals) of the expenses (the balance 5% and 10% respectively will be payable by the Insured as "Co-payment") as arrived at for each head of costs as mentioned below for the hospitalization due to the illness/ailments/procedure/group of illness other than those mentioned above under 4.2.1.

4.2.2.1 Room rent, boarding expenses subject to a daily limit of 1.5% of the Sum Insured for each day of non Intensive Care Unit hospitalisation and 3% of the Sum Insured for each day of Intensive Care Unit hospitalisation. Room rent and boarding expenses would include Registered Medical Officer charges, administration charges for IV Fluids/Blood Transfusion/Injections/Nursing Care Charges.

4.2.2.2 Operation theatre charges.

4.2.2.3 Special Nursing expenses incurred for deployment of Qualified Nurse will be reimbursed, subject to the treating Doctor's advice and submission of receipt from the registered Nurse's Association.

4.2.2.4 Doctor's fee subject to a maximum limit of 25% of the total medical expenses incurred on in-patient treatment of the member. Total medical expenses mean the total hospitalization expenses less the cost of inadmissible items as defined under exclusions clause in point no. 6 and other applicable clauses.

4.2.2.5 Anaesthesia, Blood, Oxygen, Medicines and Drugs, Diagnostic Materials, X-ray, Surgical Appliances, any Disposable Surgical Consumables, Dialysis, Radiotherapy, Cardiac Pacemaker, Artificial limbs, Stents and Implants.

In respect of Clause 4.2.1 & 4.2.2 inclusive, the company will make payment only for those days of treatment as an in-patient, falling within the policy term.

4.2.3 Minimum 24 hours inpatient will not apply if the hospitalization has taken place due to 150 day care procedures as mentioned in Annexure B and in such case, the expenses will be reimbursed in the same manner as mentioned in clause 4.2.2 above.

4.2.3.1 With respect to clause 4.2.1, 4.2.2 & 4.2.3 above, if no claims are reported during the previous policy year, the Sum Insured under the policy will be increased by an amount equivalent to 5% of the basic Sum Insured in the subsequent policy year subject to a maximum increase of 30% of the basic Sum Insured over the duration of the policy including renewals, where the basic Sum Insured is the Sum Insured chosen as on policy commencement date.

If a claim is made by the member after this provision has come into force, then the sum insured under the policy will be reduced by an amount equivalent to 5% of the basic sum insured in the subsequent policy year without any corresponding change in the premium subject to minimum sum insured equal to basic sum insured at commencement in the subsequent policy year

4.2.4 A flat benefit of 5% of the bills submitted of reimbursable/admissible hospital expenses subject to a maximum of Rs.5000/- will be paid on each hospitalisation claim towards pre- hospitalisation and post-hospitalisation expenses. Reimbursable hospital expenses mean the total expenses reimbursable by the company on account of each hospitalisation excluding pre and post hospitalisation. Bills of pre/post hospitalization expenses are not required.

4.2.5 In case the hospitalisation requires an ambulance, the expenses for ambulance will be reimbursed by the company subject to a maximum reimbursement of Rs.1,000 for a Member in a policy year provided the member is hospitalised for more than 24 continuous hours.

4.3 If a particular hospitalization claim spreads for a period over two policy years i.e. straddles, over two policy years the eligible expenses would be reimbursed pro-rated on the basis of number of days hospitalisation in each of the years, subject to eligible limits not exceeding the sum insured in each of the years.

5. Waiting Periods:

The following waiting periods will apply from either the Commencement Date of Your Policy or date of revival, whichever is the later, during which time no benefit will be payable in respect of the conditions or surgical procedures specified:

5.1. 30 days waiting Period: Any Medical Condition.

5.2. 90 days waiting period: Inclusion of dependant members at a policy anniversary other than at the commencement or revival of the policy where the new entrant is hospitalised due to illness /treatment within 90 days from the date of inclusion of member/s will be excluded.

5.3 One year waiting Period: Tonsillectomy and Cancer of any kind.

5.4 Two year waiting Period: Kidney Stone/ Ureteric Stone / Lithotripsy, Cataract, Hysterectomy, Cholelithiasis, Choledocholithiasis, surgery of Gall bladder and Bile ducts excluding Malignancy, surgery of Benign Prostatic Hypertrophy, Hernia (Inguinal), Hemorrhoids, Anal Fissure, Fistula-in-anus, Exploratory Laparotomy, Lapcholecystectomy, diagnostic Laparoscopy, any gynaecological disease, Hydrocoele, Fibroids,

5.5 Up to first term renewal of 3 years waiting Period: Tympanoplasty, Valve Replacement, Valvotomy, Cerebral Haemorrhage; Angiographies, Angioplasty (with or without stent), Coronary Artery Bypass Graft unless post Accident.

5.6 Up to Completion of One year from the first term renewal or Four years waiting Period: Total Knee Replacement, Total Hip Replacement, Discktectomy, Arthroscopy, unless post Accident for each of these treatments/surgeries/procedures, Pelvic Inflammatory Disease; Varicose Veins; Diabetes and its complications, high blood pressure and its complications, Chronic Renal Failure, no matter when detected.

The Waiting Periods will not apply for Hospitalisation or Medical Expenses incurred due to Accident.

6. Exclusion:

Unless expressly stated to the contrary We shall not be liable to make any payment for any claim in respect of any Insured Person when that claim is directly or indirectly caused by, arises from or is in any way attributable to any of the following :

6.1 Pre-existing diseases i.e. any medical condition or complication directly or indirectly arising from it which, existed before the commencement of the Policy Period (even if unknown to the policy holder), or for which, care , treatment or advice was sought, recommended by or received from a doctor. The exclusion shall cease to apply if the member has maintained the Policy with the company for a continuous period of a full 4 years without break from the date of the first Policy with the company.6.2 Hospitalisation / Medical expenses not directly related to the specific illness or injury for which hospitalisation took place and the expenses which are not approved by the attending doctor.

6.3 Any treatment not performed by a doctor or any treatment of a purely experimental nature.

6.4 Expenses which are not for actual, necessary and reasonable expenses incurred in the treatment of the Illness or Physical Injury, or any elective surgery or treatment which is not medically necessary.

6.5 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 complication arising due to supplying services.

6.6 Any diagnosis or treatment arising from or traceable to pregnancy or child birth, miscarriage, abortion or complications of any of these including caesarean section, medical termination of pregnancy and/or any treatment related to pre and post natal care of the mother or the new born. However, this exclusion will not apply to Ectopic pregnancy proved by diagnostic means and certified by the attending medical practioner.

6.7 Hospitalization for correction of birth defects or congenital anomalies.

6.8 Any sexually transmitted diseases or any condition directly or indirectly caused by or associated with Human Immune Deficiency Virus (HIV) or any Syndrome or condition of a similar kind commonly referred to as AIDS (Acquired Immune Deficiency Syndrome).

6.9 Dental treatment or surgery of any kind unless necessitated by an Accident.

6.10 Cost of spectacles contact lenses hearing aids and the cost of treatment for vision correction.

6.11 Self afflicted 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.

6.12 Non-allopathic methods of surgery and treatment.

6.13 Hospitalisation for donation of an organ.

6.14 Medical or surgical treatment for weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition.

6.15 Psychiatric, mental disorders (including mental health treatments, Parkinson and Alzheimer's disease, general debility or exhaustion ("run-down conditions"), generic disorders: stem cell implantation or surgery, or growth hormone therapy.

6.16 Medical expenses relating to any Hospitalisation primarily for diagnostic, X-ray or any other investigations.

6.17 Any experimental or unproven procedures or treatments, devices or pharmacological regimens of any description (not recognized by Indian Medical Council).

6.18 Stay in Hospital for domestic reason where no active regular treatment is given by a Doctor.

6.19 Charges for services received in convalescent home and nursing homes, nature cure clinics and similar establishments.

6.20 Circumcision unless necessary for treatment due to an accident.

6.21 Plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident or illness.

6.22 Any treatment related to sleep disorder or sleep apnea syndrome.

6.23 Medical Expenses incurred due to Ventral/Incisional Hernia unless the Company has paid the first operation.

6.24 Expenses for any routine or prescribed medical check up or examination, external and or durable Medical / Non medical equipment of any kind used for diagnosis and/or treatment and/or treatment and/or monitoring and/or maintenance and/ or support including CPAP,CAPD,Infusion pump, oxygen concentrator etc, ambulatory devices that is walker, crutches, belts, collars, caps, splints, stings, braces, stockings, gloves, hand soaps etc. of any kind, Diabetic footwear, glucometer/ thermometer and similar related items and also any medical equipment, which are subsequently used at home.

6.25 Any kind of service charges, surcharges, admission fees, registration charges etc. levied by the Hospital.

6.26 Any natural peril (including but not limited to avalanche, earthquake, volcanic eruptions, or any kind of natural hazard). Nuclear disaster, radioactive contamination and/or release of nuclear or atomic energy,

6.27 War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, terrorism, rebellion, active participation in strikes, riots or civil commotion, revolution, insurrection or military or usurped power, and full-time service in any of the armed forces.

6.28 Naval or military operations (including duties of peace time) of the armed forces or air force and participation in operation requiring the use of arms or which are ordered by military authorities for combating terrorists, rebels and the like.

6.29 Participation in any hazardous activity or sports including but not limited to racing scuba dividing, aerial sports, bungee jumping or mountaineering, activities such as hang-gliding, ballooning, and any other hazardous activities or sports unless agreed by special endorsement.

6.30 Expenses incurred for procurement of a replacement organ, transportation costs of the replacement organ and associated administration costs and all costs incurred by the donor.

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

6.32 Expenses for services or treatment which are paid for by any other party or which are claimable under workmen's compensation insurance. In such case, the Company will reimburse the difference between the expenses that would have been reimbursable by the Company had there been no other insurer or workmen's compensation insurance involved and the amount already reimbursed or reimbursable by other party or by workmen's compensation insurance.

6.33 Non Medical expenses including Personal comfort and convenience items or services such as telephone, television, personal attendant or barber or beauty services, diet charges, food , cosmetics, napkins, toiletry items, guest services and similar incidental expenses or services.

6.34 Any hospitalization or medical expenses incurred outside of Republic of India.

6.35 Hospitalization and / or treatment within the Waiting Period and Hospitalization and / or treatment following the diagnoses within the Waiting Period mentioned in point no. 5.

7. Inclusion / Exclusion of members:

At any policy anniversary, the Primary Insured can include his/her spouse and/or children (aged between 90 days and 18 years) and/or parents, under the policy subject to underwriting; and the waiting period (mentioned in point no. 5) for those members will apply afresh as per terms and conditions of the policy from the date of their joining the family policy. Any inclusion is subject to receipt of any applicable premium and will be effected through endorsement in the schedule.

Exclusion is possible at any policy anniversary if case of the following conditions:

a) Death of any member covered under the policy (premium will not be refundable in part or full)

b) The dependant daughter being married

c) The dependent children being economically self-sufficient

d) Divorce

The above changes (exclusion) will be effected through endorsement in the schedule

8. Premium

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

8.2 Frequency of Premium Payment: The Policyholder can pay the regular premiums in yearly and monthly mode. The annual 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. Alteration in premium frequency is allowed only on policy anniversaries by giving written notice to the Company at least 30 days before the policy anniversary.

8.3 Premium Guarantee: The premium rates for the plan, once applied on any policy, shall be guaranteed for the first three years of the policy. After three years period, the Company may change the premium rates in the event the policyholder opts to continue the policy on the same terms & conditions.

9. Grace Period, Lapse & Revival

9.1 Grace Period for payment of premium: There is a grace period of 30 days from the due date for payment of premium in the yearly mode and 15 days in the event of premium payment through monthly mode. If hospitalisation of the member occurs during this grace period, the policy would be treated as inforce provided the unpaid premium due is paid by the policyholder before sanction of the claim or expiry of the grace period whichever is earlier.

9.2 REVIVAL (REINSTATEMENT) within the term of the policy:

9.2.1 A policy lapses if premium are not paid within the days of grace.

9.2.2 A lapsed policy may be revived within 90 days of the due date of the first unpaid premium by paying arrears of premium along with prevailing rate of interest subject to medical examination, if requested by the company, at the own expense of policyholder.

9.2.3 The company will not be liable to make any payments if claims are made due to any treatment of illness/ailment/disease diagnosed or hospitalization taking place during the period when the policy lapsed.

9.2.4 The revival/ reinstatement of the policy will be on the terms then prevailing rather than those that applied at the policy commencement date or at subsequent renewal date

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

9.2.5.1 A written application for revival is received from the policyholder by the company within 90 days of the due date of the first unpaid premium.

9.2.5.2 The applicant being the proposer / member, at his own expense, agrees to undergo medical examination and provides any additional documentation and information if requested by the company so as to satisfy the company with the current health condition of the member.

9.2.5.3 In the event of revival of the policy, waiting period shall commence afresh from the date of revival.

9.2.6 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.

10. Term Renewal (after expiry of the policy term of initial 3 years):

10.1 The policyholder has the option to renew the policy within 30 days after the expiry of the previous premium guaranteed term of 3 years/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 premium guaranteed term of 3 years /policy term and no cover exists during this period of 30 days.

10.2 If the Sum Insured after renewal is more than the Sum Insured of previous premium guaranteed term/policy term, the renewal of policy would be subject to the member(s) satisfying the financial and medical underwriting requirements of the company. The company shall have the right to refuse the increase in Sum Insured on renewal.

10.3 On renewal, the waiting period would be reduced by the number of continuous years the member(s) has been Insured with company under this plan or any other plan of the company of similar nature.

10.4 The company shall not be bound to give notice that such renewal premium is due provided however that if the Insured shall apply for renewal and remit the requisite premium before the expiry of this policy, renewal shall not normally be refused unless the Company has reasonable justification to do so.

10.5 A policy that is sought to be renewed after the grace period of 30 days will be underwritten as a fresh policy. Waiting period shall commence afresh from the date of revival of the policy.

10.6 After term renewal if the Sum Insured is increased and a claim is preferred for treatment of any ailment contracted in the previous Policy Year/Term the liability of the company will be restricted to the former Sum Insured.

10.7 In the event of death of the primary insured in, the insured spouse may opt to renew the policy, wherein the insured spouse will be eligible for all the benefits which the primary insured would have availed, if he/she was alive on the date of renewal.

11. Renewal Discount:

On every renewal, where renewal occurs within 30 days after the expiry of the previous premium guaranteed term/policy term, there will be a discount on the premium applicable to a new policy. The current rate of discount is 15%, which may change in future subject to regulator's approval.

12. No Claim Bonus

12.1 If the Insured does not claim during the previous policy year, the Sum Insured under the policy will be increased by an amount equivalent to 5% of the basic Sum Insured in the subsequent policy year without any corresponding increase in premium subject to a maximum increase of 30% of the basic Sum Insured over the duration of the policy including renewals. The basic Sum Insured is the Sum Insured chosen as on policy commencement date.

12.2 If a claim is made by the member after the provision mentioned above in point no. 12.1 has come into force, then the sum insured under the policy will be reduced by an amount equivalent to 5% of the basic sum insured in the subsequent policy years without any corresponding change in the premium subject to minimum sum insured equal to basic sum insured at commencement in the subsequent policy year.

13. Contribution:

If two or more policies are taken by an insured during a period from one or more insurers, where the purpose of such policies is to indemnify the treatment costs, company shall not apply the contribution clause, but the policyholder shall have an option to chose insurer with whom the claim to be settled. In all such cases, the company shall be obliged to settle the claim without insisting for contribution clause

14. Death

14.1 No death benefit will be payable under this policy.

14.2 In the event of death of the Primary Insured during the term of the policy, the insured spouse may opt to continue the policy, as the proposer & Primary Insured with due notification of the same within 15 days of the death of the primary insured.

14.3 In the event where the insured spouse opts to continue the policy as the primary insured, he/she shall be treated as the primary insured effective from the premium due date falling immediately after the date of death of the deceased primary insured.

14.4 In such an event mentioned above in point no. 3 RLIC may call for document(s) and may choose to underwrite the policy.

14.5 If this option as mentioned in point no. 14.3 is not availed by the insured spouse the policy will automatically terminate at the end of the policy year of death of Primary Insured.

15. Claim Information & Documentation:

15.1 We shall be under no obligation to make any payment unless You have provided Us with any documentation and information requested either by Us or the TPA necessary in the proving and assessment of any claim and You have complied fully with Your obligations under this Policy.

15.2 The Policyholder will be issued with a membership card by the TPA. The membership card is not a credit or debit card but is issued to identify the Member as being insured with Us and to facilitate the cashless settlement of covered Medical Expenses directly with a Network Hospital (Cashless facility). Any shortfall in the reimbursement of Medical Expenses will remain the responsibility of the Member. The membership card will remain Our property.

15.3 To qualify for the Cashless facility mentioned in above You must contact the TPA at least 48 hours in advance of any planned admission to hospital or in the event of an emergency admission to hospital contact the TPA within 24 hours of admission. The TPA will authorize Your treatment and arrange direct settlement of those covered medical expenses with a Network Hospital.

15.4 If You do not authorize Your treatment as per 15.3 above or your admission is to a Non-Network Hospital You must notify Us in writing within seven days of Your admission to hospital. You will need to settle Your accounts for medical services and claim reimbursement from Us. You will need to provide us with all the documentation that we require to assess your claim including a fully completed claim form and original invoices for any Medical Expenses claimed.

15.5 If Your claim is in respect of Medical Expenses incurred as a result of an Accident, You will need to provide full details of the Accident, a First Investigation Report from Police Authorities and a Medical Legal Certificate. You will also need to inform Us of any other party or insurance that may cover the cost of Your Medical Treatment and cooperate with Us in accordance with point 15.4 above.

15.6 In the event of the death of the Policyholder we shall make payment to the Nominee.

15.7 This Policy only covers medical treatment undertaken in India and all payments will be made in Indian Rupees.

16. 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.

17. Claims Payment:

17.1 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 in original or copy attested by any other insurer in case the claim is lodged with more than one insurer 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.

17.2 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.

17.3 Cashless service: If any treatment, consultation or procedure for which a claim may be made is to be taken at a Network Hospital, then the company will provide a cashless service by making payment to the extent of our liability direct to the Network Hospital as long as the company is given notice that the Insured Person wishes to take advantage of a cashless service accompanied by full particulars at least 48 hours before any planned treatment or Hospitalisation or within 24 hours after the treatment or Hospitalisation in the case of emergency namely a sudden, urgent, unexpected occurrence or event or occasion requiring immediate medical attention.

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

17.5 The company shall not pay any benefits until the company's requirements have been met to the company's satisfaction. The company may ask for and policyholder shall supply:

- The original policy
- Proof of age of the Primary insured if his or her age is not already admitted in the records of the company,
- KYC documents of the claimant as per AML Guidelines. (Address Proof & Idendity Proof)
- ECS Mandate form/ Cancelled cheque leaf of the claimant
- Copy of the First Information Report filed with the concerned police station (FIR)
- 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. Original payment receipts
- Discharge card
- Doctor's certificate
- Prescriptions, diagnostic reports and such other document as may be called for by company and/ or Third Party Administrator (TPA) relevant for stated treatment.
- Any information or clarification or documents which are asked by the company or the TPA directly from network or non-network hospital

The requirements are indicative and not exhaustive and not limited to the list mentioned above.

18. Fraud / Misrepresentation / Concealment:

18.1 Forfeiture:

18.1.1 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 become null and void from commencement, and the Company shall cease to be liable for any Benefits under this Policy.

18.1.2 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/ recovered. Company may take suitable legal action against the member/ institution/ organization as per law.

18.2 Proof of Age: 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 Policy shall be cancelled immediately and the premiums received shall be refunded after deducting all applicable charges by the Company or 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. The Company shall cease to be liable for any Benefits under this Policy. In such a case, the Policy shall be cancelled immediately by paying the premiums less applicable charges, in accordance with Section 45 of the Insurance Act, 1938.

19. Revision or Modification:

The Provision of this policy cannot be changed or varied except by a policy endorsement signed by an officer of the Company authorised 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.

20. 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.

21. Nomination:

The Life Insured, where he is the Policyholder, may at any time during the policy term, make a nomination for the purpose of payment of benefits in the event of his 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.

22. Loss of the Policy Documentation:

22.1 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 of 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.

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

22.1 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.

23. Taxes, duties and levies and disclosure of information

23.1 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.

23.2 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.

23.3 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.

23.4 If any Direct or Indirect tax, present or future is levied by the Government and /or any Statutory Authority and is recoverable from You in present or future then the Company may at its sole discretion raise a specific demand to pay the said direct / Indirect taxes or levies or may deduct the said direct / Indirect taxes or levies from any claim, Death and /or Benefits payable to You and /or Your Nominee(s).

23.5 Service Tax: The service Tax and education cess 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 and education cess declared by the Government from time to time. The service tax levy is required to be borne by the policyholder.

24. Notice / Communication / Instruction by/ to the Company under the Policy:

Any of the notices / Communication / Instruction required to be issued 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

25. Entire Contract

25.1 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.

25.2 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.

26. Governing Law and Jurisdiction

26.1 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.

26.2 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.

27. 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.

28. 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 on 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 Bolck, 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 Legal & Compliance at rlife.gro@relianceada.com or at the address mentioned above.

27. Dispute reconciliation

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 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-issuance 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 should be made in writing duly signed by the complainant or by his legal heirs with full details of the complaint and the contact information of complainant. 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.

As per provision 13(3)of the Redressal of Public Grievances Rules 1998, the complaint to the Ombudsman can be made

- only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer
- within a period of one year from the date of rejection by the insurer
- if it is not simultaneously under any litigation.

While we expect to satisfactorily resolve your grievances, you may also at any time approach the Insurance Ombudsman at the following address:

The detailed list of Ombudsman is provided in Annexure A

You are requested to examine this policy document and if any mistake be found therein, return it immediately for correction.

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

SECTION 45 OF THE INSURANCE ACT 1938:

No Policy of life insurance 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 a statement made in the proposal for insurance 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 policyholder and that the policyholder 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.

SECTION 41 OF THE INSURANCE ACT1938:

Section 41 (1) No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India any rebate of the whole or part of commission payable or any rebates of the premium shown on the policy, nor shall any person taking out or renewing continuing a policy accept any rebate, except such rebate as a may be allowed in accordance with the published prospectus 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 condition establishing that he is a bona fide insurance agent employed by the insurer.

Section 41 (2) Any person making default in complying with the provisions of the section shall be punishable with fine, which may extend to five hundred rupees.

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:chennaiinsuranceombuds-man@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

Annexure B - Day Care Procedure

1 Surgical debridement of wound
2 Therapeutic Ascitic Tapping
3 Therapeutic Pleural Tapping
4 Therapeutic joint Aspiration
5 Aspiration of an internal abscess under ultrasound guidance
6 Aspiration of hematoma
7 Endoscopic Foreign Body Removal- trachea/- pharynx- Larynx/bronchus/esophagus/stomach/rectum
8 True cut Biopsy-Breast/-liver/-kidney-Lymph Node/-Pleura/-lung/-Muscle biopsy/Nerve Biopsy/-Synovial Biopsy/-Bone trephine Biopsy/-pericardial biopsy
9 Sclerotherapy
10 Dilatation of digestive tract strictures
11 Endoscopic Ultrasonography and biopsy
12 Nissen fundoplication for Hiatus Hernia/Gastro esophageal reflux disease
13 Endoscopic placement/removal of stents
14 Endoscopic Gastrostomy
15 Replacement of Gastrostomy tube
16 Endoscopic polypectomy
17 Endoscopic decompression of colon
18 Therapeutic ERCP
19 Brochoscopic treatment of bleeding lesion
20 Brochoscopic treatment of fistula/stenting
21 Bronchoalveolar lavage & Biopsy
22 Tonsillectomy without Adenoidectomy
23 Tonsillectomy with Adenoidectomy
24 Excision and destruction of lingual tonsil
25 Myringotomy
26 Myringotomy With Grommet Insertion
27 Myringoplasty/Tympanoplasty
28 Antral Wash under LA
29 Quinsy drainage
30 Direct Laryngoscopy With biopsy
31 Reduction of nasal fracture
32 Mastoidectomy
33 Removal of tympanic drain
34 Reconstruction of middle ear
35 Incision of mastoid process & middle ear
36 Excision of nose granuloma
37 Therapeutic Phlebotomy
38 Haemodialysis /Peritoneal Dialysis
39 Chemotherapy
40 Radiotherapy
41 Coronary Angioplasty (PTCA)
42 Pericardiocentesis
43 Insertion of filter in inferior vena cava
44 Insertion of gel foam in artery or vein
45 Carotid angioplasty
46 Renal angioplasty
47 Tumor embolisation
48 TIPS Procedure for portal hypertension
49 Endoscopic Drainage of Pseudopancreatic cyst
50 Lithotripsy
51 PCNS (Percutaneous nephrostomy)
52 PCNL (Percutaneous nephrolithotomy)
53 Suprapubic cystostomy
54 Trans urethral resection of bladder tumor
55 Hydrocele surgery
56 Epididymectomy
57 Orchidectomy
58 Herniorrhaphy
59 Hernioplasty
60 Incision and Excision of tissue in the perianal region
61 Surgical treatment of anal fistula
62 Surgical treatment of hemorrhoids
63 Sphincterotomy / Fissurectomy
64 Revision of a tympanoplasty
65 Other microsurgical operations on the middle ear
66 Excision and destruction of diseased tissue of the nose
67 Operations on the turbinates (nasal concha)
68 Nasal sinus aspiration
69 Other operations on the tear ducts
70 Excision and destruction of diseased tissue of the eyelid
71 Other operations on the cornea
72 Incision of a pilonidal sinus
73 Other incisions of the skin and subcutaneous tissues
74 Other excisions of the skin and subcutaneous tissues
75 Chemosurgery to the skin
76 Laparoscopic appendicectomy
77 Laparoscopic Cholecystectomy
78 TURP (endoscopic Resection prostate)
79 Varicose vein stripping or ligation
80 Excision of dupuytren's contracture
81 Carpal tunnel decompression
82 Arthroscopic therapy
83 Surgery for ligament tear
84 Surgery for meniscus tear
85 Surgery for hemoarthrosis/pyoarthrosis
86 Removal of fracture pins/nails
87 Removal of metal wire
88 Incision of bone, Septic and aseptic
89 Closed reduction of fracture, subluxation or epiphysiolysis with osteosynthesis
90 Structure
91 Reduction of dislocation under GA
92 Eye Surgery
93 Excision of lacrymal cyst
94 Excision of perigiiem
95 Glaucoma Surgery
96 Surgery for retinal detachment
97 Chalazion Removal (Eye)
98 Incision of lacrymal glands
99 Incision of diseased eye lids
100 Excision of eye lid granuloma
101 Operation on canthus & epicanthus
102 Corrective surgery for entropion & ectropion
103 Corrective surgery for blepharoptosis
104 Foreign body removal from Conjunctiva
105 Foreign body removal from cornea
106 Incision of cornea
107 Foreign body removal from lens of the eye
108 Foreign body removal from posterior chamber of eye
109 Foreign body removal from orbit and eyeball
110 Excision of breast lump/Fibro adenoma
111 Operations on the nipple
112 Incision/Drainage of breast abscess
113 Excision of pilonidal sinus
114 Local excision of diseased tissue of skin and subcutaneous tissue
115 Simple restoration of surface continuity of the skin and subcutaneous tissue
116 Free skin transportation, donor site
117 Free skin transportation, recipient site
118 Revision of skin plasty excepting burns / injuries
119 Destruction of the diseases tissue of the skin and subcutaneous tissue
120 Incision, excision, destruction of the diseased tissue of the tongue
121 Incision and lancing of the salivary gland and salivary duct
122 Resection of Salivary duct
123 Reconstruction of a salivary gland and salivary duct
124 External incision and drainage in the region of the mouth, jaw and face
125 Incision of hard and soft palate
126 Excision and destruction of the diseased hard and soft palate
127 Incision, Excision and destruction in the mouth
128 Surgery to the floor of mouth
129 Palatoplasty
130 Transoral incision and drainage of pharyngeal abscess
131 Dilatation and curettage, Myomectomy, hysterscopic or laparascopic biopsy or removal
132 Vaccination/Inoculation forming a part of post bite treatment
133 Coronary Angiography
134 Dental surgery due to Accident
135 Any surgery under general an aesthesia requiring OT
136 Genital surgery
137 Laparoscopic therapeutic surgeries
138 Other operations on the salivary glands and salivary ducts
139 Other operations on the tonsils and adenoids
140 Other operations on the anus
141 Incision of the ovary
142 Insufflation of the Fallopian tubes
143 Dilatation of the cervical canal
144 Conisation of the uterine cervix
145 Other operations on the uterine cervix
146 Culdotomy
147 Operations on Bartholin's glands (cyst)
148 Incision of the scrotum and tunica vaginalis testis
149 Other operations on the scrotum and tunica vaginalis testis
150 Cystoscopical removal of stones