1. SALIENT FEATURES OF POLICY

BASE COVERS

- In-patient Hospitalization
- Day Care Treatment
- Other Expenses- Disease/ Procedure wise sub limits, Bariatric Surgery
- Pre-hospitalization Medical Expenses
- Post -hospitalization Medical Expenses
- Modern Treatment Method and Advancement in Technologies
- AYUSH Treatment
- Emergency Road Ambulance
- Maternity Expenses
- Cumulative Bonus

OPTIONAL COVER

- Consumables / Non-Medical Expenses Cover

2. SCOPE OF COVER

The Policy Schedule will specify the Sum Insured and the benefits which is in force for the Insured Persons. For a complete description of the Benefits available as well as any specific sub-limits on the amount payable under any benefit, please refer to the "Schedule of Benefits" section of this Policy.

2.1 BASE COVERS

The benefits available under the Base Covers are in-built into the product and are listed below:

2.1.1 Medical Expenses

a) In-patient Hospitalization:

We will pay the reasonable & customary charges for medical expenses incurred towards one or more of the following charges, arising out of an Insured Person's Hospitalization following an Illness or Injury sustained during the Policy Year, up to the Sum Insured as specified in the Policy Schedule.

(i) Room Rent for accommodation in Hospital room and other boarding charges, up to the limits as specified in Schedule of Benefits.
(ii) Intensive Care Unit (ICU) expenses, up to the limit as specified in Schedule of Benefits.
(iii) Operation theatre charges.
(iv) Medical Practitioner's fees, including fees of surgeon, consultants, physicians, specialists, and anesthetists.
(v) Qualified Nurses charges.
(vi) Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner.
(vii) Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized.
(viii) Anesthesia, blood, oxygen and blood transfusion charges, Surgical Appliances.
(ix) Prosthetic and other devices recommended by the attending Medical Practitioner that are implanted internally during a Surgical Procedure.

b) Day Care Treatment:

We will pay the reasonable and customary charges incurred towards Medically Necessary Treatment required by the Insured Person towards Day Care Treatments following an Illness or Injury that occurs during the Policy Year.

The list of such Day Care Treatments is specified in **Annexure I** of the Policy.

c) Other Expenses:

(i) Disease/ Procedure wise sub limits:

Expenses in respect of the following specified illness will be restricted to the sublimit as detailed below. The sublimit shall be applicable on an individual basis irrespective of the type of policy being floater or Individual.

S. No	Disease / Procedure (Sublimit per Year)	SI - ₹ 5 Lakhs	SI - ₹ 10 Lakhs	SI - ₹ 15 Lakhs
1	Cataract (Per Eye)	₹ 25,000	₹ 35,000	₹ 50,000
2	Lasik (Per eye)	₹ 25,000	₹ 35,000	₹ 50,000
3	Normal Delivery	₹ 25,000	₹ 35,000	₹ 50,000
4	ENT disorder	₹ 25,000	₹ 35,000	₹ 50,000
5	Infectious / Fever Disorders	₹ 30,000	₹ 40,000	₹ 50,000
6	Caesarean section	₹ 30,000	₹ 45,000	₹ 60,000
7	Liver Disorder (No cap on transplant)	₹ 30,000	₹ 45,000	₹ 60,000
8	Lung Disorder (No cap on transplant)	₹ 30,000	₹ 45,000	₹ 60,000
9	Kidney Disorder (No cap on transplant)	₹ 30,000	₹ 45,000	₹ 60,000
10	Appendix related disorder	₹ 30,000	₹ 45,000	₹ 60,000
11	Kidney Stone related disorder	₹ 50,000	₹ 75,000	₹ 1,00,000
12	Gall Bladder Stone related disorder	₹ 50,000	₹ 75,000	₹ 1,00,000
13	Hernia	₹ 50,000	₹ 75,000	₹ 1,00,000
14	Hysterectomy	₹ 50,000	₹ 75,000	₹ 1,00,000
15	Musculoskeletal disorder	₹ 50,000	₹ 75,000	₹ 1,00,000
16	Spinal/Cerebrovascular/Neurological disorde	₹ 75,000	₹ 1,00,000	₹ 1,50,000
17	Bariatric Surgery	₹ 75,000	₹ 1,00,000	₹ 1,50,000
18	Cancer	₹ 1,00,000	₹ 1,50,000	₹ 2,00,000
19	Angioplasty including angiography	₹ 1,25,000	₹ 1,50,000	₹ 2,00,000
20	Joint replacement (Per joint)	₹ 1,50,000	₹ 2,00,000	₹ 2,50,000
21	CABG/any other cardiac surgery	₹ 1,50,000	₹ 2,00,000	₹ 2,50,000
22	Mental / Psychiatric Disorders	₹ 30,000	₹ 45,000	₹ 60,000
23	Internal Congenital Anomalies (Not included in above procedures / diseases list)	₹ 50,000	₹ 75,000	₹ 1,00,000

Note: Any internal congenital Illness falling within the above-mentioned list or requiring the insured to undergo any of the listed procedure, from among the first 22 listed illness or procedure, shall be sub limited to amount as specified against the relevant disease or procedure. For any other internal congenital illness, not included in the first 22 listed illness or procedure, the sublimit as mentioned in point no. 23 of list shall be applicable.

(ii) Bariatric Surgery - We will pay the reasonable and customary charges for medical expenses incurred towards surgical procedure for obesity, subject to below conditions:

(a) Our obligation to make payment in respect of Bariatric Surgery (after 36 months of continuous coverage from the first inception of the Health Vital Policy with Us), shall be restricted to an amount as specified in the Schedule of Benefits.

(b) The claim related to Bariatric Surgery shall be payable only for expenses related to the surgical treatment of obesity that fulfil below conditions:

i) Surgery to be conducted is upon the advice of the Medical Practitioner

ii) The surgery/ procedure conducted should be supported by clinical protocols.

iii) The Insured Person has to be 18 years of age or older and

iv) Body Mass Index (BMI):

1) greater than or equal to 40 or

2) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

(c) Migration and portability shall not be applicable to this benefit.

2.1.2 Pre-Hospitalization Medical Expenses:

We will pay the reasonable and customary charges for Pre-Hospitalization Medical Expenses incurred immediately prior to the date of the Insured Person's hospitalization for the number of days as specified in the Schedule of Benefits.

Our maximum liability under this benefit shall be up to Sum Insured. However, the sublimit as specified under Section 4.1.1.c.i. for specified diseases/ procedures, shall be applicable for the benefit under this section.

2.1.3 Post – Hospitalization Medical Expenses:

We will pay the reasonable and customary charges for Post-Hospitalization Medical Expenses incurred immediately following the Insured Person's discharge from Hospital for the number of days as specified in the Schedule of Benefits.

Our maximum liability under this benefit shall be up to Sum Insured. However, the sublimit as specified under Section 4.1.1.c.i. for specified diseases/ procedures, shall be applicable for the benefit under this section.

2.1.4 Modern Treatment Method and Advancement in Technologies:

We will pay the reasonable & customary charges for medical expenses incurred towards Modern Treatment Method and Advancement in Technologies under In-Patient Hospitalization (Section 2.1.1.a) or Day Care Treatment (Section 2.1.1.b) arising out of an Insured Person's Hospitalization following an Illness or Injury sustained during the Policy year, up to disease/ procedure wise sublimit (Section 2.1.1.c.i) or 50% of Sum Insured whichever is lower.

We will cover medical expenses incurred on the following procedures:

(a) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

(b) Balloon Sinuplasty

(c) Deep Brain stimulation

(d) Oral chemotherapy

(e) Immunotherapy - Monoclonal Antibody to be given as injection.
(f) Intra vitreal injections
(g) Robotic surgeries
(h) Stereotactic radio surgeries
(i) Bronchial Thermoplasty
(j) Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
(k) IONM - (Intra Operative Neuro Monitoring)
(l) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

2.1.5 AYUSH Treatment

We will pay reasonable and customary charges for medical expenses incurred by Insured Person towards Hospitalization for Ayurveda, Yoga and Naturopathy, Unani, Siddha, or Homeopathy treatment, provided that the treatment has been undergone in an AYUSH Hospital.
Our maximum liability under this benefit shall be up to Sum Insured. However, the sublimit as specified under Section 2.1.1.c.i., for specified diseases/ procedures, shall be applicable for the benefit under this section.

Specific Exclusion:

i) All preventive and rejuvenation treatments (non-curative in nature)
ii) Outpatient Medical Expenses.

2.1.6 Emergency Road Ambulance:

We will reimburse expenses incurred towards Road Ambulance charges for transportation of an Insured person, by an ambulance of a hospital or of a registered ambulance service provider.
This cover limit under this benefit, as specified in the Schedule of Benefits, shall be over and above the sublimit applicable to the Policy, but it shall be subject to the Sum Insured availability under the Policy.

Following Expenses shall be covered under this benefit:

(i) Transportation Costs towards transferring the Insured Person from the place of incident to Hospital or from one Hospital to another Hospital or to a diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital and advised by the treating medical practitioner.
(ii) When the Insured Person requires to be moved to home after discharge from the hospital and the medical condition of Insured Person is such that it requires services of Ambulance as certified by treating medical practitioner.

Special Conditions:

a) The ambulance services of a hospital or a registered ambulance service provider is utilized.
b) The original Ambulance bills and payment receipt is submitted to Us.
c) We have accepted a claim under In-Patient Hospitalization (Section 2.1.1.a) or Day Care Treatment (Section 2.1.1.b) for the same Illness/Injury.

2.1.7 Maternity Expenses:

Our Maximum liability per Pregnancy (delivery /lawful medical termination / Miscarriage) shall be subject to the sub-limit specified under section 2.1.1.c.i.
Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report, would not be covered under this

Benefit, but would be considered as a claim made under Section 2.1.1.a(In-patient Hospitalization Expenses).

Special Conditions:

a) Pre & Post Natal expenses are not covered.
b) Maximum two maternity (including lawful medical termination and Miscarriage) events shall be paid in the lifetime of a policy.
c) Migration and portability shall not be applicable to this benefit.

2.1.8 Cumulative Bonus

Cumulative Bonus (CB) shall be increased by 10% in respect of each claim free policy year where no claims are reported, provided the policy is renewed with Us without a break subject to maximum of 100% of the sum insured under the current policy year.
If a claim is made in any particular year, the cumulative bonus accrued shall be reduced by 10% or at the same rate at which it has been accrued. However, Sum Insured will be maintained and will not be reduced in the policy year.

Special Conditions:

a) In the case where the policy is on an individual basis, the Cumulative Bonus shall be added and available individually to the Insured Person if no claim has been reported. Cumulative Bonus shall reduce only in case of claim from the same Insured Person.
b) In case where the policy is on floater basis, the Cumulative Bonus shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. Cumulative Bonus shall be reduced in case of claim from any of the Insured Persons.
c) Cumulative Bonus shall be available only if the Policy is renewed within the Grace Period.
d) If the Insured Persons on the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Cumulative Bonus for such Insured Person under the expiring policy and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule, then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
e) In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/ individual policies, or in cases where the policy is split due to the child attaining the age of 25 years, the Cumulative Bonus of the expiring policy shall be apportioned to such Renewed Policies in the proportion to the Sum Insured of each Renewed Policy.
f) If the Sum insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured in current Policy.
g) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
h) If a claim is made in the expiring Policy Year and is notified to Us after the acceptance of Renewal premium any awarded Cumulative Bonus shall be withdrawn.

2.2 OPTIONAL COVER

The benefit mentioned under the optional cover is to be selected by the Insured Person based on his/ her requirement and shall be available on payment of additional premium.
The Policy schedule shall specify such selected benefit, which shall be in force for the Insured Persons during the Policy Period.

2.2.1 Consumables / Non-Medical Expenses Cover

We will cover expenses incurred towards consumables and non-medical expenses which are listed in "List I – Items for which coverage is not available in the Policy" under Annexure II.

Our maximum liability under this benefit shall be up to Sum Insured. However, the sublimit as specified under Section 4.1.1.c.i. for specified diseases/ procedures, shall be applicable for the benefit under this section.

Special Conditions:

a) Such consumables are utilized or consumed during the treatment related to the Insured Person's medical or surgical treatment.
b) We have accepted a claim under In-Patient Hospitalization (Section 2.1.1.a) or (Day Care Treatment (Section 2.1.1.b) and provided that the expenses on Non-Medical Items pertain to the same Illness/injury admitted by us.
c) Pre and post hospitalization expenses will be excluded from this cover.
d) Section 4.2.16 shall not apply to the extent of cover provided under this benefit except Annexure -II (List- I).

3. WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

3.1 Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
b) In case of the enhancement of the sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then the waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

3.2 Specific Waiting Period (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 and 36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of the enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then the waiting period for the same would be reduced to the extent of prior coverage.

24 Months waiting period.

1) Benign ENT disorders

2) Tonsillectomy
3) Adenoidectomy
4) Mastoidectomy
5) Tympanoplasty
6) Hysterectomy
7) All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps.
8) Benign prostate hypertrophy
9) Cataract and age-related eye ailments
10) Gastric/ Duodenal Ulcer
11) Gout and Rheumatism
12) Hernia of all types
13) Hydrocele
14) Non-Infective Arthritis
15) Piles, Fissures and Fistula in anus
16) Pilonidal sinus, Sinusitis and related disorders
17) Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident.
18) Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19) Varicose Veins and Varicose Ulcers
20) LASIK Procedure

36 Months waiting period.

1) Treatment for joint replacement unless arising from accident.
2) Age-related Osteoarthritis & Osteoporosis
3) Maternity Expenses
4) Bariatric Surgery

3.3 First Thirty Days Waiting Period (Code- Excl03)

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

4.1 Standard Exclusions

4.1.1 Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.1.2 Rest Cure, rehabilitation and respite care (Code- Excl05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.1.3 Obesity/ Weight Control (Code- Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a) Surgery to be conducted is upon the advice of the Doctor.
b) The surgery/Procedure conducted should be supported by clinical protocols.
c) The member has to be 18 years of age or older and
d) Body Mass Index (BMI).
    1) greater than or equal to 40 or
    2) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnea
        iv. Uncontrolled Type2 Diabetes

4.1.4 Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.1.5 Cosmetic or Plastic Surgery (Code- Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medically necessity, it must be certified by the attending Medical Practitioner.

4.1.6 Hazardous or Adventure sports (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.1.7 Breach of law (Code- Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.1.8 Excluded Providers (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.1.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

4.1.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or

private beds
registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons**. (Code- Excl13)**

4.1.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**

4.1.12 Refractive Error (Code- Excl15)
Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

4.1.13 Unproven Treatments (Code- Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.1.14 Sterility and Infertility (Code- Excl17)
Expenses related to sterility and infertility. This includes:
(i) Any type of sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

4.2 Specific Exclusions

4.2.1 Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).
4.2.2 Circumcision, unless necessary for treatment of an Illness or necessitated due to an Accident.
4.2.3 Vaccination/ inoculation (except as post bite treatment)
4.2.4 Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and oxygen concentrator for asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces, stocking, Glucometer and the like), namely that equipment used externally for the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose, such cost of all appliances/devices whether for diagnosis or treatment after discharge from the Hospital.
4.2.5 Venereal /Sexually Transmitted disease other than HIV/AIDS.
4.2.6 External Congenital Anomaly and related Illness/ defect.
4.2.7 Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.
4.2.8 Stem cell storage.
4.2.9 Non-prescribed drugs and medical supplies, hormone replacement therapy.
4.2.10 Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
4.2.11 Outpatient diagnostic, medical and Surgical Procedures or treatments.
4.2.12 Dental Treatment or Surgery of any kind unless requiring Hospitalization as a result of Injury.
4.2.13 A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges.
4.2.14 Treatment outside India.

4.2.15 Intentional self-Injury.

4.2.16 Standard list of excluded items as mentioned in Annexure II and on our website https://generalicentralinsurance.com

4.2.17 Any specific exclusion(s) applied by Us, specified in the Schedule and accepted by the insured.

5. GENERAL TERMS AND CONDITIONS

5.1 Standard General Terms and Clauses

5.1.1 Disclosure of Information:

The Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

5.1.2 Condition Precedent to Admission of Liability:

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

5.1.3 Material Change:

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

5.1.4 Records to be Maintained:

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within a reasonable time limit and within the time limit specified in the Policy.

5.1.5 Complete Discharge:

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.1.6 Notice & Communication:

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

5.1.7 Territorial Limit:

All medical treatment for the purpose of this insurance will have to be taken in India only.

5.1.8 Multiple Policies:

i. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer,

if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

iv. Where an insured has policies from more than one insurer to cover the same risk on an indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

5.1.9 Fraud:

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy: —

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true.

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact.

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent.

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

5.1.10 Automatic change in Coverage under the policy:

The coverage for the Insured Person(s) shall automatically terminate:

i. In the case of his/ her (Insured Person) demise.
However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardians appointed by court. All relevant particulars in respect of such a person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

ii. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

5.1.11 Territorial Jurisdiction:

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

5.1.12 Possibility of Revision of Terms of the Policy Including the Premium Rates:

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

5.1.13 Free look period:

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

5.1.14 Endorsements (Changes in Policy):

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such a change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

5.1.15 Withdrawal of Policy:

a) In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.
b) Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

5.1.16 Moratorium Period:

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty

continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

5.1.17 Nomination:
The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.1.18 Redressal of Grievance:
In case of any grievance, the Insured Person may contact the company through:
Website: https://generalicentralinsurance.com
Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800
Email: https://generalicentralinsurance.com
Courier: Grievance Redressal Cell, Generali Central Insurance Company Limited. Lodha I – Think Techno Campus, B Wing –2nd Floor, Pokhran Road –2, Off Eastern Express Highway Behind TCS, Thane West – 400607

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at GCIGRO@generalicentral.com or call at: 7900197777.

For updated details of grievance officer, kindly refer the link-
generalicentralinsurance.com/customer-service/grievance-redressal
If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
Kindly refer the annexure on Grievance Redressal Procedures.

Grievance may also be lodged at IRDAI Bima Bharosa (an Integrated Grievance Management System) - https://bimabharosa.irdai.gov.in/

5.2 Specific General Terms and Clauses

5.2.1 Change of Sum Insured:
Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

5.2.2 Terms and conditions of the Policy:
The terms and conditions contained herein and, in the Policy Schedule, shall be deemed to form part of the Policy and shall be read together as one document.

5.2.3 Migration:

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

i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link-
https://generalicentralinsurance.com/portability-and-migration

5.2.4 Portability:

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

i. The waiting periods specified in Section 3 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link-
https://generalicentralinsurance.com/portability-and-migration

5.2.5 Cancellation

a) The policyholder may cancel this policy by giving 7 days written notice.
b) In case the Policyholder requests for cancellation of the Policy, where no claims are reported under the Policy, the Company shall refund premium for the unexpired policy/ instalment period as detailed below:
   i. Single Premium Payment (1/2/3 years Policy Term) – There shall be refund of proportionate premium for the unexpired policy period on prorate basis.
   ii. Premium paid in multiple instalments (1/2/3 years Policy Term) - There shall be refund of proportionate premium for the unexpired instalment period on prorate basis.
c) In case the Policyholder requests for cancellation of the Policy, where there are claims reported under the Policy, then the Company shall refund premium for the unexpired/ instalment policy period as detailed below:
   i. Single Premium Payment
      1) 1 year Policy Term - There shall be no refund of premium for the unexpired policy period.
      2) 2/3 years Policy Term – There shall be no refund of premium for the current Policy Year in which the claim got reported. However, the premium for the unutilized subsequent Policy Years (if any), shall be refunded.

ii. Premium paid in multiple instalments –

1) 1/2/3 years Policy Term - There shall be no refund of premium for the unexpired instalment period.

d) The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud or non-cooperation by the insured person by giving 15 days' written notice. There would be no refund of premium upon cancellation on the abovementioned grounds.

e) In the event of death of an Insured Person, We shall refund the premium for the unutilized Policy / Instalment period based on the guidelines for various scenarios as mentioned below:

Scenario 1 – In case of no claim reported under the policy-

A. Policy Term – 1 / 2 / 3 Years; Payment Mode – Single Premium Payment

1) Non-Floater Policy - the corresponding premium pertaining to the deceased insured person for the unutilized Policy period shall be refunded on pro rata basis.
2) Floater policy - the premium for pertaining to the deceased Insured person for the unutilized Policy Period shall be refunded on pro rata basis.

B. Policy Term – 1/ 2 / 3 Years; Payment Mode – Multiple Instalments

1) Floater / Non-Floater Policy - the instalment premium pertaining to the deceased Insured Person for the unutilized instalment period shall be refunded on pro-rata basis.

Scenario 2 – In case of claim reported under the policy –

A. Policy Term – 1 Year; Payment Mode – Single Premium Payment

1) Non-Floater Policy
   i. Claims incurred by the deceased Insured Person in the current Policy Year, The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded.
   ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased shall be refunded on pro-rata basis.
2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Policy Year, The premium for the deceased Insured Person for the unutilized subsequent Policy Period, will not be refunded.

B. Policy Term – 2 / 3 Years; Payment Mode – Single Premium Payment

1) Non-Floater Policy
   i. Claims incurred by the deceased Insured Person in the current Policy Year –The premium pertaining to the deceased Insured Person for the unutilized current Policy Year shall not be refunded. However, premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.
   ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Policy Year- The premium pertaining to the deceased Insured Person for the unutilized Policy Period, shall be refunded on pro-rata basis.
2) Floater Policy - Claims incurred by the deceased Insured Person or any

other Insured Person in the current Policy Year – The premium for the deceased Insured Person for the unutilized current Policy Year, will not be refunded. Premium pertaining to the deceased Insured Person for the unutilized subsequent Policy Years (if any), shall be refunded.

C. Policy Term – 1 / 2 / 3 Years; Payment Mode – Multiple Instalments

1) Non-Floater Policy
   i. Claims incurred by the deceased Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.
   ii. Claims incurred by any other Insured Person, but no claims incurred by deceased Insured Person in the current Instalment Period –The premium pertaining to the deceased Insured Person for the unutilized instalment Period, shall be refunded on pro-rata basis.
2) Floater Policy - Claims incurred by the deceased Insured Person or any other Insured Person in the current Instalment Period, the instalment premium pertaining to the deceased Insured Person for the unutilized current instalment period shall not be refunded.

5.2.6 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

a) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
e) No loading shall apply on renewals based on individual claims experience.
f) Health Vital Policy shall be renewable lifelong.
g) The brochure/ prospectus mentions the premiums as per the age / Sum Insured and the same would be charged as per the completed age at every Renewal.
h) The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the IRDAI. However, such revised premiums would be applicable only from subsequent Renewals and with due notice whenever implemented.
i) Any Change (increase/ decrease) in Sum Insured is not allowed during the currency of the Policy. However, an increase/decrease in Sum Insured or change in cover, will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling in the Proposal before the expiry of the Policy.
j) In the case of enhancement of sum insured, the waiting periods shall apply afresh to the extent of sum insured increase.

5.2.7 Premium Payment in Instalment

If the insured person has opted for Payment of Premium on an instalment basis i.e., Half Yearly, Quarterly, Monthly and Single in case of Long-Term policies, as mentioned in the policy Schedule

the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

a) Grace Period of 15 days would be given to pay in case of monthly instalment premium and grace period of 30 days shall be given to pay in case of quarterly / Half Yearly installment premiums, due for the policy.
b) The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
c) No interest will be charged If the instalment premium is not paid on the due date.
d) In case the instalment premium due, is not received within the grace period, the policy will get cancelled.
e) In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
f) The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
g) The payment will be accepted through E-NACH / ACH/ ECS / any other mode approved by Government of India.
h) On successful registration for the mandate/ E-NACH/ any other mode approved by Government of India; the premium shall be auto debited as per the frequency opted.
i) In case of withdrawal of E-NACH/ ACH/ ECS / any other mode approved by Government of India; a written communication will be required from policyholder.
j) In case there is failure in transaction in E-NACH/ ACH/ ECS mode/ any other mode approved by Government of India, or the instalment premiums are not received within the grace period, the Policy will get cancelled. A fresh policy with all waiting periods would be issued.
k) If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.

5.2.8 Proportionate Deduction

In case the Insured Person is admitted to a Room at rates above the admissible Room Rent limits as specified in the Schedule of Benefits, then we will reimburse / pay all other associated medical expenses incurred at the Hospital as per the proportion of the admissible rate per day to the actual rate per day of Room Rent.

Proportionate Deductions shall not be applied to the following:

a) in respect of Hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on room category.
b) to ICU Charges
c) in respect of the Policy where the Policyholder has opted for Room Rent without any capping.

5.2.9 Revision of Premium due to Inflation

The premium rates of the product shall be subject to revision after 3 years of its first launch. Such revision in rates shall be:

a) based on the inflation index prevalent during that period.
b) implemented after prior approval from IRDAI.

All the extant regulations/guidelines/circulars prescribed by IRDAI shall be followed to implement the premium rate revision.

5.2.10 Cost of Pre-Policy Medical Examination

We will reimburse 100% of the cost of any pre-insurance medical examination conducted at our empaneled diagnostic center once the Proposal is accepted and the Policy is issued for that Insured Person.

5.2.11 Discounts & Loadings:

a) Long Term Discount - (applicable in case of single payment for policy term of more than one year)

Number of years	Discount
1 year	Nil
2 years	7.5%
3 years	10%

b) Web sales / Tele sales discount -

A discount of 15% in lieu of intermediary commissions if policy is sourced directly from the Company's website or through leads generated via Tele sales channel.

c) Employee discount -

we shall accord a discount of 15 %, on the premium amount, against proposals received from the following categories of individuals, provided that the respective individual, at least till the date of issuance of the policy cover, continues to be in/of such capacity:

a) Employed with Generali Central Insurance Company Limited., recorded through its official rolls/register.
b) Employed with Generali Central Life Insurance Company Limited., recorded through its official rolls/register.
c) Contracted for provision of services directly by Generali Central Insurance Company Limited., recorded through appointment/engagement letter or like document.
d) Contracted for provision of services directly by Generali Central Life Insurance Company Limited., recorded through appointment/engagement letter or like document. Towards entitlement of the discount, each eligible proposer shall have to submit with Generali Central Insurance Company Limited., alongside the proposal, a self-certified copy of the identification card or appointment/engagement letter or such document that may have been issued in favour of the proposer to evidence the relationship, which bears an identification mark/logo of the issuing entity.

Note: - Either Website/Employee discount would apply in a single policy

d) Floater discount -

Age Band	Floater Discount	Age Band	Floater Discount
0-17	60%	51-55	40%
18-25	55%	56-60	35%
26-30	50%	61-65	35%
31-35	45%	66-70	35%
36-40	45%	71-75	35%
41-45	40%	76-80	25%
46-50	40%	>=81	25%

The premium applicable for the Primary Insured will be the standard individual premiums from the premium table. For remaining dependent members, floater discounts applicable on their respective premium is as per table above.

For example – In case of a family of Self, spouse and 1 child, the premium for floater for Sum Insured ₹ 10,00,000 would be charged in the following manner –

Sum insured is 1000000			
	Self (Male)	Spouse (Female)	Child (Female)
Age (in years)	36	31	0-17
Premium as per Individual rate table (in ₹)	9,515	8,876	5,741
Applicable premium (in ₹)	9,515	4,882	2296
		(45% discount applied on the respective person's premium)	(60% discount applied on the respective person's premium)
Total Premium to be charged (in ₹)	9,515+4,882+2,296		
	16,693		

e) **Instalment Loading -** Insured has an option to pay a premium on an instalment basis. Given below are the loadings applicable on Standard premiums in case of instalments.

Instalment Frequency	Loading on standard premiums
Monthly	5%
Quarterly	4%
Half Yearly	3%

f) **Loading On Claim Experience -** There will be no loading on premium for adverse claims experience.

g) **Underwriting Loading –**

S.No.	Condition	Underwriting Decision
1	Diabetes	
a	Pre-Diabetic/ Not a known case of Diabetes (HbA1c 5.9 - 6.49%)	Exclusion#
b	Known case of Diabetes (HbA1c up to 5.9 - 6.49%)	10% loading with Exclusion for preexisting
c	Diabetic (HbA1c level 6.5% - up to 8%)	15% loading with Exclusion for preexisting
d	Diabetic (HbA1c level >8%)	Decline
2	Hypertension	
a	Known / not known Hypertensive (140mm HG Systolic /90 mmHg diastolic)	10% loading with Exclusion for preexisting
b	Known / not known Hypertension (141 to 150 mmHg Systolic / 91 to 100 mm Hg diastolic)	15% loading with Exclusion
c	Known / not known Hypertension (Above 150 mmHg Systolic / Above 100 mm Hg diastolic)	Decline
3	Serum Cholesterol	
a	Above +25 mg/dl to +50 mg/dl above the maximum *Normal range	10% loading

b	+51 mg/dl to +100 mg/dl above the maximum *Normal range	15% loading
4	Serum creatinine	
a	up to 0.3 mg/dL above the maximum *Normal range	10% loading
b	Above 0.3 up to 0.8 mg/dl of the maximum *Normal range	15% loading
5	Asthma	
a	Asthma	10% loading
6	Smoking and or Tobacco chewing/ Ghutka	10% loading
7	BMI	
a	(BMI from 32.1 to 34)	10% loading
b	(BMI from 34.1 to 36)	15% loading
c	36.1 and above	Decline
8	Combination of any two or more conditions	To be Reviewed for Acceptance/ Declinature
9	Positive history of any other ailment(s)/ disease(s)	To be Reviewed for Acceptance/ Declinature

5.2.12 Eligibility

a) Policy Options: Individual/Non-Floater and Family Floater.

b) Policy Tenure: 1,2 & 3 Years

c) Age Eligibility:

Minimum Entry Age	Dependent Child - 1 Day
	Adult - 18 years
Maximum Entry Age	Dependent Child – 25 Years
	Adult - 60 Years
Maximum Renewal Age	Life Long

d) Family Definition:

Individual/Non-Floater - Self, legally married spouse/Live-in Partner, up to 3 dependent children, parents and parents in law.
Individual – Max 9 members can be covered under single policy.

Family Floater - Self, legally married spouse/Live-in Partner, up to 3 dependent children.
Family Floater – Max 5 members can be covered under single policy.

e) Sums Insured Available in the product are as below:

Sum Insured (In ₹)	₹ 5L, ₹10L, ₹15L

6. CLAIM PROCEDURES

6.1 Procedure for Cashless Claims

Cashless Facility is only available at a Network Provider. In order to avail Cashless Facility, the following procedure must be followed:

1) We must be called at Our call center and a request for pre-authorization must be made by way of the written form prescribed by Us.

2) After considering the request and obtaining any further information or documentation that We have sought, We may, if satisfied, send the Network Provider an authorization letter. The authorization letter, the ID card issued to the Insured Person along with this Policy and any other information or documentation that We have specified must be produced to the Network Provider identified in the pre-authorization letter at the time of the Insured Person's admission to the Hospital.
3) If the above procedure is followed, the Insured Person will not be required to directly pay for those Medical Expenses to the Network Provider that We are liable to indemnify under this Policy. The original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorization does not guarantee that all costs and expenses that are incurred will be covered. We reserve the right to review each claim for medical expenses incurred and accordingly coverage will be determined according to the terms, conditions and exclusions of this Policy. All other costs and expenses that are not covered under this Policy must be settled directly with the Network Provider and We shall have no liability in this regard.

6.2 Procedure for Reimbursement Claims

If a pre-authorization request is denied by Us or if treatment is taken in a Hospital other than a Network Provider or if You/ Insured Person does not wish to avail Cashless Facility, then:

1) We must be given Notification of Claim immediately and in any event within 48 hours of admission to the Hospital.
2) The Insured Person must take reasonable steps or measures in good faith to minimize the quantum of any claim that may be made under this Policy.
3) The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.

6.3 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

1) Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
2) At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

6.4 Documents to be submitted:

We must be given promptly, and in any event within 15 days of the Insured Person's discharge from a Hospital, the documentation including written details of the quantum of any claim along with all original supporting documentation, including but not limited to the following, and other information we ask for to investigate the claim for Our obligation to make payment for it:

1) The claim form specified by Us duly completed and signed by the claimant or a family member.
2) First consultation letter.
3) First prescription from the Medical Practitioner.
4) Original vouchers/ invoice of original bill.
5) Original Hospital bills giving a detailed break up of all expense heads mentioned in the bill.
6) Money receipt duly signed with a revenue stamp.
7) Birth/Death certificate (as applicable).
8) The original Hospital discharge card/ summary.
9) All original laboratory and diagnostic test reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc
10) If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist.
11) If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the

actual test reports and the bill from the diagnostic centre for the tests.

12) Copy of proposer's photo ID proof & address proof
13) NEFT Form with photocopy of cancelled cheque with printed name of proposer
14) Copy of Operation theatre Notes, if applicable
15) Copy of the Claim Intimation, if any
16) Copies of health insurance policies held with any other insurer covering the insured persons.
17) If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that original claim documents are retained at their end.
18) It is a condition precedent to Our liability under this Benefit that the following information and documentation shall be submitted to Us immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
19) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir claiming on his/her behalf must inform Us immediately and send Us a copy of the postmortem report (if any).

If We are not given notice/documentation within the time frames set out above, then We may accept the claim notice/ documentation if it is demonstrated to Us that the delay was for reasons beyond the control of the claimant.

6.5 Payment of Claim

We shall make payment in Indian rupees and in India only.

6.6 Claim Settlement

1) The Company shall settle or reject a claim within 15 days of the date of receipt of last necessary document.
2) In the case of a delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
4) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
5) Our Claims team will scrutinize the claims on the receipt of the last necessary documents specified Section 6.4 above.
6) In case of 'pending' claims, we will ask for submission of incomplete documents.
7) 'Rejected' claims will be informed to the Insured Person in writing with reasons for rejection.

Annexure to Prospectus –

A. Schedule of Benefit (Refer Policy Wordings)
B. Annexure I: Day Care List (Refer Policy Wordings)
C. Annexure II: List of Non-Medical Expense (Refer Policy Wordings)
D. Grievance Redressal Procedures (Refer Policy Wordings)

This is only for ready reference and is indicative in nature. For complete terms of this product, please refer to the Policy Wordings. For assistance, please visit our website

at https://generalicentralinsurance.com/customer-service/downloads or call us at 1800 103 8889.

PREMIUM TABLE: Exclusive of Goods & Services Tax (age in completed years)

Age Band/SI	₹ 500,000	₹ 1,000,000	₹ 1,500,000
0-17	4,532	5,741	6,328
18-25	6,097	7,778	10,150
26-30	6,687	8,530	10,982
31-35	7,065	8,876	11,456
36-40	7,566	9,515	12,163
41-45	8,435	10,619	13,372
46-50	10,877	13,725	16,786
51-55	17,933	22,312	24,834
56-60	23,144	28,964	32,192
61-65	36,884	48,400	53,693
66-70	55,238	71,828	79,610
71-75	73,838	95,570	105,874
76-80	92,261	119,090	131,890
>81	115,290	148,490	164,411

Premium for Optional Cover – Consumables / Non-Medical Expenses Cover

Sum Insured (In INR)	₹ 500,000	₹ 1,000,000	₹ 1,500,000
Premium (In INR)	600	750	1000

Note:

- *Premiums exclusive of Goods & Services Tax*
- *Age in completed years*
- *For Family Floater, the premium applicable for the primary insured will be the standard individual premiums. For the remaining dependent members, floater discounts will be applicable on their respective premium.*
- *Insured has an option to change the plan, and sum insured at the time of renewal of the policy, subject to underwriting.*
- *The premiums above are subject to revision as and when approved by the regulator. However, such revised premiums would be applicable only from subsequent renewals and with due notice whenever implemented*

This prospectus shall form part of your proposal form, hence please sign as you have noted the contents of this prospectus.

"I agree to undergo medical tests as advised by the Insurance Company. I agree to a medical underwriting loading as per underwriting guidelines of the Company."

Signature	Place
Name	Date

In case of any claims, contact Claims Department:

Generali Central Health (GCH),
Generali Central Insurance Company Limited.

Qubix Business Park, Building No. Block IT – 1,
Ground Floor, Plot No. 2, Blueridge Township,
Near Rajiv Gandhi Infotech Park, Phase – 1,
Village Hinjawadi, Taluka Mulshi, Pune,
Maharashtra – 411057
Toll Free Number: 1800 103 8889, Toll Free Fax: 1800 103 9998
Email: GCH@generalicentral.com

Generali Central Insurance Company Limited (Formerly known as Future Generali India Insurance Company Limited) | Registered Office: Unit No. 801 & 802, 8th Floor, Tower C, Embassy 247 Park, LBS Marg, Vikhroli (West), Mumbai – 400083 | IRDAI Regn. No.: 132 | CIN: U66030MH2006PLC165287 | Website: www.generalicentralinsurance.com | Email ID: gcicare@generalicentral.com| Toll-free Phone: 1800 220 233 / 1860 500 3333/ 022 6783 7800
ISO No: GCH/HP/VIT/PRS/001