POLICY WORDINGS
ACCIDENT SURAKSHA

PREAMBLE

This Policy is issued to You based on the Disclosure to information norm, Your Proposal to Us and Your payment of the Premium. This Policy records the agreement between Us and You and sets out the terms of insurance and the obligations of each party.

A. OPERATION OF COVER

1. The cover provided by this Policy will only apply during the Policy Period stated in the Schedule.
2. The Insured Person is eligible to be covered under this Policy from 18 years up to the age of 70 years with lifelong renewability subject to continuous Renewal of the Policy. This Policy records the agreement between Us and You and sets out the terms of insurance and the obligations of each party. Child can be covered from 3 years to 25 years as a Dependent Child.

B. DEFINITIONS

Following words are phrases whenever they appear in bold in this **Policy** have special meanings as defined below against each of them:

I. Standard Definitions

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

3. **Coma of Specified Severity** means
   a) A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
      i. no response to external stimuli continuously for at least 96 hours;
      ii. life support measures are necessary to sustain life; and
      iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
   b) The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

4. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

5. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

6. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

7. **Day Care Centre** means any institution established for day care treatment of illness and/ or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:-
   a) has qualified nursing staff under its employment;
   b) has qualified medical practitioner/s in charge;

c) has a fully equipped operation theatre of its own where surgical procedures are carried out;
d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

8. **Day Care Treatment** means medical treatment, and/ or ***surgical procedure*** which is:
   a) undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hrs because of technological advancement, and
   b) which would have otherwise required hospitalisation of more than 24 hours
   Treatment normally taken on an out-patient basis is not included in the scope of this definition.

9. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the **insurer** will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the **insurer**. A deductible does not reduce the **Sum Insured**.**Disclosure to information norm** means that 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.

10. **Grace Period** means the specified period of time immediately following the premium due date during which premium payment can be made to renew or continue a **policy** in force without loss of continuity benefits pertaining to waiting periods and coverage of **pre-existing diseases**. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be fifteen days where premium payment mode is monthly and thirty days in all other cases.
    Provided the insurer shall offer coverage during the grace period, if the premium is paid in installments during policy period.

11. **Hospital** means any institution established for ***in-patient care*** and ***day care treatment*** of **illness** and/ or **injuries** and which has been registered as a **hospital** with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act **Or** complies with all minimum criteria as under:
    a) has qualified nursing staff under its employment round the clock;
    b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    c) has qualified **medical practitioner(s)** in charge round the clock; has a fully equipped operation theatre of its own where **surgical procedures** are carried out;
    d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

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

13. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    (a) Acute condition - Acute condition is a disease, illness or **injury** that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ **injury** which leads to full recovery
    (b) Chronic condition - A chronic condition is defined as a disease, illness, or **injury** that has one or more of the following characteristics:
        a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        b) it needs ongoing or long-term control or relief of symptoms

c) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
d) it continues indefinitely
e) it recurs or is likely to recur

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

15. **Inpatient Care** means treatment for which the **insured person** has to stay in a **hospital** for more than 24 hours for a covered event.

16. **Intensive Care Unit** means an identified section, ward or wing of a ***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.

17. **IRDAI** means the Insurance Regulatory and Development Authority of India;

18. **Medical Advice** means any consultation or advice from a **Medical Practitioner** including the issue of any prescription or follow-up prescription.

19. **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.

20. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The registered Medical Practitioner should not be the Insured Person or close family member.

21. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    a) is required for the medical management of the illness or injury suffered by the insured;
    b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c) must have been prescribed by a medical practitioner;
    d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India

22. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer

23. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility

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

25. **Notification of Claim** means the process of intimating a claim to the **insurer** or TPA through any of the recognized modes ofcommunication.

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

27. **Permanent Paralysis of Limbs** means total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

28. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.
    b) For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.

29. **Pre-hospitalization Medical Expenses** means **medical expenses** incurred during pre-defined number of days preceding the **hospitalization** of the **Insured Person**, provided that:
    a) Such **Medical Expenses** are incurred for the same condition for which the **Insured Person's Hospitalization** was required, and
    b) The In-patient **Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company.

30. **Post-hospitalization Medical Expenses** means **medical expenses** incurred during pre-defined number of days immediately after the **insured person** is discharged from the **hospital** provided that:
    a) Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    b) The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
31. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

32. **Reasonable and Customary Charges** means the charges for 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 a ccount the nature of the **illness**/ **injury** involved.

33. **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 gaining credit for **pre-existing diseases**, time-bound exclusions and for all waiting periods.

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

35. **Unproven/ Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or

unproven.

II. Specific Definitions

36. **Accidental Death** means death due to **Accident**.

37. **Adventure sports** are activities having high level of inherent danger. These activities often involve speed, height, a high level of physical exertion, and highly specialized gear such as racing on wheels or horseback, big game hunting, mountaineering, winter sports, skydiving, parachuting, scuba diving, riding or driving in races or rallies, mountain climbing, hunting or equestrian activities, rock climbing, pot holing, bungee jumping, skiing, ice hockey, aviation activities, ballooning, hand gliding, diving or under-water activity, river rafting, canoeing involving rapid waters, polo, yachting or boating.

38. **Assignee** means the person to whom the rights and benefits under this Policy are transferred by virtue of assignment under Section 38 of the Insurance Act, 1938 as amended from time to time.

39. **Base Sum Insured** means the sum insured for the Insured Person as stated in the Schedule of the first Accident Suraksha Policy taken with Us.

40. **Bank Rate** means Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

41. **Burn** is a type of injury to skin, or other tissues, caused by heat, electricity or chemicals.

42. **Common Carrier** means any civilian land conveyance operated under a valid license for the transportation of passengers for hire

43. **Dependent Child** refers to a child (natural or legally adopted), who is up to 25 years of age, financially dependent on the primary
Insured Person or proposer and does not have his/ her independent sources of income.

44. **Drowning** means the process of experiencing respiratory impairment from submersion/immersion in liquid/water.

45. **Family** means self, spouse and children.

46. **Fingers** or **Toes**, whether in the singular or plural, means the digits of a hand or foot.

47. **Hazardous Activities** mean recreational or occupational activities which pose high risk of injury.

48. **Insured Person** whether in singular or plural means the person(s) who come within the description of Insured Persons stated in the Schedule, who are nominated by You from time to time and for whom premium has been paid.

49. **Limb** whether in singular or plural, means an arm at or above the wrist or a leg at or above the ankle.

50. **Nominee** shall mean the person selected by the policyholder to receive the benefit in case of death of the insured thus giving a valid discharge to the insurer on settlement of claim under an insurance policy.

51. **Occupation** means occupation of Insured Persons as shown in the Schedule or as declared to Us in the Proposal.

52. **Permanent Partial Disablement** means a bodily Injury caused by accidental, external, violent and visible means, which as a direct consequence thereof, disables any part of the Limbs or organs of the body of the Insured Person and which falls into one of the categories listed in the "Table of Events" set out in the Policy.

53. **Permanent Total Disablement** means a bodily Injury caused by accidental, external, violent and visible means, which as a direct consequence thereof totally disables and prevents the Insured Person from attending to any business or Occupation of any and every kind or if he/she has no business or Occupation, from attending to his/her usual and normal duties that last for a continuous period of twelve calendar months from the date of the Accident, with no hopes of improvement at the end of that period.

54. **Policy** means the complete documents consisting of the Proposal, policy wording, Schedule and endorsements and attachments, if any.

55. **Policy holder** means the person stated in the Schedule.

56. **Policy Period** means the period starting with the commencement date mentioned in the Schedule till the end date mentioned in the Schedule.

57. **Policy Year** means every annual period within the Policy Period starting with the commencement date.

58. **Principal Sum Insured** means the Sum Insured under Accidental Death, which would be highest Sum Insured under any cover.

59. **Proposal** means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

60. **Schedule** means that portion of the Policy which sets out Your/Insured Person's personal details, the type of insurance cover in force, the period and the Sum Insured. Any annexure or endorsement to the Schedule shall also be a part of the Schedule.

61. **Sum Insured** means the amount stated in the Schedule for the Insured Person which represents Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of that Insured Person.

62. **Temporary Total Disablement** means disablement which temporarily and totally prevents the **Insured Person** from attending to the duties of his usual business or **Occupation** and shall be payable for a maximum period of 100 weeks during such disablement from the date on which the **Insured Person** first became disabled.

63. **We, Our, Us, Insurer** GCICL, Generali Central Insurance Company Limited
64. **You, Your, Yourself –** The **Policy holder** shown in the **Schedule**.

Please note

a. Insect and mosquito bites is not included in the scope of definition of Accident.
b. Medical Expenses would include both medical treatment and/ or surgical treatment

C. WHAT WE WILL PAY FOR

Following an **Injury** to the **Insured Person** which results in any of the events listed in the Table of Events, **We** will pay the **Insured Person** such percentage of the **Sum Insured** stated against the event in the Table of Events and specified in the **Schedule** provided that the **Schedule** mentions that **You** have opted for coverage against that event and paid premium for the same.

I.PRIMARY COVERS

The Primary Cover includes the following benefits. We will make payment for the benefits as specified in the Schedule.

1 **Accidental Death**

2 **Permanent Total Disablement**

3 **Permanent Partial Disablement**

4 **Temporary Total Disablement**

1. Accidental Death

If during the Policy Year, the Insured Person sustains Injury which directly and independently of all other causes results in death of the Insured Person within twelve (12) months from the date of Accident, then We will pay the Sum Insured as stated in the Schedule.

Special Condition:

a) Disappearance

In the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a civilian aircraft in which such Insured Person was known to have been travelling as an occupant or passenger, or as a result of any Act of God, it shall be deemed after twelve (12) months, that such Insured Person shall have died as a result of an Accident.

If, at any time, after the payment of the Accidental Death benefit, it is discovered that the Insured Person is still alive, all payments shall be reimbursed in full to the Insurer.

b) Drowning

In the event the body of the **Insured Person** is not found on account of **Drowning**, it shall be deemed as per the provisions of Indian Law that such
Insured Person is dead as a result of an **Accident**.

We will pay the percentage of the Sum Insured shown in the table below:

Event	Percentage of Sum Insured
Accidental Death	100%

2. Permanent Total Disablement

If during the **Policy Year**, the **Insured Person** sustains **Injury** which directly results in **Permanent Total Disablement** within twelve (12) months from the date of **Accident**, then **We** agree to pay the percentage of the **Sum Insured** shown in the Table of Events below and as specified in the **Schedule**.

It is clarified that for the purpose of this cover, **Permanent Total Disablement** shall entail one of the following:

i. Permanent total loss of sight of both eyes
ii. Permanent total loss of sight of one eye and physical separation of or the loss of ability to use either one hand or one foot
iii. Permanent total loss and physical separation of or the loss of ability to use both hands or both feet
iv. Permanent total loss and physical separation of or the loss of ability to use one hand and one foot

Special Conditions -

a) Coma of Specified Severity

i. If an **Insured Person** sustains **Injury** which directly results in the **Insured Person** being in an **Intensive Care Unit** of a **Hospital** in a state of **Coma of Specified Severity**, within 30 days of the date of **Accident**, then **We** will pay to the **Insured Person** the **Sum Insured** stated in the Permanent Total Disablement section of the **Schedule**.

ii. The **Coma of Specified Severity** should be for a minimum continuous period of 180 days or more for any benefits to be payable.

b) Permanent Paralysis of Limbs

Permanent Paralysis of Limbs arising out of accident should be for a minimum continuous period of 12 months or more for any benefits to be payable. And should be confirmed by specialist medical practitioner.

c) Accidental Head injury

The Accidental Head injury must result in an inability to perform at least four (4) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology. The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

We will pay the percentage of the Sum Insured shown in the table below:

Event	**% of Permanent Total Disablement Sum Insured**
Permanent Total Disablement:	**150%**
Permanent total loss of sight of both eyes	150%
Permanent total loss of sight of one eye and physical separation of or the loss of ability to use either one hand or foot	150%
Permanent total loss and physical separation of or the loss of ability to use both hands or both feet	150%
Permanent total loss and physical separation of or the loss of ability to use one hand and foot	150%
Coma of Specified Severity due to **Injury**	150%
Permanent paralysis of Limbs	150%
Accidental Head injury	150%

3. Permanent Partial Disablement

If during the Policy Year, the **Insured Person** sustains **Injury** which directly results in **Permanent Partial Disablement** within twelve (12) months from the date of **Accident**, then **We** agree to pay the percentage of the **Sum Insured** shown in the Table of Events below and as specified in the **Schedule**. The Table of Events below sets out the events which constitute 'Permanent Partial Disablement'.

Special Conditions

a) **Burns**

If during the Policy Year, the Insured Person sustains Injury which results in Second Degree Burns or Third Degree Burns, then We agree to pay the percentage of the Sum Insured shown in the Table of Events below and as specified in the Schedule.

i. Rule of nine - A system used by **Medical Practitioners** for assessing the percentage of the body surface affected by **Burns**. In this system, the head and each arm cover 9% of the body; the front of the body and the back of the body and each leg covers 18% of the body. The groin covers the remaining 1%.
ii. Second Degree Burns - **Burns** which penetrate beyond the epidermis, causing formation of blisters.
iii. Third Degree Burns – There must be third-degree burns with scarring that cover, at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

We will pay the percentage of the Sum Insured shown in the table below:

Event	**Percentage of Sum Insured**
Permanent Partial Disablement:	**As Follows**
An arm at the shoulder joint	75%
An arm above the elbow joint	70%
A hand at the wrist	50%
An arm beneath the elbow joint	60%
A thumb	25%
An index Finger	10%
Any other Finger	5%
A leg above mid-thigh	75%
A leg up to mid-thigh	60%
A leg up to beneath the knee	50%
A leg up to mid-calf	45%
A foot at the ankle	40%
A large Toe	5%
Any other Toe	2%
Permanent loss of sight of one eye	50%
Hearing of one ear	25%
Hearing of both ears	75%
Sense of smell	10%
Sense of taste	5%
Shortening of leg by at least 5%	7%
Burns as calculated on Rule of nine for each area of body affected	As Follows
Burns at least 18% of the body surface area.	30% of Sum Insured
Burns at least 27% of the body surface area.	50% of Sum Insured
Burns at least 45% of the body surface area.	100% of Sum Insured

If the Permanent Partial Disablement event not listed above, then the disability percentage certified by the

Government Civil Surgeon would be considered under this section.

If there is more than one Permanent Partial Disablement due to an Injury, the claim amount payable for all such losses put together should not exceed the Sum Insured as opted by the Insured Person under this section

4. Temporary Total Disablement

If during the Policy Year, the Insured Person sustains Injury which directly results in Temporary Total Disablement which completely prevents the Insured Person from performing each and every duty pertaining to employment or Occupation, then We will pay a weekly benefit, provided that:

i. The Temporary Total Disablement is certified by a Medical Practitioner, and
ii. Our liability to make payment will be limited to an amount payable weekly for each week during the period of Temporary Total Disablement for a period not exceeding 100 weeks from the date of the Accident and if the Insured Person is disabled for a part of a week, then only a proportionate part of the weekly benefit will be payable.

We will pay the percentage of the Sum Insured shown in the table below:

Event	Percentage of Sum Insured
Temporary Total Disablement (weekly benefit)	weekly benefit up to a maximum of 100 weeks or as mentioned in the Schedule

Specific conditions applicable to Primary Covers section:

a. If a claim has already been settled for any of the Primary Covers the amount payable for the subsequent claims/s under the Primary Covers shall be reduced by this amount/s already paid. Regardless of one or more claims made during the Policy Year, the maximum amount payable towards the Primary Cover shall be restricted to the Principal Sum Insured.
b. If more than one loss results from any Accident, only one amount, the largest, will be paid.
c. This Policy shall not be further renewed for the particular Insured Person on payment of a claim for Accidental Death or Permanent Total Disablement. In case of long term policies with single premium payment option, in the event of claim for Accidental Death or Permanent Total Disablement of that insured person, in a particular policy year, the premium for the subsequent (unutilized) Policy Year(s), if any, shall be refunded. In case of long term policies with instalment option, please refer to Section E. ii. 12. xi. of the Policy Wordings.

II. INBUILT COVERS

I. **Repatriation of remains and Funeral Benefit**

In the event of We making payment for a claim for Accidental Death, We will also make payment towards

a. Expenses for burial or cremation and transportation of Insured Person's body to his/her city of residence.
b. Insured person's funeral expenses.

The benefit payable towards a & b together shall be limited to 1% of the Principal Sum Insured subject to a maximum of Rs 12500/-. (No additional premium will be charged for this cover.)

III. ADDITIONAL COVERS

We will make payment for the following additional benefits if the Schedule mentions that You have availed the same and paid the additional premium wherever applicable.

A. Child Education Support

In the event of We making payment for a claim for Accidental Death or Permanent Total Disablement, We will also make payment towards the education support of the Insured Person's Dependent Child/ Children, which will be an amount mentioned against this benefit per month for the maximum period as stated in the Schedule. This benefit shall be limited to the maximum as stated in the Schedule irrespective of the number of Dependent Children.
However, We reserve the right to pay the claim under this benefit as lump sum benefit.

B. Life Support Benefit
In the event of We making payment for a claim for Permanent Total Disablement, We will also make payment towards life support of the Insured Person which will be an amount mentioned against this benefit per month for the number of months mentioned in the Schedule. However, We reserve the right to pay the claim under this benefit as lump sum benefit.

C. Accidental Medical Expenses
In the event of a valid claim under this Policy for any of the following covers: Accidental Death, Permanent Total Disablement, Permanent Partial Disablement, or Temporary Total Disablement, We will reimburse the Reasonable and Customary Charges, for medical treatment or Surgery for the Injury sustained, provided the treatment is during the Policy Year and availed in a Hospital or Day Care Centre in India including OPD treatment/ Day Care Treatment. The maximum amount payable shall be 40% of the valid personal Accident claim amount or 20% of the relevant Sum Insured, whichever is less subject to maximum of Rupees Ten lakhs only.
Note:
Relevant Sum Insured refers to the Sum Insured of the primary covers, under which the claim is payable. Primary covers include Accidental Death/ Permanent Total Disablement/ Permanent Partial Disablement/ Temporary Total Disablement
Valid claim refers to the claim payable under primary covers i.e. Accidental Death/ Permanent Total Disablement/ Permanent Partial Disablement/ Temporary Total Disablement

D. Accidental Hospitalisation
If the Insured Person suffers an Injury during the Policy Year that requires the Insured Person's Hospitalisation for Inpatient Care, then We will reimburse the Reasonable and Customary charges for Medical Expenses incurred for the Inpatient Care of such Insured Person in India provided that the Hospitalisation commences within the same Policy Year. Our liability to meet Medical Expenses of Hospitalisation caused by such Accident will be limited to the Sum Insured of that Policy Year. This cover is independent of any claim under the Primary Covers and Our liability would be limited upto the Sum Insured mentioned in the Schedule.

The Insured Person can opt for Accidental Hospitalisation as a standalone cover. We shall reimburse such expenses up to a limit of Sum Insured as mentioned in the policy schedule subject to a maximum of Rs. 10 Lakhs.

E. Hospital Cash Allowance
If the Insured Person suffers an Injury during the Policy Year that requires that Insured Person's Hospitalisation for Inpatient Care, then We will make payment of the sum mentioned in the Schedule for each completed day of Hospitalisation in India, for a maximum period of 30 days per Policy Year mentioned in the Schedule provided that the hospitalisation commences within the same policy year.

F. Loan Protector
i. In the event of Us making a payment for Accidental Death or Permanent Total Disablement, We will also pay the sum mentioned in the Schedule against this benefit per month for the maximum period mentioned in the Schedule.
ii. We will also make payment towards this benefit for each completed month of Hospitalisation within India in the event of the Insured Person meeting with an Accident and getting hospitalized.

The maximum period for payment during the Policy Period shall be the number of months mentioned in the Schedule.

However, We reserve the right to pay the claim under this benefit as lump sum benefit.

G. Adaptation Allowance

If the Insured Person is required to modify his/her vehicle or make some changes in his/her house as necessitated by a Permanent Total Disablement which resulted from an Accident covered under this Policy, We shall reimburse such expenses up to a limit of 10% of the Permanent Total Disablement Sum Insured or as mentioned in the policy schedule, whichever is less, subject to a maximum of Rs. 50,000 provided We have paid the claim towards Permanent Total Disablement.

H. Family Transportation Allowance

Following an Injury which results in Accidental Death, Permanent Total or Permanent Partial Disablement benefit payable under this Policy, if the Insured Person is confined in a Hospital outside 100 kms of his normal place of residence and the attending Medical Practitioner recommends the personal attendance of Family member, We shall reimburse the expenses incurred for the immediate Family member for transportation by the most direct route by a licensed common carrier to the place of Hospitalization of the Insured Person. The maximum amount payable for this cover shall be limited to 10% of the Principal Sum Insured or as mentioned in the policy schedule, whichever is less, subject to maximum Rs 50,000/.

I. Broken Bones

If an Accident causes an Insured Person to suffer a fracture (a break in the continuity of a bone) and this is certified by a Specialist Medical Practitioner and also confirmed by imaging investigations such as by X-ray, then We will pay the percentage of the Sum Insured specified in the table below.

SN.	FRACTURE	%OF SUM INSURED
1	Injury to vertebral body resulting in spinal cord damage	100%
2	Pelvis	100%
3	Skull (excluding nose and teeth)	30%
4	Chest (all ribs and breast bone)	50%
5	Shoulder (collar bone and shoulder blade)	30%
6	Arm	25%
7	Leg	25%
8	Vertebra – vertebral arch (excluding coccyx)	30%
9	Wrist (Colles' or similar fractures)	10%
10	Ankle	10%
11	Coccyx	5%
12	Hand	3%
13	Finger	3%
14	Foot	3%
15	Toe	3%
16	Nasal Bone	3%
17	Any other broken bone	Percentage as assessed by registered Medical Practitioner

Specific Conditions

i. If an Insured Person suffers a fracture not mentioned in the table above, then We will assess

the fracture with Our medical advisors and determine the amount of payment to be made.

ii. Our maximum liability is limited to the Sum Insured, irrespective of the number of fractures caused by the same Accident.

iii. If a claim in respect of any fracture of a whole bone also encompasses some or all of its parts, Our liability to make payment will be limited to the whole bone only and not any of its parts.

Note: In this benefit:

- Pelvis means all pelvic bones, which shall be treated as one bone. The sacrum is part of the vertebral colum n.
- Skull means all skull and facial bones, (excluding nasal bones and teeth) which shall be treated as one bone.

J. Road Ambulance Cover

If the Insured Person suffers an Injury in India during the Policy Year and it is necessary to immediately transfer such person from the site of Accident to the nearest Hospital/ Day Care Centre/ Nursing Home by road in an ambulance offered by a healthcare or an ambulance service provider, then We shall reimburse the actual expenses of the transfer to the nearest Hospital or up to a maximum amount as mentioned in the Schedule, subject to a valid claim being admissible under the Primary Cover(s) of the Policy.

Specific Conditions

a. Expenses for road ambulance transportation are restricted within India only.

b. Return transportation to the Insured Person's home by ambulance is excluded.

k. Air Ambulance Cover

If the Insured Person suffers an Injury which causes emergency life threatening conditions during the Policy Year and it is necessary to immediately transfer such person from the site of Accident to the nearest Hospital/ Day Care Centre/ Nursing Home, then we will pay the expenses incurred for ambulance transportation in an airplane or helicopter for rapid ambulance transportation as set out in the Schedule.

Specific Conditions

i. Expenses for air ambulance transportation are restricted within India.

ii. Return transportation to the Insured Person's home by ambulance is excluded.

iii. Insured needs to make an intimation before availing the benefit under Air Ambulance Cover.

l. Adventure Sports Benefit

In case of Injury which causes Accidental Death or Permanent Total Disablement whilst engaged in Adventure sports in a non- professional capacity and under the supervision of a trained professional, during leisure trip, We will pay the Sum Insured as given in the Schedule under this benefit.

However, the Sum Insured for this cover shall be limited to 50% of Sum Insured under Accidental Death benefit to a maximum of ₹ 50,00,000/-.

m. Chauffeur Plan Benefit

If during the Policy Year, the Insured Person sustains an Injury and in the event of We making payment for a claim under Permanent Partial Disablement or Temporary Total Disablement, then We will pay the daily amount up to the Sum Insured upto a maximum of 30 days mentioned in the Schedule, for the hire of a taxi or chauffeur driven car or other necessarily incurred extra costs to maintain the Insured Person's mobility to meet his/her work/Occupational commitments.

Specific conditions applicable to Additional Covers section:

i. In case of claim paid under the Accidental Death or Permanent Total Disablement, the claim will also be paid under the respective
Additional Cover, in case opted, as per the terms and conditions of the policy.

ii. This Policy shall not be further renewed for the particular Insured Person on payment of a claim

for Accidental Death or Permanent Total Disablement and additional covers related to Accidental Death or Permanent Total Disablement. In case of long term policies with single premium payment option, in the event of claim for Accidental Death or Permanent Total Disablement of that insured person, in a particular policy year, the premium for the subsequent (unutilized) Policy Year(s), if any, shall be refunded. In case of long term policies with instalment option, please refer to Section E. ii. 12. xi. of the Policy Wordings.

D. EXCLUSIONS

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or attributable to anyof the following:

1. **Standard Exclusions**
   a. **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.
   b. **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.
   c. **Code- Excl12**
   Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
   d. **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.

2. **Specific Exclusions**

A. Applicable to all the sections

   e. Intentional self-Injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol).
   f. Mental or nervous disorder, anxiety, stress or depression.
   g. Accident while under the influence of alcohol or drugs.
   h. Participation in an actual or attempted felony, riot, crime, misdemeanor or civil commotion.
   i. Whilst engaging in aviation or whilst mounting in to, dismounting from or traveling in any aircraft other than as passenger (fare paying or otherwise) in any duly licensed standard type of aircraft.
   j. Curative treatments or interventions that the Insured Person carries out or have carried out on his body.
   k. Pregnancy and childbirth, miscarriage, abortion or complications arising out of any of these.
   l. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage or under the order of any government or public authority.
   m. Nuclear energy, radiation.
   n. Any existing disablement prior to the inception of the Policy.
   o. Any Medical Expenses, services, supplies or treatment or Hospital stay which were not recommended or approved as Medically Necessary Treatment by a Medical Practitioner.
   p. Expenses incurred for emergency medical evacuation, unless specifically insured.
   q. Any claim caused by osteoporosis (porosity and brittleness of the bones due to loss of protein from the bones matrix) or pathological fracture (any fracture in an area where Pre-Existing Disease has caused the weakening of the bone) or chronic degenerative diseases if osteoporosis or bone disease or chronic degenerative diseases diagnosed prior to the commencement date of the Policy.
   r. Expenses incurred on neck belts, wrist bandages, walking sticks, abdomen belts, CPAP and any other similar external aid /devices, the use of which has been necessitated following an accident.

s. Bodily Injury caused by or arising from terrorism, except in case where the policy holder is a victim of terrorist act and not abetting terrorism
t. Standard list of excluded items as mentioned in our website https//generalicentralinsurance.com
u. Treatment taken in any hospital or by any Provider that We have blacklisted, as mentioned in our website https://generalicentralinsurance.com/hospital-locator

B. Specific Exclusions for Accidental Hospitalisation

i. **Pre-hospitalization Medical Expenses** and **Post-hospitalisation Medical Expenses** are not covered.
ii. AYUSH are not covered.

C. Specific Exclusions for Hospital Cash Allowance

i. AYUSH are not covered.

3. **Exclusion shall be waived on payment of additional premium**

For Exclusion D 1. (a) related to Adventure sports– We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or attributable to whilst engaging in Adventure Sports

E. General Terms and Clauses:

i. Standard Terms and Clauses

1. **Disclosure to information norm:**
The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. **Condition Precedent to Admission of Liability**
The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. **Free Look Period**
The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/ migrating the policy.
The insured person shall be allowed free look period of 30 days from date of receipt of the policy document 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 person, 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;

4. **Migration**
The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on 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, the insured person will get all the accrued continuity benefits in waiting periods as per the IRDAI guidelines on migration.

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

5. **Complete Discharge**
Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6. **Multiple Policies**
a) In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person 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 chosen by the insured person 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.
b) Insured person 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 shall independently settle the claim subject to the terms and conditions of this policy.
c) If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
d) Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

7. **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 and the premium paid shall be forfeited.
Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an 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.

8. **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 effected.

9. **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. 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.

10. **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: GCIcare@generalicentral.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
https://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/

ii. Specific Terms and clauses

11. **Conditions applicable during the contract**

i. **Insured Person**

Only those person(s) named as an Insured Person in the Schedule shall be covered under this Policy. Any person may be added during the Policy Period as an Insured Person after his/her application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

ii. **Assignment and Transfer of Insurance Policies**

Any assignment or transfer of this Policy or any benefit thereunder shall be in accordance with the provisions of Section 38 of Insurance Act 1938, (as amended from time to time), which is set out as follows:

a) A transfer or assignment of this Policy, wholly or in part, whether with or without consideration, may be made by an endorsement upon the Policy itself or by a separate instrument, signed in either case by the transferor or by the assignor or his duly authorised agent and attested by at least one witness, specifically setting forth the fact of transfer or assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made.
b) The Insurer may, accept the transfer or assignment, or decline to act upon any endorsement made under sub-clause a) hereinabove, where it has sufficient reason to

believe that such transfer or assignment is not bona fide or is not in the interest of the Policy holder or in public interest or is for the purpose of trading of the Policy.

c) The Insurer shall, before refusing to act upon the endorsement, record in writing the reasons for such refusal and communicate e the same to the Policy holder not later than thirty days from the date of the Policy holder giving notice of such transfer or assignment.

d) Any person aggrieved by the decision of the Insurer to decline to act upon such transfer or assignment may within a period of thirty days from the date of receipt of the communication from the Insurer containing reasons for such refusal, prefer a claim to the IRDAI.

e) Subject to the provisions in sub-clause b) hereinabove, the transfer or assignment shall be complete and effectual upon the execution of such endorsement or instrument duly attested but except, where the transfer or assignment is in favour of the Insurer, shall not be operative as against the Insurer, and shall not confer upon the transferee or assignee, or his legal representative, any right to sue for the amount of such Policy or the moneys secured thereby until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or a copy thereof certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to and received by the Insurer with written acknowledgement by the Insurer:
Provided that where the Insurer maintains one or more places of business in India, such notice shall be delivered only at the place where the Policy is being serviced.

f) The date on which the notice referred to in sub-clause e) hereinabove is delivered to the Insurer shall regulate the priority of all claims under a transfer or assignment as between persons interested in the Policy; and where there is more than one instrument of transfer or assignment the priority of the claims under such instruments shall be governed by the order in which the notices referred to in sub-clause e) hereinabove are delivered:
Provided that if any dispute as to priority of payment arises as between assignees the dispute shall be referred to the IRDAI.

g) Upon the receipt of the notice referred to in sub-clause e) hereinabove, the Insurer shall record the fact of such transfer or assignment together with the date thereof and the name of the transferee or the assignee and shall, on the request of the person by whom the notice was given, or of the transferee or assignee, on payment of such fee as may be specified by the regulations, grant a written acknowledgement of the receipt of such notice; and any such acknowledgement shall be conclusive evidence against the Insurer that he has duly received the notice to which such acknowledgement relates.

h) Subject to the terms and conditions of the transfer or assignment, the Insurer shall, from the date of the receipt of the notice
referred to in sub-clause e) hereinabove, recognize the transferee or assignee named in the notice as the absolute transferee or assignee entitled to benefit under the Policy, and such person shall be subject to all liabilities and equities to which the transferor or assignor was subject at the date of the transfer or assignment and may institute any proceedings in relation to the Policy, obtain a loan under the Policy or surrender the Policy without obtaining the consent of the transferor or assignor or making him a party to such proceedings.
Explanation.—Except where the endorsement referred to in sub-clause a) hereinabove expressly indicates that the assignment or transfer is conditional in terms of sub-clause j) hereunder, every assignment or transfer shall be deemed to be an absolute assignment or transfer and the assignee or transferee, as the case may be, shall be deemed to be the absolute assignee or transferee respectively.

i) Any rights and remedies of an assignee or transferee of a policy of life insurance under an assignment or transfer effected prior to the commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by the provisions of this clause 4.

j) Notwithstanding any law or custom having the force of law to the contrary, an assignment in favour of a person made upon the condition that—

i. The proceeds under the Policy shall become payable to the Policy holder or the

Nominee or Nominees in the event of either the assignee or transferee predeceasing the Insured Person; or

ii. The Insured Person surviving the term of the Policy, shall be valid: Provided that a conditional assignee shall not be entitled to obtain a loan on the Policy or surrender a Policy.

k) In the case of the partial assignment or transfer of the Policy under sub-clause a) hereinabove, the liability of the Insurer shall be limited to the amount secured by partial assignment or transfer and such Policy holder shall not be entitled to further assign or transfer the residual amount payable under the same Policy.

iii. **Change of Occupation**

You will give Us notice of any change in the business or Occupation of any Insured Person within 30 days of such change and
We will issue an endorsement to this effect.

If at the time a claim arises under this Policy the Insured Person has changed his Occupation without Us being notified, then Our
maximum liability will be limited to the amount that would have been payable for the premium paid and the new Occupation.

iv. **Alterations to the Policy**

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by any one (including an insurance agent or broker) except Us, and any change We make will be evidenced by a written endorsement signed and stamped by Us.

v. **Cancellation**

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

b) The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

i. In case the Policy Period is one year, the Company shall refund premium for the unexpired policy period as detailed below.

Policy Period	Premium retained (% of annual rate)
Up to 1 month	20%
Up to 3 months	40%
Up to 6 months	75%
Up to 9 months	90%
Exceeding 9 months	100%

ii. In case the **Policy Period** exceeds one year, We shall refund premium on a pro-rata basis by reference to the time period for which cover is provided, subject to a minimum retention of premium of 25%.

c) The Company may cancel this **Policy** by giving **You** at least 15 days written notice, and if no claim has been made then **We** shall refund a pro-rata premium for the unexpired **Policy Period**.

d) Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

vi. **Policy Period**

a) The Policy can be issued for tenure of 1 year, 2 years, 3 years.
b) For providing coverage to specific events, the Policy can also be issued for less than 1 year

vii. **Communication**

1. You/Insured Person should send any communication meant to Us in writing to Our address shown in the Schedule.
2. We will send any communication meant to You/Insured Person (as the case may be) to the address shown in the Schedule.
3. We have agreed to issue this Policy based on the Occupation of the Insured Person that You have declared to Us while taking this Policy. If there is change in Occupation then You must tell Us in writing within 30 days of the change by filling a fresh Proposal. If You do not do this, then this Policy will cease as far as that Insured Person is concerned from the date of change of Occupation.

viii. **Compliance with Policy Provisions**

Failure by You or the Insured Person to comply with any of the provisions in this Policy may invalidate all claims here under.

ix. **Territorial Limits And Law**

a. We cover Injury sustained by the Insured Person during the Policy Period anywhere in the world (subject to the travel and other restrictions that the Indian Government may impose), but We will make payment within India and in Indian Rupees.
b. For sections - Accidental Medical Expenses, Accidental Hospitalisation and Hospital Cash Allowance, we will make payment for expenses incurred in India & in Indian rupees only.
c. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian Law.

x. **Special Conditions applicable for Policies Issued with Premium payment on Instalment basis**

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. 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.
ii. No interest will be charged If the instalment premium is not paid on due date.
iii. In case of instalment premium due not received within the grace period, the policy will get cancelled and a fresh policy will be issued.
iv. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
v. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
vi. In case of any claim, an amount equivalent to the balance of the instalment premiums payable in the Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person. In such case where the balance instalment premium is recovered, the policy shall continue for the remaining policy year.
vii. If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered.
viii. In the event of claim for Accidental Death or Permanent Total Disablement of the insured person, in a particular Policy Year, the policy shall not continue for subsequent Policy Year(s) and further instalment premium shall not be applicable.

12. **Condition when a Claim arises**

i. Claims Procedure

If the Insured Person meets with an Injury that may result in a claim, then

a. The Insured Person must immediately consult a Medical Practitioner and follow the Medical Advice and treatment that he recommends.
b. The Insured Person or someone claiming on his/her behalf must inform Us in writing immediately and in any event within 15days.
c. The Insured Person must take reasonable steps immediately or at the earliest possible to lessen the consequences of his/her Injury.
d. The Insured Person or someone claiming on his/her behalf must promptly give Us the documentation and other information We ask for to investigate the claim for Our obligation to make payment for it.
e. The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.
f. In case of the Insured Person's death, the Nominee must inform Us in writing immediately and send Us a copy of the post-mortem report, FIR or any other document that We ask for within 15 days.
g. We will make claim payment to the Insured Person or his/her Nominee, as the case may be. Any payment We make in good faith in this way will be a complete and final discharge of Our liability to make payment for the claim.

ii. **Settlement of Claim**

a. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
b. In the case of 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.
c. 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.
d. 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.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)
e. Pending claims will be asked for submission of incomplete documents.
f. Rejected claims will be informed to the Insured Person in writing with reason for rejection.
g. We will make claim payment to You or the Insured Person who met with the Accident.
h. Any payment We make in good faith in this way will be a complete and final discharge of Our liability to make payment for the claim.
i. We will make all claim payments in Indian rupees within India only.

iii. Claims Procedure applicable only for Accidental Hospitalisation section

If Insured Person meets with any Injury that may result in a claim, then as a Condition Precedent to Our liability, the Insured Person must comply with the following:

a. Insured Person must give Notification of Claim in writing immediately, and in any event within 48 hours of the aforesaid Injury. Insured Person must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.
b. Insured Person must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation (written details of the quantum of any claim along with all original supporting documentation, including but not limited to first cons ultation letter, original vouchers, bills and receipts, birth/ death certificate (as applicable)) and other information We ask for to investigate the claim or in relation to Our obligation to make payment for it.

c. The periods for intimation or submission of any documents as stipulated under (a), and (b) will be waived in case of any hardships being faced by the Insured Person or his representative which is supported by some documentation.

iv. Claim Documents

The Insured / Insured Person or his / her legal representatives as the case may be, is required to submit the following documents while lodging a claim under the Policy. The documents mentioned below are an indicative list. Additional documents may be asked, if required, for specific claims.

Photocopies of any document submitted must be attested by the Generali Central Insurance Company Branch Manager/ Gazetted Officer.

- Duly Completed Personal Accident Claim Form signed by Insured/ Nominee along with completely filled Attending Physician's Statement
- Photocopy of Policy Schedule
- Copies of medical documents supporting the accidental injury and treatment taken related to the same
- Disability Certificate
  - For Physical Disabilities related with separation of limbs or complete loss of organs - Copy of Disability Certificate issued by Orthopedic Surgeon mentioning the type and percentage of disability
  - For Physical Disabilities NOT related with separation of limbs or complete loss of organs - Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel only
  - For Non - Physical Disabilities - Copy of Disability Certificate issued by a Government Doctor / Disability Board / Panel only for the related speciality (e.g. Loss of memory, sense organs, vision, hearing etc.)
- Original Investigation Reports and copies of reports, X - Ray films supporting the accidental injury. Post-Operative X-ray films, if any
- Photographs of the Insured Person highlighting the injury / disability
- Copy of FIR / MLC (if registered)/ Panchnama, wherever applicable
- Leave Records with seal and signature of Authorized signatory of the organization specifying the period of leave and reason for the same
- Copy of Photo ID and Address Proof of Insured Member for whom Claim is lodged
- Copy of Photo ID, Address Proof and Recent Photograph of Proposer *(if claimed amount is above INR 1 Lakh).*
- Copy of Death Summary, Treatment Papers & Investigation Reports, in case of Death Claim
- Copy of Death Certificate, in case of Death Claim
- Copy of Post Mortem / Viscera Report, in case of Death Claim
- Copy of Final Police Investigation Report, in case of Death Claim
- Photographs and Newspaper reports related to the accident, in case of Death Claim
- Original Discharge Summary of Hospital mentioning the date of admission, date of discharge, presenting complaints with duration, clinical condition, detailed line of treatment, final diagnosis and past medical and surgical history with duration, wherever applicable
- Original final hospital bill for hospitalization period, with pre numbered paid receipt with hospital seal and signature of authorized signatory, wherever applicable
- Original pharmacy bills along with copies of prescriptions, wherever applicable
- Legal Heir Certificate containing affidavit and indemnity bond both duly signed by all legal heirs and notarized (*Mandatory* if Nominee name is not mentioned on policy schedule)

Claim Documentation Specific to Deaths/Disappearance/Coma Arising out of Causes Mentioned Below in Addition to above documentation

- **Driving -** Valid Driving License
- **Drowning -** In case the body is not found, then after an interval of 1 year from the date of loss,

certificate issued by the appropriate authority that the member has died due to drowning is required.

- **Fire -** If the body is completely charred to ashes, certificate issued by the appropriate authority that the member has died due to fire will be required.
- **Stroke of Lightning or Electric Shock -** Report from the Electricity Supply Department certifying that the death is due to an electric shock
- **In case of claim for Disappearance of Civilian Aircraft:** Boarding/ Travel certificate from Registered Airlines mentioning necessary details , on letterhead with seal and signature of authorized signatory
- **Coma:** Certificate from Treating Neurophysician, on letterhead with seal and signature and Registration number, mentioning severity of Coma as specified and comatose state extending beyond 180 days, necessitating ICU care.

Air Ambulance cover:

- Original pre-numbered paid receipt and bill for availing Ambulance services
- Copy of registration certificate for Air ambulance

Broken Bones:

- X-ray/MRI/CT scan/any other radiological investigation films and reports supporting diagnosis.
- Other medical documents as per Temporary Total Disability check list, as above.

Family Transportation Allowance:

- Certificate from treating consultant recommending the personal attendance of one immediate family member.
- Original pre-numbered paid receipt and bill/ ticket for transportation of family member by most direct route and by licensed common carrier.

For claims for Accidental Burns:

- Certificate from Treating Consultant on his letterhead with seal and signature with registration number mentioning % of Burns as per rule of Nine and degree of burns sustained.

Chauffeur Plan cover:

- Original pre-numbered paid receipt and bill for hiring licensed Chauffer and/ or Taxi services, for Chauffeur Plan cover

13. **Conditions for renewal of the contract**

Renewal of Policy

a. The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
b. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
c. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
d. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
e. 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.
f. Coverage is not available during the grace period.
g. No loading shall apply on renewals based on individual claims experience
h. The premium rates/ per mille rates as shown in the prospectus/ brochure 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. If **You Renew** this **Policy** with **Us** within 30 days of expiry of the **Policy**, **We** shall give **You** a **Cumulative Bonus** which shall be a 5% increase on the **Base Sum Insured** for each continuous and claim free **Policy Year**. The maximum increase shall be 25% of the **Base Sum Insured** including if **Your** policy has been ported to **Us**. **You** will be eligible for **Cumulative Bonus** only if the **Schedule** specifies that this option is in force.
j. In case a claim is made during a **Policy Year**, the **Cumulative Bonus** would reduce by 5% in the

following year. However the Base
Sum Insured will be maintained at all times.

k. If any **Dependent Child** has completed 25 years at the time of **Renewal**, then such person can be covered under a separate policy. The
Cumulative Bonus will be passed on to the separate policy taken by such person
l. No increase/ decrease in Sum Insured during the currency of the **Policy**. However increase/decrease in Sum Insured or change in cover, addition/deletion of Insured Persons, etc will be allowed at the time of Renewal of the Policy. **You** can submit a request for the changes by filling the **Proposal** before the expiry of the Policy.

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
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GRIEVANCE REDRESSAL PROCEDURE

Dear Customer,
At Generali Central Insurance, we continuously strive for service excellence to give you exceptional customer experience. This helps us build trust and long-term relationship with you.

We request you to read the policy document including the terms and conditions carefully. This will help you understand your plan and drive maximum benefits. We want to ensure the plan is working for you and welcome your feedback.

What is a grievance?

"Complaint" or "Grievance" means written expression (includes communication in the form of electronic mail or voice based electronic scripts), of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.

“Complainant” means a policyholder or prospect or any beneficiary of an insurance policy who has led a complaint or grievance against an insurer or a distribution channel.

We are always here for your help. You may use any of the following channels to reach us-

Helpline	Website	Email	Branch GRO	Complaint Form
Call us on **1800 220 233/ 1860 500 3333/022-67837800** Senior citizens can avail priority support by choosing the senior citizen option from the helpline menu.	**Click here to know more**	**Write to us at** **GCIcare@generalicentral.com** Senior citizens can avail priority support by writing to care.assure@generalicentral.com	**Click here** to know your nearest branch.	**Click here** to raise complaint.

By when will my grievance be resolved?

- You will receive grievance acknowledgement from us immediately for your complaint.
- Final resolution will be shared with you within 2 weeks of receiving your complaint.
- Your complaint will be considered as closed if we do not receive any reply from you within 8 weeks from the date of receipt of response.

How do I escalate my complaint if I don't receive a response on time?

- You may write to our Grievance Redressal Officer at **GCIGRO@generalicentral.com**
- You may send a physical letter to our Grievance Redressal Cell, Head Office at the below address:
  GENERALI CENTRAL INSURANCE COMPANY LIMITED (Formerly known as Future Generali India Insurance Company Limited)
  Lodha I – Think Techno Campus, B Wing – 2nd Floor, Pokhran Road – 2, Off Eastern Express Highway Behind TCS, Thane West – 400607

GRIEVANCE REDRESSAL PROCEDURE

What if I am not able to register my grievance?

You can comfortably raise a grievance via any of the above-mentioned avenues. If you face any challenge, you may write to the provided email IDs for help.

If you still face any challenge, you may use any of the below options to raise a complaint with the Insurance Regulatory and Development Authority of India (IRDAI).

- Call on toll-free number: **155255**
- **Click here** to register complaint online

Is there any special provision for senior citizen to raise grievance?

We understand our customers and their needs. Thus, have a separate channel to address the grievances of senior citizens. The concerns will be addressed to the senior citizen's channel **(care.assure@generalicentral.com)** as complaints for faster attention or speedy disposal of grievance, if any.

Insurance Ombudsman:

If you are still dissatisfied with the grievance redressal, you may approach the Office of the Insurance Ombudsman located in your vicinity, provided the same is under their purview. The guidelines for taking up a complaint with the Insurance Ombudsman, are available on the website a **(https://www.cioins.co.in/About**) of the Insurance Ombudsman. **Click here** to access the list of insurance Ombudsman offices.

You can also lodge an online complaint through the website of the Council for Insurance Ombudsmen (CIO): **https://www.cioins.co.in/**