PART - A

Date:<_____>

Name of the Master Policyholder:
Address of the Master Policyholder:

Sub.: Your Policy No. <<_____>> - Edelweiss Life – Group Total Secure (A Group, Non-Linked, Non-Participating, Pure Risk Premium, Life, Credit Insurance Product)

Thank you for choosing Edelweiss Life as your preferred life insurance partner.

We are confident that the product chosen by you will suit your need.

Policy Document:
We have prepared your Policy Document on the basis of the Proposal Form submitted by you. We request you to go through the enclosed Policy Document in detail and check for accuracy of information. A copy of your Proposal Form as submitted by you, Customer Information Sheet (CIS) and other related documents (if any) are enclosed along with this Policy Document for your information and records.

In case you are keen to know more about your Policy or you need any further assistance, you may contact your salesperson who advised you while purchasing this Policy at the below details:

Name of the PFA / Corporate Agent/ Relationship Manager/ Broker	Code/License No.	Contact Details

Alternatively, you may contact our Service Expert at 1800 2121 212 or email us at Corp-Care@edelweisslife.in

Cancellation in the Free Look Period by Master Policyholder:

You have a Free Look period of *thirty (30) days* from the date of receipt of the Policy Document, whether received electronically or otherwise, to review the terms and conditions of this Policy. If you disagree with any of the terms or conditions, or otherwise, and you have not made any claims, you may return this Policy for cancellation to us by giving us written reasons for your objection within the said Free Look period. We will refund the Premium received after deducting stamp duty charges, proportionate risk premium for the period of cover and expenses incurred by us on medical examination (if any) of the Insured Member(s).

To exercise the Free Look option, you would need to send the Policy Document along with a request letter to us at our Corporate Office address provided below. You are required to maintain the acknowledgement received from the Company as a proof of submission.

Cancellation in the Free Look Period by Insured Member:

Insured Member has a Free Look period of *thirty (30) days* from the date of receipt of the Certificate of Insurance, whether received electronically or otherwise, to review the terms and conditions of the Certificate of Insurance. If the Insured Member disagrees with any of the terms or conditions, or otherwise, and he/she has not made any claims, he/she may return the Certificate of Insurance for cancellation to us by giving us written reasons for your objection within the said Free Look period. We will refund the Premium received after deducting stamp duty charges, proportionate risk premium for the period of cover and expenses incurred by us on medical examination (if any) of the Insured Member.

To exercise the Free Look option, you would need to send the Certificate of Insurance along with a request letter to us at our Corporate Office address provided below. You are required to maintain the acknowledgement received from the Company as a proof of submission.

We look forward to serve you.

Regards,

For **Edelweiss Life Insurance Company Limited**
Authorised Signatory

Registered & Corporate Office Address: 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai 400070

Edelweiss Life Insurance Company Limited
(formerly known as Edelweiss Tokio Life Insurance Company Limited)
Registered & Corporate Office: 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai 400070.

Policy Document - Edelweiss Life Group Total Secure

(A Group, Non-Linked, Non-Participating, Pure Risk Premium, Life, Credit Insurance Product)

UIN No: 147N059V03

POLICY PREAMBLE

This document is the evidence of a contract of insurance between Edelweiss Life Insurance Company Limited ('the Company') and the Master Policyholder as described in the Policy Schedule given below. This Policy is based on the Proposal made by the within named Master Policyholder and submitted to the Company along with the required documents such as signed quotation sheet, Member Data, declarations, statements, other information. This Policy is effective upon receipt and realisation, by the Company, of the consideration payable under the Policy. This Policy is written under and will be governed by the applicable laws in force in India and all Premiums and Benefits are expressed and payable in Indian Rupees.

POLICY SCHEDULE

Policy Number	Product Name and UIN
<< >>	Edelweiss Life – Group Total Secure <<147N059V03>>

Name of the Master Policyholder	
<< >>	

Address of the Master Policyholder

POLICY DETAILS	
Nature of Scheme/Type of Loan	<< >>
Available Plan Option	<<Life Cover | Life Cover with Terminal Illness>>
Available Coverage Type	<<Level Sum Assured | Decreasing Sum Assured>>
Policy Commencement Date	<<dd/mm/yyyy>>
Available Member Coverage Details	<<Single Life | Joint Life>>
Minimum | Maximum Age at Entry – 'Life Cover'	Minimum - << >> years | Maximum - << >>years
Minimum | Maximum Age at Entry – 'Life Cover with Terminal Illness'	Minimum - << >> years | Maximum - << >>years
Minimum | Maximum Age at end of Coverage Expiry Date – 'Life Cover'	Minimum - << >> years | Maximum - << >>years
Minimum | Maximum Age at end of Coverage Expiry Date – 'Life Cover with Terminal Illness'	Minimum - << >> years | Maximum - << >>years
Minimum Premium (per Insured Member)	Rs. << >>
Maximum Premium (per Insured Member)	As per the Board Approved Underwriting Policy of the Company
Minimum Base Sum Assured (per Insured Member)	Rs. << >>
Maximum Base Sum Assured (per Insured Member)	Life Cover - As per the Board Approved Underwriting Policy of the Company | Life Cover with Terminal Illness – Rs.<< >>
Minimum Coverage Term	Single Pay - << >> years | 5 years - << >> years | 7 years - << >> years | 10 years - << >> years | Regular Pay - << >> years
Maximum Coverage Term	<< >> years
Available Premium Paying Option*	<<Single Pay | Limited Pay – 5 years | Limited Pay – 7 years | Limited Pay – 10 years | Regular Pay>>
Available Premium Paying Frequency#	Annually, Semi Annually, Quarterly, Monthly

* Regular Pay is available only with Coverage Type – Level Sum Assured

Applicable only for Limited Pay and Regular Pay

ADDITIONAL BENEFIT INFORMATION								
Benefit Type	Age at Entry		Sum Assured (per Insured Member)		Coverage Term		Age at end of Coverage Expiry Date	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Accidental Death Benefit	<< >> years	<< >> years	Rs. << >>	Rs. << >>	<< >> years	<< >> years	<< >> years	<< >> years

Critical Illness Benefit	<< >> years	<< >> years	Rs. << >>	Rs. << >>	<< >> years	<< >> years	<< >> years	<< >> years
Total and Permanent Disability Benefit	<< >> years	<< >> years	Rs. << >>	Rs. << >>	<< >> years	<< >> years	<< >> years	<< >> years

Stamp Duty of Rs. /- is paid as provided under Article 47 (D) of Indian Stamp Act, 1899 and included in Consolidated Stamp Duty Paid to the Government of Maharashtra Treasury vide Order of Addl. Controller Of Stamps, Mumbai at General Stamp Office, Fort, Mumbai - 400001., vide this Order No.(LOA/CSD/ /2021/Validity Period Dt. / / To Dt. / / (O/w.No.)/Date : / /).

For **Edelweiss Life Insurance Company Limited**

Authorised Signatory
This Policy Document is signed using a digital signature for and on behalf of Edelweiss Life Insurance Company Limited.

We request you to go through the Policy Document and check for the accuracy of information provided therein. In case you notice any mistake you may return the Policy Document to us for necessary correction.

PART - B

DEFINITIONS

Defined Term	Meaning
Accident:	means sudden, unforeseen and involuntary event caused by external, visible and violent means.
Age/ Age at Entry:	means the age (last birthday) of Insured Member in completed years and as stated in the Certificate of Insurance issued to the Insured Member.
Annualized Premium	Annualized premium shall be the premium amount payable in a year excluding taxes, rider premiums, underwriting extra premiums and loadings for modal premiums.
Appointee:	means the person registered with us in the Nomination Schedule in Certificate of Insurance who is authorised to receive and hold in trust the benefits under the Insurance Cover on behalf of the Nominee/(s), if the Nominee/(s) is/are less than Age 18 on the date of payment.
Benefit Schedule:	means the table as provided in the Certificate of Insurance that defines the Sum Assured applicable at each month during the Coverage Term and which is payable on happening of death and/or any contingent event covered.
Certificate of Insurance:	means the certificate issued by us to the Insured Member evidencing the Coverage/(s) under the Insurance Cover in this Policy.
Claimant:	means the person entitled to receive the Coverage benefits and includes the nominee/the legal heir/the legal representative/s, or the holder of succession certificate as the case may be.
Coverage Commencement Date:	means the date as mentioned in the Certificate of Insurance issued to each Insured Member and when the Coverage for the Insured Member starts.
Coverage:	means the cover provided with respect to Plan Option and Additional Benefits, if any, chosen by the Insured Member under the Insurance Cover as specified in the Certificate of Insurance.
Coverage Term:	means the period specified in Certificate of Insurance with respect to Plan Option and Additional Benefits, if any, chosen by the Insured Member during which the respective Coverage continues.
Death Benefit:	means the Benefits which would be payable on death of the Insured Member and as specified in the Policy Document and Certificate of Insurance.
Grace Period:	means a period of fifteen (15) days for monthly Premium Paying Frequency and thirty (30) days for other Premium Paying Frequencies from the Premium Paying Due Date specified in the Certificate of Insurance, for the payment of Modal Coverage Premium, without any penalty/late fee, during which the Insurance Cover is considered to be In-Force.
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.
In-Force:	means the status of the Coverage during the respective Coverage Term when all the due Modal Coverage Premiums have been paid or the Insurance Cover is not in a state of discontinuance.
IRDAI / Authority:	means Insurance Regulatory and Development Authority of India.
Insurance Act:	means The Insurance Act, 1938 as amended from time to time.
Insurance Cover:	means the contract of insurance as evidenced in the Certificate of Insurance for various Coverages chosen by the Insured Member under this Policy.
Insured Member:	means a Member admitted to the benefits under the Policy, for whom the risk is accepted by us and the Certificate of Insurance has been issued.
Master Policyholder /	means or refers to the Policyholder stated in the Policy Schedule and who is also the group administrator and whose Members are insured under this Policy.

Policyholder / You / you / Your / your:	
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 its scope and jurisdiction of license. The Medical practitioner should not be • The policyholder/insured person himself/herself; or • An authorised insurance intermediary (or related persons) involved with selling or servicing the insurance contract in question; or • Employed by or under contractual engagement with the insurance company; • Related to the policyholder/insured person by blood or marriage.
Member:	means the person who has - i. enrolled in the Scheme and ii. met the eligibility criteria specified under this Policy
Member Enrolment Form:	means the form submitted by the Member to us through the Master Policyholder containing details of the Insured Member on the basis of which the Company shall provide Insurance Cover to such Insured Member under the Policy.
Modal Coverage Premium:	means the contractual premium amount applicable for each Coverage opted by the Insured Member under the Insurance Cover payable to us by the Premium Paying Due Dates, at the Premium Paying Frequency and as stated in the Certificate of Insurance.
Nominee:	means the person/(s) registered with us as Nominee/(s)in the Nomination Schedule in the Certificate of Insurance who has/have been nominated by the Insured Member in accordance with the Section 39 of the Insurance Act, 1938 as amended from time to time.
Policy:	means the contract of insurance as evidenced by this Policy Document including the Proposal Form, the Member Enrolment Form, the Schedule/(s), the Certificate of Insurance and any other information/document/(s) provided to/by us in respect of the Proposal Form and any endorsement issued by us.
Policy Document:	means this entire document from Part A to Part G
Policy Commencement Date:	means the date as shown in the Policy Schedule from which the Policy commences.
Policy Schedule:	means the Schedule and any endorsements attached to and forming part to this Policy and if any updated Schedule is issued, then the Schedule latest in time.
Proposal Form:	means the signed and dated form and any accompanying declarations or statements submitted to us by the Master Policyholder, as applicable for the purpose of obtaining this Policy.
Regulations:	means the IRDAI (Insurance Products) Regulations 2024 and any other applicable laws issued and as may be amended from time to time.
Revival:	means restoration of the policy, which was discontinued due to the nonpayment of premium, by the insurer with all the benefits mentioned in the policy document, with or without rider benefits if any, upon the receipt of all the premiums due and other charges or late fee if any, during the revival period, as per the terms and conditions of the policy, upon being satisfied as to the continued insurability of the insured or policyholder on the basis of the information, documents and reports furnished by the policyholder, in accordance with Board approved underwriting policy.
Revival Period:	means the period of five consecutive complete years from the Discontinuance Date.
Scheme:	means the scheme as described in the Policy Schedule

Surrender:	means the complete withdrawal or termination of the entire policy contract.
Unexpired Risk Premium Value:	means an amount, if any, that becomes payable on Surrender of the policy during its term, in accordance with the terms and conditions of the policy.
Survival Period:	means the period of time after the date of diagnosis of Critical Illness that the Insured Member has to survive to become eligible for benefit payment under the Critical Illness Benefit.
Total Premiums Paid:	Total premiums paid means total of all the premiums paid under the base product, excluding any extra premium and taxes, if collected explicitly.
Terminal Illness:	means an advanced or rapidly progressing incurable disease where, in the opinion of two appropriate independent Medical Practitioners, life expectancy is no greater than six (6) months from the date of notification of claim. The Insured Member must not be receiving any form of treatment other than palliative medication for symptomatic relief.
Waiting Period:	means the period starting from either Coverage Commencement Date or date of Revival of the Insurance Cover, whichever is later, during which no Critical Illness Benefit is payable.
We/we/Our/Us/us/ Company:	means Edelweiss Life Insurance Company Limited.

PART - C

BENEFITS

1. Enrolment Process:

A Member may apply for Insurance Cover to the Company through the Master Policyholder by completing the following process –

A. By submitting the Member Enrolment Form along with the satisfactory evidence of insurability. Notwithstanding the aforesaid, the Company may, at its discretion, require medical and/or other additional information in respect to the Insured Member.

B. If the total proposed Sum Assured (for each Coverage) combined with amounts already insured or proposed to be insured under other policies issued by the Company exceeds the Non-Medical limits as determined under the Board approved underwriting policy of the Company, then it is required for the Insured Member to undergo medical examination.

C. The maximum Sum Assured at inception is restricted to the loan amount.

D. The maximum Coverage Term shall be less than or equal to loan tenure.

E. If any person that was previously covered as an Insured Member under this Policy, wishes to re-apply for Insurance Cover, then the request for enrolment shall be considered only if that person is a Member on the date of enrolment and the Insurance Cover is accepted in accordance with the provisions set out above.

F. If an Insured Member applies for a new/additional Insurance Cover, a separate Certificate of Insurance will be issued to the Insured Member for the purpose of this Policy.

G. Notwithstanding anything to the contrary contained in this Policy, the Insurance Cover in respect of the Member shall commence only upon acceptance of the Insurance Cover by the Company through issuance of a Certificate of Insurance in respect of such Member.

In the application for grant of Insurance Cover in respect of a Member, the Policyholder is required to provide the true and correct information in respect of such Member, as it may be required by the Company from time to time.

We reserve the right to refuse to grant Insurance Cover without assigning any reason in respect to the Member that represent a sub-standard risk as determined by the Company based on evidence of health and other information received by the Company during the enrolment process.

2. Register of Insured Members:

A. The Policyholder shall maintain a register of Insured Members which shall have all their details. This register shall form an integral part of this Policy.
B. We reserve the right to inspect the register of Insured Members at anytime.
C. A person's name can be removed from the register at any time if he ceases to be an Insured Member. If it is discovered that a person included in the register is not a Member of the scheme or has ceased to be a Member of the scheme, the person's name will be removed from the register.

3. Benefit on Death and other Contingent Events:

Benefits will be paid only if the Insured Member Insurance Cover is In-Force and if the occurrence giving rise to the claim takes place within the Coverage Term.

The Insured Member can choose the Coverage Type, Plan Option and the Additional Benefits within the Coverage Type, Plan Option and the Additional Benefits opted by the Master Policyholder and as set out in the Policy Schedule of the Policy. The premium amount for each Insured Member will vary as per the options chosen by the Insured Member.

Benefit amount payable will depend on the Coverage Type, Plan Option and the Additional Benefits opted by the Insured Member and as specified in the Certificate of Insurance. The Additional Benefits can be chosen only at inception of the Policy.

A. Coverage Type –

Based on the Coverage Type chosen by the Insured Member the Certificate of Insurance will specify the benefit payable on death and/or on applicable contingent event. The Coverage Type for Additional Benefits, if any would be same as that of Plan Option chosen by the Insured Member.

Following are the two Coverage Types. The Coverage Type/(s) will have to be chosen at inception of the Policy.

a) Level Sum Assured
Under this Coverage Type, Sum Assured payable at any point in time in case of death and/or any other contingent event would remain level throughout the Coverage Term.

b) Decreasing Sum Assured
Under this Coverage Type, the Sum Assured chosen by the Insured Member which is payable in case of death and/or any other contingent event, decreases during the Coverage Term as per the Benefit Schedule (as detailed below) provided in the Certificate of Insurance.

Benefit Schedule
The Benefit Schedule will be provided in the Certificate of Insurance issued to each Insured Member. It will define the Sum Assured applicable at each month during the Coverage Term and will be payable on happening of death and/or any contingent event covered under the plan.

The benefits will be paid exactly as per the Benefit Schedule provided by us at inception, irrespective of the actual outstanding loan, if any. In case if the Insured Member defaults on the EMI (Equated Monthly Instalment) or in case of any part pre-payment, the benefit payable on happening of death and/or any contingent event will be as per the Benefit Schedule provided in the Certificate of Insurance at the outset. In case of full pre-payment, The Insured Member also has an option to continue the Insurance Cover or surrender the Insurance Cover for the applicable Unexpired Risk Premium Value.

The applicable Sum Assured during the month will be same as the Sum Assured at the beginning of the month. However, the Modal Coverage Premiums will be level throughout the Premium Paying Term, wherever applicable.

The Benefit Schedule will be based on the Coverage Type. Similarly, for Additional Benefits there will be separate Benefit Schedules.

Moratorium Period
The moratorium period is a repayment holiday during the loan tenure. During the moratorium period, the accrued interest is assumed to be paid separately by the Insured Member to the Master Policyholder, and the Sum Assured would remain the same during the moratorium period and would start decreasing from the end of the moratorium period when the repayment/EMIs would commence. Moratorium period is applicable for Decreasing Sum Assured Coverage Type only.

The minimum moratorium period available is 6 months and the maximum moratorium period is 7 years, however it should be lower than the loan tenure. The moratorium period can be chosen in the interval of 6 months only, subject to the minimum and maximum moratorium period.

B. Plan Option -

No.	Plan Option	Applicable Benefit	Amount Payable
(a)	Life Cover	Death Benefit	In the event of death of the Insured Member, while the Coverage is In-Force, the Sum Assured as per the Benefit Schedule applicable as on the date of death will be payable. The Coverage will terminate once the Death Benefit is paid.
(b)	Life Cover with Terminal Illness	Death Benefit and Terminal Illness	In the event the Insured Member is diagnosed with a Terminal Illness while the Coverage is In-Force, the Sum Assured as per the Benefit Schedule as on the date of diagnosis of Terminal Illness will be payable and the Coverage will be terminated. In case if the Insured Member is not diagnosed with Terminal Illness during the Coverage Term, then on death of the Insured Member, while the Coverage is In-Force, Sum Assured as per the Benefit Schedule applicable as on the date of death is payable. The Terminal Illness must be diagnosed and confirmed by two Medical Practitioners. The Medical practitioner should be a specialist from that field of medicine for which the Terminal Illness is been claimed. The Company reserves the right for an independent assessment by a different Medical Practitioner other than the two Medical Practitioners whose diagnosis has been provided by the Insured Member. The Insured Member will not be entitled to any Terminal Illness benefit - If it is caused directly or indirectly due to or occasioned, accelerated or aggravated by intentional self-inflicted injury or attempted suicide, whether medically sane or insane.

Note:
The minimum death benefit or health cover for other than single premium shall be at least 105% (one hundred and five percent) of the total premiums paid up to the date of occurrence of covered contingency.

C. Joint Life Coverage

This plan allows for an option to cover 2 Insured Members, subject to insurable interest is clearly established. Joint Life option is available only if the Plan Option opted for is 'Life Cover' and no additional benefit/s are chosen.

In case of death of either of the joint Insured Members, the Sum Assured as per the Benefit Schedule as applicable on the date of death will be paid on first death basis and the Coverage will be terminated for both the lives. The applicable Sum Assured to be paid out as death benefit will not exceed the amount specified in the Benefit Schedule under any circumstance.

Note:
The minimum death benefit or health cover for other than single premium shall be at least 105% (one hundred and five percent) of the total premiums paid up to the date of occurrence of covered contingency.

D. Additional Benefits

The Plan Options can be further enhanced with Additional Benefits. The Insured Member can choose to add these Additional Benefits only at inception of the Coverage by paying additional premium. Following are the Additional Benefits offered under this Policy–

a) Accidental Death Benefit
b) Total and Permanent Disability Benefit
c) Critical Illness Benefit

The Insured Member can choose multiple Additional Benefits and, in any combination, however combining of Critical Illness and Total Permanent Disability is not permissible.

Note:
The minimum death benefit or health cover for other than single premium shall be at least 105% (one hundred and five percent) of the total premiums paid up to the date of occurrence of covered contingency.

a) Accidental Death Benefit -

If the Insured Member has opted for Accidental Death Benefit, then in the event of death of the Insured Member due to an Accident, while the Accidental Death Benefit Coverage is In-Force we shall pay an additional Sum Assured as per the Benefit Schedule for Accidental Death Benefit applicable as on the date of death.

Accidental Death shall mean death

i. which is caused by bodily Injury resulting from an Accident and
ii. which occurs due to the said bodily Injury solely, directly and independently of any other causes and
iii. which occurs within 180 days of the occurrence of such Accident during the Coverage Term while the Coverage is in-force. In case of occurrence of death after the expiry of the Coverage Term, Accidental Death Benefit shall not be paid.

Exclusions for Accidental Death Benefit:

Accidental Death benefit shall not be paid on death of the Insured Member occurring directly or indirectly as a result of (any of the following):

1. Intentional self-inflicted injury, attempted suicide, while sane or insane;
2. Insured person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a Doctor;
3. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes;
4. Taking part in any naval, military or air force operation during peace time or during service in any armed forces or paramilitary organization;
5. Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline or Pilots and cabin crew of a commercial airline, on regular routes and on a scheduled timetable;
6. Participation by the insured person in a criminal or unlawful act with illegal or criminal intent;
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee jumping;
8. Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

b) Total and Permanent Disability Benefit –

If the Insured Member has opted for Total and Permanent Disability Benefit, then in the event of occurrence of Total and Permanent Disability due to Accident or sickness, while the Total and Permanent Disability Coverage is In-Force we shall pay an additional Sum Assured as per the Benefit Schedule for Total and Permanent Disability Benefit applicable as on the date of disability.

Total and Permanent Disability means disablement, of the Insured Member, which meets the following definition mentioned below. The condition should last for an uninterrupted period of 180 days during

the Coverage Term while the Coverage is in-force. In the event of death of the Insured Member within the above period, no benefits will be payable under Total and Permanent Disability.

The Insured Member shall be regarded as being totally and permanently disabled, only if due to Accident or sickness which is caused during the Coverage Term while the Coverage is In-Force, he/she has been subject to one or more of the following impairments:

i. the total and permanent loss of sight in both eyes, or
ii. the loss by physical severance (or total and permanent loss of use) of two limbs at or above the wrist or ankle, or
iii. the total and permanent loss of sight in one eye and the loss by physical severance (or total and permanent loss of use) of one limb at or above the wrist or ankle.
iv. In order for a benefit to be payable, such disability must have persisted continuously for a period of at least 180 days and must, in the opinion of an Independent Medical Practitioner, appointed by the company, be deemed permanent.

v. Except in the cases of severance of limbs, all other disability should last for an uninterrupted period of 180 days during the Coverage Term. The Benefit will be paid out even if this period of 180 days crosses the Coverage Term.

Exclusions for Total and Permanent Disability:

No benefit shall be payable if Total and Permanent Disability results from or is accelerated by any of the following:

1. Sickness or disability which was a Pre-Existing Condition or Sickness or disability which was induced by or as a result of a Pre-Existing Condition.
2. Intentional self-inflicted injury, attempted suicide, while sane or insane.
3. Insured person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a doctor.
4. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes.
5. Taking part in any naval, military or air force operation during peace time or during service in any armed forces or paramilitary organization.
6. Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline or Pilots and cabin crew of a commercial airline, on regular routes and on a scheduled timetable.
7. Participation by the insured person in a criminal or unlawful act with illegal or criminal intent.
8. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee jumping.
9. Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

c) Critical Illness Benefit -

If the Insured Member has opted for Critical Illness Benefit, then on diagnosis of the Insured Member of any of the covered Critical Illnesses (as specified below) while the Critical Illness Coverage is In-Force, we shall pay an additional Sum Assured. The additional Sum Assured payable will be as per the Benefit Schedule for Critical Illness applicable as on the date of diagnosis of Critical Illness.

The Critical Illness Benefit is available for a maximum Coverage Term of 10 years. If the Coverage Term of the Plan Option chosen is more than 10 years, Critical Illness Benefit will terminate on the expiry of 10 years from the Coverage Commencement Date and the Coverage will continue for the remaining benefits chosen. The diagnosis should meet the conditions, definitions and exclusions as specified below.

In case where Critical Illness Benefit is opted with the Plan Option - Life Cover with Terminal Illness, then on diagnosis of any covered Critical Illness which meets the definitions and conditions of both Terminal Illness and Critical Illness, both the benefits i.e. Critical Illness Benefit and Terminal Illness Benefit will be payable as per the Benefit Schedule.

Conditions for Critical Illness Benefit

i. The benefit shall not apply or be payable in respect of any Critical Illness of which the signs or symptoms have occurred or for which care, treatment or advice was recommended by or received from a Physician, or which first manifested itself or was contracted during the waiting period (90 days from the Coverage Commencement Date or date of revival of the Insurance Cover whichever is later).

ii. The benefit shall be applicable upon the first occurrence of one of the defined Critical Illness conditions covered and proved to have undergone the type of surgery indicated, subject to satisfaction of definitions, policy conditions and exclusions. Critical Illness Benefit is applicable only in respect of the first incidence of one of the covered critical illness condition after policy issuance. Once the claim is availed for any such occurrence of the covered Critical Illnesses, the Coverage for Critical Illness Benefit will terminate and no benefits shall be payable for any future occurrence of the same or different Critical Illness covered.

iii. There is a minimum survival period of 30 days applicable for the claim. If the Insured Member is diagnosed with Critical Illness within the Coverage Term, the Critical Illness Benefit will be paid even if the Survival Period of 30 days crosses the Coverage Term. There may be a longer survival period for specific illnesses which are detailed in the definitions of Critical Illnesses provided below.

Critical Illness definitions:

1) Open Chest CABG
The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
Angioplasty and/or any other intra-arterial procedures are excluded.

2) Myocardinal Infarcation (First Heart Attack - of Specified Severity)
The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
   a) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   b) New characteristic electrocardiogram changes
   c) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

   The following are excluded:
   a) Other acute Coronary Syndromes
   b) Any type of angina pectoris
   c) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3) Open Heart Replacement OR Repair of Heart Valves
The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

   Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

4) Kidney Failure Requiring Regular Dialysis
End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal

dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

5) Major Organ / Bone Marrow Transplant
The actual undergoing of a transplant of:
   a) One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
   b) Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

   The following are excluded:
   a) Other stem-cell transplants
   b) Where only islets of Langerhans are transplanted

6) Stroke Resulting in Permanent Symptoms
Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

   The following are excluded:
   a) Transient ischemic attacks (TIA)
   b) Traumatic injury of the brain
   c) Vascular disease affecting only the eye or optic nerve or vestibular functions.

7) Aorta Surgery
The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta. Minimally invasive procedures like endovascular repair are covered under this definition. The surgery must be determined to be medically necessary by a Consultant Surgeon and supported by imaging findings.

   For the above definition, the following are not covered:
   a) Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts)
   b) Surgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlos syndrome)
   c) Surgery following traumatic injury to the aorta

8) Permanent Paralysis of Limbs
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.

9) Coma of Specified Severity
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:
   a) no response to external stimuli continuously for at least 96 hours;
   b) life support measures are necessary to sustain life; and
   c) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

10) 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.

11) Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or Accident.

The Blindness is evidenced by:

a) corrected visual acuity being 3/60 or less in both eyes or ;
b) the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

12) Aplastic Anaemia

A definite diagnosis of Aplastic anaemia resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition must be treated with blood transfusions and, in addition, with at least one of the following:

a) Bone marrow stimulating agents
b) Immunosuppressant
c) Bone marrow transplantation

The diagnosis must be confirmed by a Consultant Hematologist and evidenced by bone marrow histology. Temporary or reversible Aplastic anemia is excluded and not covered in this Policy.

13) Cancer of Specified Severity

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. The following are excluded –

a) All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or noninvasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
b) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
c) Malignant melanoma that has not caused invasion beyond the epidermis;
d) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
e) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
f) Chronic lymphocytic leukaemia less than RAI stage 3
g) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
h) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

14) Benign Brain Tumour

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

a) Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
b) Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded - Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

15) Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

16) Multiple Sclerosis with Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a) Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and;
b) there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Neurological damage due to SLE is excluded.

Exclusions for Critical Illness Benefit:

The following are the general exclusions for the Critical Illness Benefit. Additional exclusions are disease-specific and are incorporated into the definition of the disease.

Benefits shall not be paid in case of claims arising as a result of any of the following:

1. Any diseases occurring within 90 days of the start of Coverage or date of Revival (i.e. during the waiting period). In case of diagnosis of a Critical Illness condition contracted during the waiting period, the Critical Illness Benefit will be terminated without any value or refund of premium paid.
2. Any external congenital anomaly. Congenital anomaly which is in the visible and accessible parts of the body is referred to as External Congenital Anomaly. Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
3. Sickness or Critical Illness which was a Pre-Existing Condition or Sickness or Critical Illness which was induced by or as a result of a Pre-Existing condition.
4. Intentional self-inflicted injury, attempted suicide, while sane or insane.
5. Insured person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
6. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes.
7. Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.
8. Participation by the insured person in a criminal or unlawful act with illegal or criminal intent.

9. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee jumping.
10. Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

Pre-Existing disease Definition for Total and Permanent Disability and Critical Illness –

Pre-Existing Conditions or conditions connected to a Pre-Existing Condition will be excluded.

Pre-existing Disease (PED) means any condition, ailment, injury or disease:
a) That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer or its reinstatement or
b) For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy or its reinstatement.

4. Payment of Premium and Discontinuance of Premium Payment:

A	**Payment of Premium:**
	For the Insurance Cover to continue, the Modal Coverage Premium for all the Coverages opted by the Insured Member under the Insurance Cover is required to be paid for the entire Premium Paying Term. If there is a claim on any of the Coverages, then for the benefits of residual Coverages to continue, the Modal Coverage Premiums with respect to the residual Coverages will be required to be paid as and when due. The amount of Modal Coverage Premium payable, the frequency at which it must be paid, the Premium Paying Term and the Premium Paying Due Date are stated in the Certificate of Insurance issued to each Insured Member. For Premium Paying Frequencies other than annual mode, additional loadings as applicable will be applied on the premium.
B	**Grace Period:**
	The Insured Member has a period of fifteen days (15) where the Premium Paying Frequency is monthly mode and thirty (30) days for all other Premium Paying Frequencies from the Premium Paying Due Date for the payment of Modal Coverage Premium, without any penalty/late fee. The Insurance Cover will remain In-Force during the Grace Period. In case of death and/or any contingent event during the Grace Period, the benefits as applicable will be paid subject to the deduction of the due Modal Coverage Premiums from the benefits.
C	**Premium Discontinuance**
	Single Pay – Not applicable **Limited Pay -** **5 Pay & 7 Pay -** (i) If all the Modal Coverage Premiums for at least first two years have not been paid in full within the Grace Period, the Insurance Cover shall lapse and no benefits shall be payable by us under the Insurance Cover unless the Insurance Cover is revived within the revival period as mentioned in Clause 4 of Part D. (ii) If all the Modal Coverage Premiums for at least first two years have been paid in full, and if we do not receive subsequent Modal Coverage Premiums within the Grace

	Period, the Insurance Cover will acquire Reduced Paid-Up status and benefits will continue as per the Reduced Paid-Up provision. **10 Pay -** (i) If all the Modal Coverage Premiums for at least first three years have not been paid in full within the Grace Period, the Insurance Cover shall lapse and no benefits shall be payable by us under the Insurance Cover unless the Insurance Cover is revived within the revival period as mentioned in Clause 4 of Part D. (ii) If all the Modal Coverage Premiums for at least first three years have been paid in full, and if we do not receive the subsequent Modal Coverage Premiums within the Grace Period, the Insurance Cover will acquire Reduced Paid-Up status and benefits will continue as per the Reduced Paid-Up provision. The Insured Member will be given five years from the date of first unpaid Modal Coverage Premium to revive the Policy. **Regular Pay -** If any Modal Coverage Premium remains unpaid at the end of Grace Period, the Insurance Cover shall lapse and no benefits shall be payable by us under the Insurance Cover. In case the Modal Coverage Premium with respect of any Insured Member is collected by the Master Policyholder within grace period but is not remitted to us for some reason, then the risk cover for those Insured Members will continue even on expiry of grace period.

PART – D

1. Unexpired Risk Premium Value:

The Master Policy can be surrendered by the Master Policyholder. In case of surrender of the Master Policy, the Insurance Cover shall continue till the end of the period for which the Modal Coverage Premiums have been paid, unless expressly surrendered by the Insured Member. There will be an option available to the Insured Member to continue the Insurance Cover by paying the future Modal Coverage Premiums as and when it is due.

The Insured Member may surrender his Insurance Cover anytime during the Coverage Term.

The surrender of an Insurance Cover by one or more members does not affect the remaining Insured Members of the Policy.

The applicable Unexpired Risk Premium Value will be based on the Premium Paying Options as follow -

A. Single Pay -

Unexpired Risk Premium Value will be acquired immediately after the Single Premium has been paid. The Unexpired Risk Premium Value payable will be:

Single Premium including extra premium for substandard lives (if any) and exclusive of applicable tax x 50% x {Number of remaining complete months of cover / Total Coverage Term in months} x {Sum assured applicable as at surrender / Sum assured at inception}

B. Limited Pay

a) 5 Pay and 7 Pay -

Unexpired Risk Premium Value will be acquired, if all the Modal Coverage Premiums have been paid for at least first two years. The Unexpired Risk Premium Value payable will be:

50% x [total Modal Coverage Premium paid including extra premium for substandard lives, if any (exclusive of applicable tax) less {total Modal Coverage Premium payable including extra premium for substandard lives, if any (exclusive of applicable tax) x (Number of completed months of Coverage + 1) / Total Coverage Term in months}] x {Sum assured applicable as at surrender / Sum assured at inception}

b) For 10 Pay -

Unexpired Risk Premium Value will be acquired, if all the Modal Coverage Premiums have been paid for at least first three years. The Unexpired Risk Premium Value payable will be:

50% x [total Modal Coverage Premium paid including extra premium for substandard lives, if any (exclusive of applicable tax) less {total Modal Coverage Premium payable including extra premium for substandard lives, if any (exclusive of applicable tax) x (Number of completed months of Coverage + 1) / Total Coverage Term in months}] x {Sum assured applicable as at surrender / Sum assured at inception}

C. Regular Pay -

No Unexpired Risk Premium Value is payable.

If there is a claim on any of the Coverages, then the Modal Coverage Premiums with respect to the residual Coverages where claim has not been made will be considered for calculating the Unexpired Risk Premium Value.

If the loan is cancelled or not taken up by the Insured Member after sanction and we have received the Modal Coverage Premium for that Insured Member, then provided that You give Us written notice to cancel the cover, We will return –

When payable	Amount payable
Request before Coverage Commencement Date	The entire Modal Coverage Premium received for that Insured Member will be refunded.
Request after Coverage Commencement Date	Unexpired Risk Premium Value, if any will be payable.

2. Reduced Paid-up:

Paid-up value is applicable only if Limited Premium Paying Option is chosen.

A. 5 Pay & 7 Pay -

If all the Modal Coverage Premiums for at least first two years have been paid in full, and if we do not receive the subsequent Modal Coverage Premiums within the Grace Period, the Insurance Cover will acquire Reduced Paid-Up status and the benefits shall be reduced proportionately.

B. 10 Pay -

If all the Modal Coverage Premiums for at least first three years have been paid in full, and if we do not receive the subsequent Modal Coverage Premiums within the Grace Period, the Insurance Cover will acquire Reduced Paid-Up status and the benefits shall be reduced proportionately.

The benefits in reduced paid-up condition will be calculated as below:

Reduced Paid-up Sum assured = Sum Assured as per the Benefit Schedule applicable on the date of death or diagnosis of Terminal Illness/Critical Illness/Total and Permanent Disability as applicable x (Number of Modal Coverage Premiums paid/ Number of Modal Coverage Premiums payable)

3. Loan under the Policy:

Loan is not available under the Policy.

4. Revival:

If Modal Coverage Premiums are not paid within the Grace Period, the Insurance Cover shall lapse or become Reduced Paid-Up as the case may be. Any such Insurance Cover may be revived within five years from the due date of the first unpaid Modal Coverage Premium by giving us a written notice to revive the Insurance Cover and payment of all overdue Modal Coverage Premiums with interest, as may be declared by the Company from time to time, for every completed month from the due date of first unpaid Modal Coverage Premium.

The revival interest rate will be based on G-sec rate with 1 - 2 year maturity. Source to determine the G-Sec yield is www.ccilindia.com.The per month interest rate shall be (x + 3%)/12 rounded upto nearest 0.25%, where x is G-Sec rate with 1 to 2 year maturity. The interest rate to be charged is currently set at 0.75% per month on unpaid premiums for every completed month from the date of the first unpaid premium.

The revival will be effected subject to the receipt of the proof of continued insurability of the Insured Member and the acceptance of the risk by the Underwriter. Cost for the medical examination, if applicable shall be borne by the Insured Member. The effective date of revival is when these requirements are met and approved by us. Revival would be as per the Board approved underwriting policy of the Company.

5. Free Look Period:

Master Policyholder:

You have a Free Look period of *thirty (30) days* from the date of receipt of the Policy Document, whether received electronically or otherwise, to review the terms and conditions of this Policy. If you disagree with any of the terms or conditions, or otherwise, and you have not made any claims, you may return this Policy for cancellation to us by giving us written reasons for your objection within the said Free Look period. We will refund the Premium received after deducting stamp duty charges, proportionate risk premium for the period of cover and expenses incurred by us on medical examination (if any) of the Insured Member(s).

To exercise the Free Look option, you would need to send the Policy Document along with a request letter to us at our Corporate Office address provided below. You are required to maintain the acknowledgement received from the Company as a proof of submission.

Insured Member:

Insured Member has a Free Look period of *thirty (30) days* from the date of receipt of the Certificate of Insurance, whether received electronically or otherwise, to review the terms and conditions of the Certificate of Insurance. If the Insured Member disagrees with any of the terms or conditions, or otherwise, and he/she has not made any claims, he/she may return the Certificate of Insurance for cancellation to us by giving us written reasons for your objection within the said Free Look period. We will refund the Premium received after deducting stamp duty charges, proportionate risk premium for the period of cover and expenses incurred by us on medical examination (if any) of the Insured Member.

To exercise the Free Look option, you would need to send the Certificate of Insurance along with a request letter to us at our Corporate Office address provided below. You are required to maintain the acknowledgement received from the Company as a proof of submission.

6. Expiry of Insurance Cover/Coverage:

In addition to the events described elsewhere in this Policy with respect of every Insured Member, the Insurance Cover shall be deemed to have been expired under any of the following circumstances, whichever is earliest:

A. upon the date of payment of applicable Unexpired Risk Premium Value; or
B. upon the date of death of the Insured Member and in case of Joint Life upon date of death of either of the Joint Insured Members; or
C. upon the payment of claim in respect to Coverage with Terminal Illness; or
D. upon the expiry of all the Coverages opted under the Insurance Cover; or
E. upon the date on which the Revival period ends after the Insurance Cover has lapsed.

If there is a claim on any of the Coverage, then the benefits for that Coverage will cease and the benefits under the residual Coverages will continue on payment of Modal Coverage Premiums with respect to the residual Coverages as and when due.

Upon expiry of respective Coverage Term, the benefits under that Coverage shall cease to apply.

PART – E

Not Applicable.

PART – F

GENERAL TERMS AND CONDITIONS

a)	**Suicide Exclusion:**
	In case of death due to suicide within 12 months from the date of commencement of risk for the individual member or from the date of revival of coverage for individual member, as applicable, the nominee or beneficiary of the individual member shall be entitled to at least 80% of the total premiums paid till the date of death or the surrender value available as on the date of death whichever is higher, provided the coverage is in force.
b)	**Claim Procedure - Critical Illness**
	We shall be given written intimation of the Member Insured's Critical Illness, immediately and in any event within 90 days from the date of diagnosis of the covered Critical Illness. However, we may condone the delay in claim intimation, if any, where the delay is proved to be for reasons beyond the control of the claimant. We shall be provided with the following documents to assess the claim: a) Claim form duly filled and signed by the Member Insured (in case of critical illness) b) Copy of diagnosis report confirming the occurrence of Critical Illness which is acceptable to Us; c) All past and present medical records (such as admission notes, Indoor case papers, discharge summary, daily records and investigation test reports, surgical notes), if applicable; d) The original Certificate of Insurance e) A copy of the Life Insured's photo identification proof, address proof and bank account details with a copy of the cancelled cheque; f) Treating doctor certificate filled by the doctor treating the Life Insured for the diagnosed ailment; g) Hospital certificate duly filled in by the hospital where the Life Insured was admitted; h) Any other information or documentation that We request. The claim intimation can be sent to any of our branch offices or to our Corporate office address mentioned below. Claims Officer Edelweiss Life Insurance Company Ltd. 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai - 400070 Email Id: claims@edelweisslife.in Phone no: 1800 2121 212 Receipt of the claim intimation does not amount to acceptance of claim by the Company under the Policy and is subject to review by the Company. The decision on acceptance and admissibility of the Claim will be communicated separately by the Company to the claimant.
c)	**Claims Procedure – Terminal Illness Benefit:**
	We shall be given written intimation of the Member Insured's Terminal Illness, immediately and in any event within 30 days from the date of diagnosis. However, we may condone the delay in claim intimation, if any, where the delay is proved to be for reasons beyond the control of the claimant. We shall be provided with the following documents to assess the claim: a) Claim form duly filled and signed by the Member Insured (in case of terminal illness) b) Copy of diagnosis report confirming the occurrence of Critical Illness which is acceptable to Us;

	c) All past and present medical records (such as admission notes, Indoor case papers, discharge summary, daily records and investigation test reports, surgical notes), if applicable; d) The original Certificate of Insurance e) A copy of the Life Insured's photo identification proof, address proof and bank account details with a copy of the cancelled cheque f) Certificate from one independent medical practitioners specializing in treatment of such illness, is highly likely to lead to death of the Insured within 6 months of the date of diagnosis if Terminal Illness. The insured must not be receiving any form of treatment other than palliative medication for symptomatic relief. The medical practitioner must be from that field of medicine for which the Terminal Illness is been claimed g) Treating doctor certificate filled by the doctor treating the Life Insured for the diagnosed ailment; h) Hospital certificate duly filled in by the hospital where the Life Insured was admitted; i) Any other information or documentation that We request. The claim intimation can be sent to any of our branch offices or to our Corporate office address mentioned below. Claims Officer Edelweiss Life Insurance Company Ltd. 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai - 400070 Email Id: claims@edelweisslife.in Phone no: 1800 2121 212 Receipt of the claim intimation does not amount to acceptance of claim by the Company under the under the Policy and is subject to review by the Company. The decision on acceptance and admissibility of the Claim will be communicated separately by the Company to the claimant.
d)	**Claims Procedure – Total Permanent Disability benefit:**
	We shall be given written intimation of the Member Insured's Permanent Disability, immediately and in any event within 90 days from the date of diagnosis/ event. However, we may condone the delay in claim intimation, if any, where the delay is proved to be for reasons beyond the control of the claimant. We shall be provided with the following documents to assess the claim: a) Claim form duly filled and signed by the Member Insured or Nominee (in case of permanent disability) b) All treatment records and hospitalisation records confirming the cause of disability c) All past and present medical records (such as admission notes, Indoor case papers, discharge summary, daily records and investigation test reports, surgical notes), if applicable; d) The original Certificate of Insurance e) A copy of the Life Insured's photo identification proof, address proof and bank account details of insured or nominee with a copy of the cancelled cheque f) Treating doctor certificate filled by the doctor treating confirming the nature (extent) of disability; g) Hospital certificate duly filled in by the hospital where the Life Insured was admitted; h) Disability Certificate issued by competent government authority i) Police report / FIR / Medico Legal Case, if any j) Any other information or documentation that We request. The claim intimation can be sent to any of our branch offices or to our Corporate office address mentioned below. Claims Officer

	Edelweiss Life Insurance Company Ltd. 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai - 400070 Email Id: claims@edelweisslife.in Phone no: 1800 2121 212 Receipt of the claim intimation does not amount to acceptance of claim by the Company under the under the Policy and is subject to review by the Company. The decision on acceptance and admissibility of the Claim will be communicated separately by the Company to the claimant.
e)	**Claims Procedure – Death:**
	In case of Death Claim: We shall be given a written intimation of the Insured Member's death and shall be provided with the following documents for us to assess the claim: i. The claim form, duly completed; ii. The original or an attested copy of the death certificate; iii. The original Certificate of Insurance; iv. Documents to establish right of the claimant in the absence of valid nomination v. Any other information or documentation that we request. In case of Death due to Accident and unnatural death, the following additional documents are required: i. Copy of FIR and Panchnama; ii. Copy of the Post Mortem report; iii. Copy of Newspaper clipping, if any; iv. Copy of the final Police Investigation Report; v. Copy of the Chargesheet in case of murder; vi. Copy of Driving License if the Life Insured was driving at the time of death You are requested to intimate us of the claim at any of our branch offices or to our Corporate Office address mentioned below: Claims Officer Edelweiss Life Insurance Company Limited 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai - 400070 Email Id: claims@edelweisslife.in Phone no: 1800 2121 212 Receipt of the claim intimation does not amount to acceptance of claim by the Company under the Policy and is subject to review by the Company. The decision on acceptance and admissibility of the Claim will be communicated separately by the Company to the claimant. The claim is required to be intimated to us along with all necessary claim documents required within 90 days from the date of death. However, we may condone the delay in claim intimation, if any, provided valid reasons are given for the delay.
f)	**Claims Payment**
	In case of a Financial Institution being the Master Policyholder, if there is a valid assignment made by the insured member in favor of the group holder of the policy , authorizing the Insurer to make payment to the extent of Outstanding loan amount in favour of the Master Policyholder, the claim amount to the extent of Outstanding loan amount shall be paid to the Master Policyholder after deduction of the same from the claim proceeds payable on the happening of the contingent event covered under the Certificate of Insurance. Any residual benefit shall be paid to the Nominee/beneficiary. In the absence of the valid assignment or in case of Other Entities, the claim payment will be made to the Nominee/beneficiary.

g)	**Nomination:**
	Nomination should be in accordance with the provisions of Section 39 of the Insurance Act, 1938 as amended from time to time. ***[A Leaflet containing the simplified version of the provisions of Section 39 of the Insurance Act, 1938 as amended from time to time is enclosed in Annexure (1) for reference].***
h)	**Assignment:**
	Assignment not allowed under this Policy.
i)	**Validity/ Non-Disclosure:**
	(i) <u>Section 41:</u> No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables or the insurer. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees. (ii) <u>Section 45:</u> Fraud and Misstatement shall be dealt with in accordance with the provisions of Section 45 of the Insurance Act, 1938 as amended from time to time. ***[A Leaflet containing the simplified version of the provisions of Section 45 of the Insurance Act, 1938 as amended from time to time is enclosed in Annexure – (3) for reference].***
j)	**Currency, Governing Law and Jurisdiction**
	The Premiums and benefits payable under the Policy shall be payable in India and in Indian Rupees. The Policy shall be governed by the laws in India. The courts of Mumbai shall have the exclusive jurisdiction to settle any disputes arising under this Policy.
k)	**Taxation**
	The tax benefits under this Policy would be as per the prevailing Income Tax laws in India and any amendment(s) made thereto from time to time. We reserve the right to recover all the applicable taxes from the Policyholder.
l)	**Duplicate Policy Document**
	<u>Duplicate Certificate of Insurance:</u> (i) If an Insured Member loses or misplaces the Certificate of Insurance then he/she may request us or You to issue a duplicate Certificate of Insurance by giving a written request and making payment of fee which is currently Rs. 50 (fees is subject to review and maybe amended from time to time) plus a Stamp Duty Fee, as applicable (ii) On issue of the duplicate Certificate of Insurance, the original shall automatically cease to have any legal effect and the Insured Member agrees to indemnify and hold us

	harmless from and against any and all claims, demands, costs, expenses, awards or judgments arising from or in connection with the original Certificate of Insurance or the issue of the duplicate Certificate of Insurance. **Duplicate Policy Document:** (i) If You lose or misplace the Policy Document You may request us to issue a duplicate Policy Document by giving us a written request and making payment of fee which is currently Rs. 200 (fees is subject to review and maybe amended from time to time) plus a Stamp Duty Fee, as applicable (ii) On issue of the duplicate Policy Document, the original shall automatically cease to have any legal effect and You agree to indemnify and hold us harmless from and against any and all claims, demands, costs, expenses, awards or judgments arising from or in connection with the original Policy Document or the issue of a duplicate Policy Document.
m)	**Intimations and Notices**
	All intimations meant for us shall be given to us at our address specified in the Policy Document or at any of our branch offices. All notices meant for you will be sent to your address specified in the Policy Schedule. If you do not notify us of any changes to your address, then notices or correspondence sent by us to the last recorded address shall be valid and legally effective. You would need to intimate us of any change in your address to enable us to provide important information pertaining to your Policy.
n)	**Entire Contract**
	The Policy comprises the entire contract of insurance between you and us. We shall not be bound or be deemed to be bound by any alterations or changes, unless such changes are made by us in writing through an endorsement. Notwithstanding anything contained in this Policy Document, the provisions herein shall stand altered or superseded to such extent and in such manner as may be required by any change in applicable law including but not limited to any regulations, circulars or guidelines issued by IRDAI.
o)	**Audit**
	i. The Company will audit or cause an audit into the accuracy of the Credit Account Statements of the Insured Members in respect of which claims were settled on the completion of every financial year and also on the accuracy of Credit Account Statements of the deceased Insured Members furnished by the Master Policyholder. ii. Notwithstanding anything contained in the above sub-clause, the Company may request the Master Policyholder to conduct audit or to cause an audit into the accuracy of the Credit Account Statements of the Insured Members in respect of which claims were settled on the completion of every financial year and provide a certification from their internal/ statutory auditors in this regard.

PART - G

Grievance Redressal Mechanism:

We have established a Grievance Redressal Mechanism to assist in the resolution of any complaint, grievance, or dispute in respect of the Policy. You are requested to submit your complaint at any of the below mentioned touch points:

- Toll free customer care number: 1-800-2121-212 (Mon-Sat 10 AM TO 7 PM).
- Email us at: complaints@edelweisslife.in
- Write to us at: Customer Care, Edelweiss Life Insurance Company Ltd, 6th Floor, Tower 3, Wing 'B', Kohinoor City, Kirol Road, Kurla (W), Mumbai 400070.
- You can lodge your grievance/complaint at any of our branches/offices
- You can also lodge a grievance/complaint on our website at: https://www.edelweisslife.in/web/guest/contact-us#fileAComplaint

Details of Grievance Redressal officer:
+91-22-71013322 (Between 10 am to 7 pm on Monday to Friday, except public

holidays), Email id: GRO@edelweisslife.in.

We will respond with a resolution within 14 days

In case the resolution does not meet your expectations or if you have not received any reply, you may approach the Policyholder's Protection and Grievance Redressal Department on the following contact details:

- IRDAI Grievance Call Centre (Bima Bharosa Shikayat Nivaran Kendra) (IGCC) - Toll free No: 155255 / 1800 425 4732
- Email ID: complaints@irdai.gov.in
- Register online at: https://bimabharosa.irdai.gov.in/LoginAdmin/Login

Address for sending the complaint through courier / letter:

Policyholder's Protection and Grievance
Redressal Department Insurance Regulatory and
Development Authority of India
Survey No. 115/1
Financial District
Nanakramguda
Gachibowli
Hyderabad – 500 032, Telangana

At any point of time, if the resolution does not meet your expectation or if you have not received any reply within a period of one month from the date of receipt of complaint by the Company, you may approach the Insurance Ombudsman for redressal as per Rule 13 and 14 of the Insurance Ombudsman Rules, 2017 ('Insurance Ombudsman Rules').

Powers of Insurance Ombudsman under Rule 13 of the Insurance Ombudsman Rules:

The Ombudsman shall receive and consider the following complaints or disputes relating to:

a. delay in settlement of claims, beyond the time specified in the Regulations, framed under Insurance Regulatory and Development Authority of India Act, 1999;
b. any partial or total repudiation of claims by the Company;

c. disputes over Premium paid or payable in terms of insurance Policy;
d. misrepresentation of Policy terms and conditions at any time in the Policy Document or Policy contract;
e. legal construction of insurance policies in so far as the dispute relates to claim;
f. policy servicing related grievances against the Company and their agents and intermediaries;
g. issuance of life insurance Policy including health insurance policy which is not in conformity with the Proposal Form submitted by the Proposer;
h. non-issuance of insurance Policy after receipt of Premium in life insurance including health insurance; and
i. any other matter resulting from the violation of provisions of the Insurance Act, 1938 as amended from time to time or the Regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the Policy contract, in so far as they relate to issues mentioned at clauses (a) to (f) as mentioned above.

Manner in which complaint is to be made in accordance with Rule 14 of the Insurance Ombudsman Rules:

1. Any person who has a grievance against the Insurer/Company/Us, may himself or through his legal heirs make a complaint in writing to the Ombudsman within whose territorial jurisdiction the branch or office of the Company, complaint against or the residential address or place of residence of the complainant is located.
2. The complaint shall be in writing duly signed by the complainant or through his legal heirs, Nominee or Assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against which the complaint is made, the fact giving rise to complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Ombudsman.
3. No complaint to the Insurance Ombudsman shall lie unless:
   (a) the complainant makes a written representation to the Company named in the complaint and—
      i. either the Company had rejected the complaint; or
      ii. the complainant had not received any reply within a period of one month after the Company received the complainant's representation; or
      iii. the complainant is not satisfied with the reply given to him by the Company;

   (b) The complaint is made within one year—
      i. after the order of the Company rejecting the representation is received; or
      ii. after receipt of decision of the Company which is not to the satisfaction of the complainant;
      iii. after expiry of a period of one month from the date of sending the written representation to the Company if the Company named in the complaint fails to furnish reply to the complainant.
4. The Insurance Ombudsman shall be empowered to condone the delay in filing a complaint as mentioned above under
   (3) (b), as he may consider necessary, after calling for objections of the Company against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under the Insurance Ombudsman Rules.
5. No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

THE LIST OF THE OMBUDSMAN WITH THEIR ADDRESSES IS GIVEN BELOW:

Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, **AHMEDABAD-380 001.** Tel.: 079-25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, **BHOPAL-462 003.** Tel.:- 0755-2769201/9202 Email: bimalokpal.bhopal@cioins.co.in
Office of the Insurance Ombudsman 62, Forest Park, **BHUBANESHWAR-751 009.** Tel.: 0674-2596455/2596461 Email: bimalokpal.bhubaneshwar@cioins.co.in	Office of the Insurance Ombudsman, SCO No.101-103, 2nd Floor, Batra Building, Sector 17-D, **CHANDIGARH-160 017.** Tel.: 0172-2706196/2706468 Email: bimalokpal.chandigarh@cioins.co.in
Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 Anna Salai, Teynampet, **CHENNAI-600 018.** Tel.: 044-24333668/24335284 Email: bimalokpal.chennai@cioins.co.in	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg.,Asaf Ali Road, **NEW DELHI-110 002.** Tel.: 011- 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in
Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, **GUWAHATI-781 001 (ASSAM).** Tel.: 0361- 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, **HYDERABAD-500 004.** Tel.: 040-23312122 Email: bimalokpal.hyderabad@cioins.co.in
Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM-682 015.** Tel: 0484-2358759/2359338 Email: bimalokpal.ernakulam@cioins.co.in	Office of the Insurance Ombudsman, Hindustan Building, Annexe, 4th Floor, 4, C.R.Avenue, **KOLKATA - 700072** Tel: 033-22124339/22124340 Email: bimalokpal.kolkata@cioins.co.in
Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, **LUCKNOW-226 001.** Tel : 0522 -2231331/2231330 Email: bimalokpal.lucknow@cioins.co.in	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), **MUMBAI-400 054.** Tel: 022-69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in
Office of the Insurance Ombudsman, Gr. Floor, Jeevan Nidhi - II, Bhawani Singh Marg, **JAIPUR – 302005.** Tel: 0141-2740363 Email: bimalokpal.jaipur@cioins.co.in	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan, C.T.S. Nos. 195 to 198, N.C. Kelkar Road, Narayan Peth **PUNE - 411030.** Tel: 020-41312555

	Email: bimalokpal.pune@cioins.co.in
Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, **BENGALURU – 560 078.** Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road Naya Bans, Sector 15, Distt: Gautam Buddh Nagar **NOIDA – 201301.** Tel: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001, Tel No: 0612- 2547068 Email id : bimalokpal.patna@ecoi.co.in	

You may refer to the list of Ombudsman with their addresses on https://cioins.co.in/Ombudsman

Annexure - 1

Section 39 - Nomination by Policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows:

01. The Policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.

02. Where the nominee is a minor, the Policyholder may appoint any person to receive the money secured by the policy in the event of Policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.

03. Nomination can be made at any time before the maturity of the policy.

04. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.

05. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.

06. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.

07. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.

08. On receipt of notice with fee, the insurer should grant a written acknowledgement to the Policyholder of having registered a nomination or cancellation or change thereof.

09. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.

10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.

11. In case of nomination by Policyholder whose life is insured, if the nominees die before the Policyholder, the proceeds are payable to Policyholder or his heirs or legal representatives or holder of succession certificate.

12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).

13. Where the Policyholder whose life is insured nominates his:

a. parents or

b. spouse or

c. children or

d. spouse and children

e. or any of them

- the nominees are beneficially entitled to the amount payable by the insurer to the Policyholder unless it is proved that Policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14. If nominee(s) die after the Policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).

15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all policies maturing for payment on the commencement of The Insurance Act, 1938.

16. If Policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.

17. The provisions of this Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 ('MWP Act') applies or has at any time applied except where, a nomination is made in favour of spouse or children or spouse and children whether or not

on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is a simplified version of Section 39 of the Insurance Act, 1938 as amended from time to time. The Policyholders are advised to refer to The Insurance Act, 1938 as amended from time to time for complete and accurate details.]

Annexure - 2

Section 38 - Assignment and Transfer of Insurance Policies

Assignment or Transfer of a Policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.

2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.

3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.

4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.

5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.

6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.

7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.

8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.

9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is

a. not bonafide or

b. not in the interest of the Policyholder or

c. not in public interest or

d. is for the purpose of trading of the insurance policy.

10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of Policyholder giving a notice of transfer or assignment.

11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.

13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except

a. where assignment or transfer is subject to terms and conditions of transfer or assignment; OR

b. where the transfer or assignment is made upon condition that

i. the proceeds under the policy shall become payable to Policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR

ii. the insured surviving the term of the policy

Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person

a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and

b. may institute any proceedings in relation to the policy

c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings

15. Any rights and remedies of an assignee or transferee of a life insurance policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Ordinance, 2014 shall not be affected by this section.

[Disclaimer: This is a simplified version of Section 38 of the Insurance Act, 1938 as amended from time to time. The Policyholders are advised to refer to The Insurance Act, 1938 as amended from time to time for complete and accurate details.]

Annexure - 3

Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938 as amended from time to time are as follows:

1. No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 years from
   a. the date of issuance of policy; or
   b. the date of commencement of risk; or
   c. the date of revival of policy; or
   d. the date of rider to the policy
   - whichever is later.
2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
   a. the date of issuance of policy or
   b. the date of commencement of risk or
   c. the date of revival of policy or
   d. the date of rider to the policy
   - whichever is later.

For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b. The active concealment of a fact by the insured having knowledge or belief of the fact;
   c. Any other act fitted to deceive; and
   d. Any such act or omission as the law specifically declares to be fraudulent.
4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Policyholder, if alive, or beneficiaries.
6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.
7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.
8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.
9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent

proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is a simplified version of Section 45 of the Insurance Act, 1938 as amended from time to time. The Policyholders are advised to refer to The Insurance Act, 1938 as amended from time to time for complete and accurate details.]