ROYAL SUNDARAM GENERAL INSURANCE CO. LIMITED

Registered office: No. 21, Patullos Road, Chennai- 600 002

Corporate Office: Vishranthi Melaram Towers, No. 2/319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai-600 097

Arogya Sanjeevani Policy, Royal Sundaram General Insurance Co. Limited.

Your search for high quality health insurance stops here

We at Royal Sundaram understand that Family is the most important influence in your life and you always want to protect them in tough times. So, it's always your top priority for the people who matter most in your life to be protected from financial hardship if the unexpected happens.

That is why, Royal Sundaram brings to you 'Arogya Sanjeevani Policy, Royal Sundaram General Insurance Co. Limited', a standard individual health insurance policy for your family. It's a Health Insurance Policy, mandated by the Insurance Regulatory and Development Authority of India (IRDAI) to remove ambiguity in different products by different insurance companies and bring in uniformity in features and structure of the Health Insurance Product.

Key Features of the Policy

Benefits-

- Hospitalisation Expenses and other Expenses
- Ayush Treatment
- Cataract Treatment
- Pre Hospitalization
- Post Hospitalization
- Modern Treatments
- Cumulative Bonus

Product Benefits – Key Highlights

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy. We cover the following expenses:

1. Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus, for

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Horne up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.

iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital

iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

1.1. Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits.
ii. Dental treatment, necessitated due to disease or injury.
iii. Plastic surgery necessitated due to disease or injury.
iv. All the day care treatments.
v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment Under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy system of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum insured or Rs. 40,000/-, whichever is lower, per each eye in one policy year.

4. Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

5. Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

6. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy - Monoclonal Antibody to be given as injection

F. Intra vitreal injection

G. Robotic surgeries

H. Stereotactic radio surgeries

I. Bronchical Thermoplastic

J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

K. IONM - (Intra Operative Neuro Monitoring)

L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Note: The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

7. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claims has been reported. CB shall reduce only in case of claim from the same Insured Person.

ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.

iii. CB shall be available only if the policy is renewed/premium paid within the Grace Period.
iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the sum insured in to two or more floater policies/individual policies or in cases where the policy is split due to child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

Policy Features

1. Age Eligibility

Children: The minimum entry age under this policy is between 3 months and 25 years. lf the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

Adult: Minimum entry age is 18 years and maximum entry age is 65 years.

2. Individual & Family Combination

The policy can be purchased on an Individual basis or on a Family Floater basis. In case of a family floater policy, one family will share a single sum insured as opted. Policy can be availed for Self and the following family members

Legally wedded spouse.

Parents and Parents- in-law.

Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. lf the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals. A floater cover can cover a maximum of 6 adults and there is no limit on the number of children in a floater policy.

Proposer needs to be mandatorily covered in the Policy. In case the proposer is more than 65 years can obtain policy for family, without covering self.

3. Policy Period Option

Customer can buy the policy for one year. 'One Policy Year' shall mean a period of one year from the date of issuance of the policy.

4. Plan & Sum Insured Options

Customer has the option to choose from a wide range of Sum Insured's available:

Sum Insured
Rs.50,000, Rs.1 lakh, Rs.1.5 lakhs, Rs.2 lakhs, Rs. 2.5 lakhs, Rs. 3 lakhs, Rs. 3.5 lakhs, Rs.4 lakhs, Rs. 4.5 lakhs, Rs. 5 lakhs, Rs.5.5 lakhs, Rs.6 lakhs, Rs.6.5 lakhs, Rs.7 lakhs, Rs.7.5 lakhs, Rs.8 lakhs, Rs.8.5 lakhs, Rs.9 lakhs, Rs.9.5 lakhs, Rs.10 lakhs

Sum Insured is on Annual basis.

5. Premium

The Premium charged on the Policy will depend on the Sum Insured, Age, Policy Type(individual or Floater) and the number of persons covered under the floater plan.

For detailed premium chart please refer Annexure "Rate Chart" attached along with this document.

Additionally, the health status of the individual will also be considered consequent to which underwriting loading may be applied.

Premium payment can be made Annual, Half-yearly, Quarterly, Monthly.

6. Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

7. Disease Specific Loading

We shall apply a risk loading on the premium payable for certain specific conditions as per Our board approved underwriting policy (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance), which shall be mentioned specifically in the Schedule of Insurance Certificate. The maximum risk loading applicable shall not exceed 150% per diagnosis / medical condition and an overall risk loading of 200%. These loadings are applied from the inception of the initial Policy including subsequent Renewal(s) with Us or on the receipt of a request for increase in Sum Insured (for which the loading shall be applied on the increased Sum Insured).

We will inform You about the applicable risk loading through post/courier/email/phone. You shall revert to Us with your written consent and additional premium (if any), within 15 days of the issuance of such counter offer. In case, You neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within the next 15 days.

Table 1

Note: In case of Table 1 and Table 1A, loading will be applicable at a policy level.

Sr. No.	Condition	Medical test	Medical test result	Product variant	Loading on base premium
1	Diabetes	HBa1C	Less than or equal to 6	All	0.0%
2	Diabetes	HBa1C	More than 8	All	Decline
3	Diabetes	HBa1C	More than 6 up to 8	Family Floater	25.0% to 100% loading
4	Diabetes	HBa1C	More than 6 up to 8	Individual	25.0% to 150% loading
5	Heart Condition	ECG / TMT	Adverse	Family Floater/ Individual	50.0% to 150% loading
6	Hypertension	Blood Pressure	Above 120/80 up to 170/100 mmHg	Family Floater	10.0% to 50% loading
7	Hypertension	Blood Pressure	Above 120/80 up to 170/100 mmHg	Individual	20.0% to 100% loading
8	Hypertension	Blood Pressure	Above 170/100 mmHg	All	Decline
9	BMI	NA	Below 16	All	Decline
10	BMI	NA	Above 35 to 40	All	20%
11	BMI	NA	Above 40	All	Decline
12	Any Malignant Cancer*	HPE	Confirmatory	All	100%
13	Rheumatoid Arthritis	RA Test	Confirmatory	All	100%
14	Peptic Ulcer Disease	Disclosure and Endoscopy Report	Presence or Old Appearance	All	10% to 25.00%
15	Ulcerative Colitis	Disclosure and Endoscopy Report	Presence or Old Appearance	All	10% to 25.00%
16	Crohns Disease	Disclosure and Endoscopy Report	Presence or Old Appearance	All	10% to 25.00%
17	Breast - Benign Lesions	Disclosure and Mammography	Presence or Old Appearance	All	10% to 50.00%

18	Breast - Benign Lesions	Disclosure and Mammography	Presence or Old Appearance	All	10% to 50.00%
19	Pancreatitis – Acute	Serum Amylase and Lipase	Increased	All	10% to 25.00%
20	Pancreatitis – Chronic	Serum Amylase and Lipase	Increased	All	10% to 50.00%
21	Hyperthyroidism	Disclosure and TFT	Increased	All	10% to 50.00%
22	Epilepsy	Disclosure and MRI	Organic or Inorganic	All	25% to 100.00%
23	Stroke#	Disclosure and MRI	Organic or Inorganic	All	50% to 150.00%*
24	Glaucoma	Eye Test	Confirmatory	All	10% to 50.00%
25	Retinal Detachment	Eye Test	Confirmatory	All	25% to 100.00%
26	Asthma	Disclosure and PFT	Confirmatory	All	10% to 50.00%
27	Osteo Arthritis	Disclosure	Confirmatory	All	10% to 100.00%
28	Polycystic Ovarian Disease	Disclosure	Confirmatory	All	10% to 25.00%
29	Prolapsed Intervertebral Disc/ Spondylosis/ Spondylitis	Disclosure	Confirmatory	All	10% to 50.00%
30	Varicose veins,	Disclosure	Confirmatory	All	10% to 50.00%
31	Implant in Situ	Disclosure/ X Ray	Confirmatory	All	10% to 25.00%
32	Renal Stones/ Gall bladder stones	Disclosure/ USG	Confirmatory	All	10% to 25.00%

*We will consider cases only when the person is cured for cancer and period of remission is > 3 years with no active findings on cancer. The ongoing cancer cases and/or where period of remission is < 3 years will be declined.

#- We will consider cases only when the person is cured for stroke and period of remission is > 3 years with no active findings on stroke. The ongoing stroke cases and/or where period of remission is < 3 years will be declined.

Table 1 A- Underwriting grid for Mental Illness Cases

Sr. No.	Duration of Condition	Condition	Loading for Each Insured	
1	Up to 5 years with no hospitalisation	Mild to Moderate	Family Floater 25%	Individual 50%
2	More than 5 Years with no hospitalisation	Moderate to High	Family Floater 50%	Individual 100%
3	Hospitalisation due to Mental Illness any time in last 10 years	Severe	Family Floater 100%	Individual 150%

Note: The maximum cumulative Underwriting Loading cannot exceed 200%.

8. General Terms and Conditions

A. Disclosure of Information

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

B. Condition Precedent to Admission of Liability

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

C. Material Change

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

D. Records to be Maintained

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

E. Complete Discharge

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

F. Notice & Communication

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

G. Territorial Limit

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

H. Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

2. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy after, the Policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

I. Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be

repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

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

(a) the suggestion as a fact of that which is not true and which the Insured Person does not believe to be true;
(b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
(c) any other act fitted to deceive; and
(d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer. Onus or disproving is upon the policyholder, if alive, or beneficiaries.

J. Cancellation

a) The Insured may cancel this Policy by giving 15 days written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	1 Yr
Up to 30 days	75.00%
31 to 90 days	50.00%
3 to 6 months	25.00%
6 to 12 months	0.00%

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

b) The Company may cancel the Policy at any time on grounds of misrepresentative, non-

disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentative, non-disclosure of material facts or fraud.

K. Automatic change in Coverage under the policy

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

1. In the case of his/her (Insured Person) demise.

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

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

L Territorial Jurisdiction

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

M Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/ difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No.3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/ arbitrators of the amount of expenses shall be first obtained.

N. Migration:

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

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.

ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefits shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the below link:-
https://www.royalsundaram.in/sitemap/HealthInsurance/ArogyaSanjeevani Policy/Migration

O. Portability

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

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the below link:-
https://www.royalsundaram.in/sitemap/HealthInsurance/ArogyaSanjeevani Policy/Portability

P. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years

ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period

iii. At the end of the Policy Period, the policy shall terminate and can be renewed with in the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

iv. If not renewed with in Grace Period after due renewal date, the Policy shall terminate.

Q. Premium Payment in Instalment

It the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of insurance, the following Conditions shall apply (not withstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.

iii. The Benefits provided under — "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged lf the instalment premium is not paid on due date.

v. In case of installment premium due not received within the grace period, the policy will get cancelled.

R. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

S. Free look period

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

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

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

T. Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policy holder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

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

U. Change of Sum Insured

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

V. Terms and conditions of the Policy

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

W. Nomination:

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

X. **Income Tax benefit**

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act 1961. (Tax benefits are subject to change in the tax laws, please consult your tax advisor for more details).

9. Waiting Periods and Exclusions:

The Company shall not be liable under this Policy for any claim in connection with or in respect of:

- **30 Days Initial Waiting Period**: We will not cover any treatment taken during the first 30 days from the first commencement of the Policy, unless the treatment is due to an Accident. This waiting period does not apply for any subsequent and continuous renewals of your Policy or Policy is enforced with any other Insurance Company (Non-Life/Health Insurance Company).

- **Pre-Existing Diseases**: Expenses related to the Pre-existing Disease until 48 months of continuous coverage have elapsed since the inception of the first Policy with us or Policy is enforced with any other Insurance Company (Non-Life/Health Insurance Company).

- **Specific Waiting Periods:** For all insured persons the 20 conditions listed below will be subject to a waiting period of 24 months and will be covered in the third policy year as long as the insured person has been insured continuously under the Policy without any break:

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

ii. 48 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

- **Personal Waiting Periods:** A special waiting period not exceeding 48 months, may be applied to Individual Insured Persons depending upon declarations on the proposal form and existing health conditions. Such waiting periods shall be specifically stated in the Schedule of Insurance Certificate and will be applied only after receiving Your specific consent.

- **Permanent Exclusions:** Investigation & Evaluation, Rest Cure, rehabilitation and respite care, Obesity/ Weight Control, Change-of-Gender treatments, Cosmetic or plastic Surgery, Hazardous or Adventure sports, Breach of law, Excluded Providers, Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences, Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons, Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure, Refractive Error, Unproven Treatments, Sterility and Infertility, Maternity expenses, War (whether **declared** or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds, Treatment received outside India, Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting

  from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense, Any expenses incurred on Domiciliary Hospitalization and OPD treatment. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

- For details of permanent exclusions please read the policy terms and conditions or visit www.royalsundaram.in .

- Existing Disease which can be permanently Excluded: In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes. The disease which can be excluded under this section are as under:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and

		pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or

		obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 - Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 - Chronic viral hepatitis B without delta-agent;

11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

- The expenses that are not covered in this policy are placed under List-I of Annexure-A.
- **Moratorium Period:** After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sum Insured of the first policy and subsequently completion of eight continuous years would be applicable from the date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

- In case of non-disclosure of a condition which is other than list of Permanent exclusions, we can incorporate additional waiting period of not exceeding 48 months for the said undisclosed disease or condition from the date the un-disclosed condition was detected and continue with the policy subject to obtaining prior consent from you or Insured Person.

- Where the non-disclosed condition allows us to continue the coverage by levying extra premium or loading based on the objective criteria laid down in the Board approved underwriting policy, we shall levy the same prospectively from the date of noticing the non-disclosed condition.

10. CLAIM PROCEDURE

Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.

ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

iii. The Company/TPA upon getting cashless request form and related medical information from the insured person/network provider will issue pre-authorization letter to the hospital after verification.

iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

v. The Company/TPA reserves the right to deny pre-authorization in case the insure person is unable to provide the relevant medical details.

vi. In case of denial of cashless access, the insure person may obtain the treatment as per treating doctor's advice and submit the claim document to the Company/TPA for reimbursement.

The reimbursement claim shall be processed subject to the admissibility of the claim as per the terms and conditions of the policy.

Procedure for reimbursement of claims:

For reimbursement of claims the insured person any submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

SI	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and Pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

10.1. Notification of Claim

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

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

10.2. Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. lnvestigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/ invoice of the Implants, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate , wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of' the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of' the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

10.3. Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

10.4. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

10.5. Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim admission and assessments, under this policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

10.6. Payment of Claim

All claims under the policy shall be payable in Indian currency only.

Disclosure:

All insured persons' personal information collected or held by Royal Sundaram may be used by Royal Sundaram for processing the claims and analysis related to insurance / reinsurance business.

How to Buy Royal Sundaram Policy

Royal Sundaram policy is sold through various channels like telesales team, direct team, individual agents, our website www.royalsundaram.in, licensed brokers and corporate agents.

1. You should go through the product brochure, policy benefits, exclusions etc to thoroughly understand the product before buying.

2. Proposal Form must be filled. You will be required to provide various information (as accurately as possible) such as;

   - Insured's' name, date of birth, and address.
   - PAN, email id and mobile no.
   - As above for all dependants to be covered by the policy.
   - Selection of sum insured.
   - Any existing health insurance policy details and claims history, if applicable.
   - Disclosure of any Pre-existing Diseases with details.
   - Medical history report for the proposed insured, if necessary.
   - Height and weight for the proposed insured.
   - Signature and date on application, wherever applicable.
   - Premium payment collected and receipted
   - Selection of Third Party Administrator (TPA)
   - Electronic Insurance Account number(if available)

3. If You are required to undergo medicals tests as per the chosen Age band and BMI, we would arrange the medical check-ups at Our network of diagnostic centres.

4. Based on the above information we will process Your proposal for Insurance and a policy kit containing the Benefit Schedule, Policy Terms and associated documents will be sent to you.

In case we are unable to underwrite Your proposal We will intimate the same to You and refund any premium that has been collected. Upon assessment if there is any change in terms or premium is loaded then We will inform You about any revised terms through a counter offer letter. We will issue the Policy only once you accept the counter offer and receipt of difference in premium, if any. Where You do not agree to the counter offer we will cancel your proposal and refund any premium collected.

Pre-policy Medical Check-up requirements:

We will require You to undergo a medical check-up based on Your age as provided in the grid below or on the basis of Your BMI as per underwriter evaluation. Wherever any pre-existing disease or any other adverse medical history is declared, We may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age. Medical tests will be facilitated by us and conducted at Our network of diagnostic centres. We will contact You and fix up an appointment for the Medical Examination to be conducted at a time convenient to You. The validity of medical tests would be; for medical tests reports with test result within normal range, the validity is for 6 months from the date of tests done, whereas for medical tests reports with test result not within the normal range, validity is for 3 months from the date of tests done.

Wherever required we may request for additional tests to be conducted based on the declarations on the proposal form and the results of any medical tests that we have received.

Medical Underwriting Grid

Age	UW Criteria
Up to 18 years	No Check-up #
19 years to 50 years	No Check-up* #
51 years and above	Set 1

Sum Insured	UW Criteria
Up to Rs. 5 lakhs	No Check-up #
Above Rs. 5 lakhs	Set 1

 # Subject to no adverse medical conditions as disclosed in proposal form.

Note: In Portability & Migration (customer induced) including Group to Retail or Retail to Retail cases, we may conduct TeleUW for Insureds up to 18 years, whereas Insureds above 18 years will be subject to TeleUW/Medical Underwriting irrespective of the sum insured. Considering the current Covid-19 situation wherever customers are not able to undergo medical test due to lockdown or Micro Containment Guidelines or customers having hesitation to go for medical test due to fear of touch, we may rely on TeleUW for evaluation of proposal. Also, all requests for sum insured enhancement will be subject to medical underwriting.

- Medical test:
  - **Set 1:** CBC, ESR, URA, MER, HbA1C, Lipid Profile, ECG(TMT/2D Echo) (can be prescribed based on declaration or Co-morbidity), LFT with GGT, RFT, HBsAg, S Creatinine

(Abbreviation of test is provided here: CBC – Complete Blood Count, ESR – Erythrocyte Sedimentation Rate, MER – Medical Examination Report, HbA1C – Glycosylated Haemoglobin Test, S Cholestrol – Serum Cholestrol, ECG – Electrocardiogram, SGPT – Serum Glutamic Pyruvate Transaminase, S Creatinine – Serum Creatinine, TMT – Treadmill Test, LFT with GGT – Liver Function Test, RFT – Renal Function Test, HBsAg – Hepatitis B Surface Antigen, URA – Urine Routine Analysis)

- * - If the BMI of proposed insured is more than or equal to 33, proposal will be subject to medical underwriting. Underwriter might trigger the medical test post evaluation of medical condition of the proposed insured.
- If Answer to Question 'Are you covering all Children?', is 'No', then the case will follow the Underwriting path.
- Underwriting grid mentioned above is common for all channels. However, we can propose to have a different grid for different channels as per Board approved Underwriting Policy with prior notification to IRDAI.
- Any additional tests such as TMT, 2D Echo USG Abdomen and pelvis, MRI, CT Angio, to be triggered as per underwriter's evaluation.

- No home visits

- Any waiver of Medical tests to be approved by Head– Underwriting and/or Chief Product Officer.

Process for arranging Pre Policy Medical Check-up (PPMC)

The Pre Policy Medical Check-up will always be triggered by the Underwriting team. The vendor appointed for the pre policy medical checkup will be notified of the details. The vendor will then call the customer and fix a mutually convenient time for the medical check-up to be conducted. The medical reports in soft copy will be made available to the Underwriting team and hard copies will be couriered directly to the Underwriting department for further processing and risk assessment.

Additionally, in some cases where past Medical Reports are triggered by the Underwriters; past Medical Reports will be collected (soft copies or hard copies) and sent by Contact Center team to Underwriting department.

Cost of Pre Policy Medical Check-up:

	Proposal Accepted	**Proposal Rejected**
Arogya Sanjeevani Policy, Royal Sundaram General Insurance Co. Limited	Royal Sundaram to reimburse 50% cost of PPMC	Customer to bear 100% cost of PPMC

Note: In case of any cancellation by customer or non-acceptance of counter-offer within specified timeline, we will refund the balance premium excluding the cost of Pre-Policy Medical Checkup (PPMC)

Underwriting Decisions
Based on the Medical Reports, Declaration in Proposal Form, Other Underwriting criteria, the Underwriter will assess if the Proposed Insured's medical condition poses any future medical risk and accordingly categorize him in one of the below 3 types of Risks;

Three potential options will be determined by the Underwriter.

A. Low to Medium Risk – accept application with no condition(s) / exclusion(s)
B. Medium to High Risk – accept application, with special conditions; waiting period (s); loading or co-payment; and (or) exclusion (s).
C. Very High Risk – decline policy cover. Royal Sundaram may decline policy cover where potential risk cannot be quantified through the use of best knowledge and expertise. Royal Sundarm will consider past medical history, pathological conditions, acquired disease conditions, deformity or disability, terminal conditions, and/or a combination thereof to determine if a risk is uninsurable.

What to do next: If you wish to know more about Royal Sundaram's 'Arogya Sanjeevani Policy, Royal Sundaram General Insurance Co. Limited' Product and/or would like a personal quote, speak to our specially trained sales team or your local agent. They'll take time to fully understand your requirements and help you to select the right plan for you.

Website: www.royalsundaram.in

Disclaimer: This is only a summary of the product features and is for reference purpose only. The details of benefits available shall be as described in the policy document, and will be subject to the policy terms, conditions and exclusions. Please call our customer service if you require any further information or clarification.

Statutory Warning: Prohibition of rebates (under section 41 of Insurance Act 1938);

No person shall allow or offer to allow either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of 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 prospectus or tables of the insurer. If any person fails to comply with sub regulation (1) above, he shall be liable to payment of a fine which may extend to ten lakhs.

Annexures:

Annexure A –

List I – Items for which coverage is not available in the policy,
List II - Items that are to be subsumed into Room Charges,
List III - Items that are to be subsumed into Procedure Charges,
List IV - Items that are to be subsumed into costs of treatment

Annexure X – Format to be filled up by the proposer for change in occupation of the Insured

Annexure 1 – Product Benefits Table

Annexure 2 – Rate Tables

Royal Sundaram General Insurance Co. Limited

Corporate Office: Vishranthi Melaram Towers, No. 2/319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097
Registered Office: No. 21, Patullos Road, Chennai - 600002
www.royalsundaram.in

Insurance is the subject matter of solicitation
Unique Identification Number:

Annexure A

List I – Items for which coverage is not available in the policy

SI No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES

24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR

50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II - Items that are to be subsumed into Room Charges

SI No	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH

3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES

31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III - Items that are to be subsumed into Procedure Charges

SI No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM

17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV - Items that are to be subsumed into costs of treatment

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES

16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure X

Format to be filled up by the proposer for change in occupation of the Insured

Policy No	**Name of the Insured**	**Date of birth/Age**	**Relationship with Proposer**	**City of residence**	**Previous Occupation or Nature of Work**	**New Occupation or Nature of Work**

Place: _____

Proposer's Signature_____

Date: _____

Name:_____

(DD/MM/YYYY)