



THE ORIENTAL INSURANCE COMPANY LIMITED,
Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002

HAPPY FAMILY FLOATER POLICY - 2015- PROSPECTUS

WE VALUE YOUR HEALTH & YOUR WEALTH...BUILD A PRODUCTIVE NATION

1.0 ELIGIBILITY

Any person of 18 years or more can take this Policy covering self and/or any one or more of the family members as mentioned below:

- i. Legally wedded spouse.
- ii. Dependent Children (i.e. natural or legally adopted) between the age of 91days to 18 years. However male child can be covered upto the age of 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she gets married. Divorced and widowed daughters, are also eligible for coverage under the policy, irrespective of age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.
- iii. Parents / Parents-in-law (either of them).
- iv. Unmarried siblings, if financially dependent.

Minimum two persons (falling within the definition) to be covered under the Policy.

Persons becoming ineligible on account of above provision for coverage under the existing Policy, may migrate to another suitable Policy at the expiry of the Policy. Upon such Migration, the credits gained by the concerned Insured Person, for Pre-existing conditions and time-bound exclusions shall be transferred to the migrated policy, provided the Policy has been maintained without a break.

1.1A NEW FEATURES IN THE POLICY

- i. Extension (on request) to SAARC countries without any additional premium.
- ii. Diamond Plan introduced- Sum Insured Rs.12lacs to Rs.20lacs
- iii. Organ Donor Benefit- When Insured Person is the donor
- iv. Medical Second Opinion -Reimbursement
- v. Maternity Expenses Cover
- vi. New Born Baby Cover
- vii. Life Hardship Survival Benefit under all Plans*
- viii. Restoration of Sum Insured*
- ix. Increase in Day Care Procedure List

1.1B OTHER SALIENT FEATURES AT A GLANCE

- i. Sum Insured from Rs.2lacs to Rs.20lacs. Existing Insured Persons covered for Rs.1lac Sum Insured may continue with the same. Those existing Insured Persons covered for Sum Insured of Rs.1.5lacs, may also opt for Sum Insured of Rs.1lac.
- ii. Three Plans available– SILVER ,GOLD and DIAMOND

- iii. A floater policy covering the proposer and his / her family under one Sum Insured under one Policy.
- iv. Maximum Entry Age is 65years for all members. However, this can be extended to 70years subject to conditions.
- v. Under Silver and Gold Plans, Pre-acceptance medical check-up is required for persons aged 60 years and above. However, under Diamond Plan, the requirement is for persons aged 55years and above.
- vi. Term of the Policy is one year and is renewable lifelong.
- vii. Pre-existing Disease coverage after four consecutive Policy periods.
- viii. Option of TPA (Cashless facility in network hospitals) and non TPA services.
- ix. Personal Accident cover as optional cover*
- x. Free Look Period
- xi. Discount of 5.5% in premium if TPA services not opted for (no discount on PA premium).
- xii. A discount of 5% on premium is allowed, if the Policy is purchased On-line and no Intermediary is involved. This discount is also applicable in case of On-line renewal of Policies, where no Intermediary was involved at any stage- either on the first purchase or in any subsequent renewal thereof.
*Available at the option of the proposer.

xiii.

Sl.No	Features / Plans	SILVER	GOLD	DIAMOND
i	Sum Insured (SI)	Rs.1,2,3,4 & 5 lacs	Rs.6,7,8,9 & 10lacs	Rs.12, 15, 18 & 20 lacs
ii	Daily Hospital Cash Allowance	Not Available	0.1% of Sum Insured (Rs.600 to Rs.1000) per day of Hospitalisation subject to a maximum compensation for 10 days per illness. Overall liability of the Company during the policy period will be limited to 1.5% of the Sum Insured.	0.1% of Sum Insured (Rs.1200 to Rs.2000) per day of Hospitalisation subject to a maximum compensation for 10 days per illness. Overall liability of the Company during the policy period will be limited to 1.5% of the Sum Insured.
iii	Attendant Allowance	Not Available	Rs.500/- per day of Hospitalisation subject to maximum compensation for 10 days per illness. Overall liability of the Company during the policy period will be limited to compensation for 15 days of Hospitalisation.	Rs.1000/- per day of Hospitalisation subject to maximum compensation for 10 days per illness. Overall liability of the Company during the policy period will be limited to compensation for 15 days of Hospitalisation.
iv	Organ Donor Benefit- when Insured Person is the donor - Waiting period 12 months.	Lumpsum payment of 10% of the Sum Insured	Lumpsum payment of 10% of the Sum Insured	Lumpsum payment of 10% of the Sum Insured

v	Medical Second Opinion for 11 specified major illnesses - taken from anywhere in the world.	Maximum Rs.5000 in a Policy period.	Maximum Rs.10,000 in a Policy period	Maximum Rs.15,000 in a Policy period
vi	Maternity Expenses (available only for the Proposer or his spouse). Both proposer & his/her spouse should be covered under the policy for atleast 24 months.	Not Available	Not Available	Medical Expenses for a delivery (including caesarean section) or lawful medical termination of pregnancy limited to two deliveries or terminations or either during the lifetime of the Insured Person, after the policy (Diamond Plan) has been continuously in force for 24 (twenty four) months Liability of the Company limited to 2.5% of the Sum Insured.
vii	New Born Baby cover. This is subject to claim being admitted under Maternity Expenses cover	Not Available	Not Available	Medical expenses incurred on treatment taken in Hospital as an In-patient in respect of the new born baby from day one upto the age of 90days. Liability of the Company limited to 2.5% of the Sum Insured. Coverage beyond 90days only on payment of requisite premium.
viii	Restoration of Sum Insured for Sum Insured between Rs.3-10lacs, both slabs inclusive.	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured	Not available
ix	Compulsory Co-payment	10% of each & every claim	NIL	NIL
x	Maximum Entry Age	65years for all members	65years for all members	65years for all members

xi	Extension of Maximum Entry Age	Upto 70 years, with compulsory Co-payment of 20% of each & every claim (in addition to the 10% compulsory Co-payment under the Plan). Co-payment to apply on all subsequent renewals also.	Upto 70 years, with compulsory Co-payment of 20% of each & every claim. Co-payment to apply on all subsequent renewals also.	Not Available
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1.2 COVERAGE

The policy covers reasonable and customary charges in respect of Hospitalisation and / or Domiciliary Hospitalisation for Medically Necessary treatment only for illnesses / diseases contracted/suffered or injury sustained by the Insured Person(s) during the Policy period, upto the limit of Sum Insured, as detailed below:

Sl. No	Expenses covered	SILVER Limits of covered Expenses	GOLD Limits of covered Expenses	DIAMOND Limits of covered Expenses
A.	HOSPITALISATION BENEFITS			
i	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home.	1 % of the Sum Insured per day	1 % of the Sum Insured per day.	Rs.10,000 + 0.5% of the Sum Insured above Rs.10lacs, per day
ii	Intensive Care Unit (ICU) Expenses as provided by the Hospital /Nursing Home.	2% of the Sum Insured per day.	2% of the Sum Insured per day.	Rs.20,000 + 1% of the Sum Insured above Rs.10lacs, per day
Number of days of stay under 'i' and 'ii' above should not exceed total number of days of admission in the Hospital. All related expenses (including iii and iv below) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This will not apply on medicines / pharmaceuticals and body implants.				
iii	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees	As per the limits of the Sum Insured.	As per the limits of the Sum Insured.	As per the limits of the Sum Insured.
iv	Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & and similar expenses.	As per the limits of the Sum Insured.	As per the limits of the Sum Insured.	As per the limits of the Sum Insured.

v	Ambulance service charges	<ul style="list-style-type: none"> • Per illness - Rs.1000 maximum. • Per Policy period- 1% of Sum Insured, subject to maximum Rs.3000. 	<ul style="list-style-type: none"> • Per illness - Rs.2000 maximum. • Per Policy period- Rs.6000 maximum 	<ul style="list-style-type: none"> • Per illness -Rs.3000 maximum. • Per Policy period- Rs.8000 maximum.
vi	Pre and Post Hospitalisation expenses	Medical expenses incurred 30days prior to Hospitalisation and upto 60 days Post Hospitalisation.		
<p>Note: 1. In case of Ayurvedic / Siddha / Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as an In-patient, in a Government Hospital or in any Institute recognised by Govt. and/or accredited by Quality Council of India / National Accreditation Board on Health.</p> <p>2. Relaxation to 24 hours minimum duration of hospitalisation is allowed in</p> <p>a) Specified Day Care procedures / Surgeries where such treatment is taken by an Insured Person in a Hospital / Day Care Centre (but not the Out-Patient department of a hospital), Or</p> <p>b) Any other Day Care Treatment as mentioned in clause 3.8 and for which prior approval from Company / TPA is obtained in writing.</p>				
B.	DOMICILIARY HOSPITALISATION BENEFITS			
i.	Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines & Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses.	10% of Sum Insured, Maximum Rs.25000/- during the Policy period.	Maximum Rs.50000/- during the Policy period.	Maximum Rs.50000 during the Policy period.
ii.	Treatment for Dog bite (or bite of any other rabid animal like monkey, cat etc.)	Maximum Rs.5,000/- actually incurred on immunisation injections in any one Policy period. This will be part of Domiciliary Hospitalisation limits as specified. However, conditions of Domiciliary Hospitalisation Benefit shall not apply.		

Domiciliary Hospitalisation benefit shall, however, not cover expenses in any of the following cases

- a) if the treatment lasts for a period of three days or less
- b) incurred on Pre and Post Hospitalisation treatment, And
- c) incurred on treatment of any of the following diseases :
 - i. Asthma
 - ii. Bronchitis
 - iii. Chronic Nephritis and Nephritic Syndrome
 - iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis
 - v. Diabetes Mellitus and Insipidus

- vi. Epilepsy
- vii. Hypertension
- viii. Influenza, Cough and Cold
- ix. All Psychiatric or Psychosomatic Disorders
- x. Pyrexia of unknown origin for less than 10 days
- xi. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis
- xii. Arthritis, Gout and Rheumatism.

Note: Liability of the Company under Domiciliary Hospitalisation Benefit is restricted as stated in 1.2B.

1.3A ORGAN DONOR EXPENSES- When Insured Person is the Recipient: The policy covers In-patient Hospitalisation Medical expenses in respect of the organ donor provided that the organ donation is for the Insured Person and conforms to the Transplantation of Human Organs Act 1994(amended) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs.

1.3B ORGAN DONOR BENEFIT: When Insured Person is the Donor: A lumpsum payment of 10% of the Sum Insured (to take care of medical and other incidental expenses) is payable to the Insured Person donating an organ in accordance with, and the organ donation having been carried out in accordance with the extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. A waiting period of 12months from the date of taking Happy Family Floater Policy-2015 shall, however, apply.

1.4 .OPTIONAL COVERS

1.4 A GEOGRAPHICAL EXTENSION TO SAARC COUNTRIES: The Policy can be extended to cover Insured Persons visiting other South Asian Association for Regional Co-operation (SAARC) countries -Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka. No additional premium will be charged for this. However, the Insured Person has to make a request for such extension, in writing, before leaving the country, duly informing the duration, purpose and country(ies) of visit. Endorsement for such extension will be issued by the Company.

1.4 B Following coverages can be taken on payment of additional premium.

Sl.no	Features / Plans	SILVER	GOLD	DIAMOND
i	RESTORATION OF SUM INSURED (only for SI of Rs.3lacs to Rs.10lacs, both inclusive)	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured	2 options-(i) 50% of the Sum Insured (ii) 100% of the Sum Insured	Not Available
ii	PERSONAL ACCIDENT	CSI in multiples of Rs.1,00,000/- upto Rs.5,00,000/-per Insured Person aged 18 years and	CSI in multiples of Rs.1,00,000/- upto Rs.10,00,000/-per Insured Person aged 18	CSI in multiples of Rs.1,00,000/- upto Rs.20,00,000/-per Insured Person aged 18 years and

		above. However, for Insured Person below 18 years of age maximum CSI of Rs.3lacs is allowed subject to this being lower than the CSI of the proposer	years and above. However, for Insured Person below 18 years of age maximum CSI of Rs.5lacs is allowed subject to this being lower than the CSI of the proposer	above. However, for Insured Person below 18 years of age maximum CSI of Rs.10lacs is allowed subject to this being lower than the CSI of the proposer
iii	LIFE HARDSHIP SURVIVAL BENEFIT	Plans as defined hereinafter	Plans as defined hereinafter	Plans as defined hereinafter

I. RESTORATION OF SUM INSURED

If during the Policy period the Sum Insured gets reduced or exhausted on account of a claim under the policy, the Sum Insured is automatically restored to the extent of the claim amount but not exceeding the Restoration limit opted (50% / 100% of Sum Insured) at the inception of the policy.

The above is subject to the following:

- i. Aggregate of all the restored amounts during the policy period shall not exceed 50% / 100% of the Sum Insured, as opted by the Insured.
- ii. At no point of time during the Policy period, will the available coverage be more than the Sum Insured mentioned in the Schedule.
- iii. Aggregate of all the claims payable for any one Insured Person under the Policy shall not be more than the Sum Insured.
- iv. During a Policy period, the maximum amount for any one claim payable shall be the Sum Insured and the aggregate of all claims payable shall not exceed the sum of the Sum Insured and Restored Sum Insured.

II. PERSONAL ACCIDENT COVER: (WORLD – WIDE)

If at any time during the currency of the policy, the Insured Person sustains any bodily injury, resulting solely and directly from sudden, unforeseen and involuntary event caused by external, visible and violent means anywhere in the world, and if such injury, within 12 months of its occurrence be the sole and direct cause of death or disability, as covered under the Policy, then the Company undertakes to pay to the Insured or his nominee or in the absence of nominee, the legal heir, as the case may be, the following sums :

Sl.	Coverage	Liability of the Company
1.	Accidental Death only	100% of CSI
2.	Loss of two entire limbs, or sight of two eyes or one entire limb and sight of one eye.	100% of CSI

3.	Loss of one entire limb or sight of one eye	50% of CSI
4.	Permanent Total Disablement resulting in totally and absolutely disabling the insured person from engaging in any employment or occupation whatsoever.	100% of CSI

- a) CSI means Capital Sum Insured opted under the Personal Accident section.
- b) CSI may vary for different members and is available separately for each member.
- c) 10% family discount will be allowed in case more than one member is covered.
- d) Overall liability in the event of one or more of the eventualities (listed above) occurring shall be restricted to the CSI of the Insured Person as mentioned in the schedule.

EXCLUSIONS: The Company shall not be liable under the Personal Accident section for injuries / death on account of

- i. Intentional self-injury, suicide or attempted suicide
- ii. Whilst under the influence of intoxicating liquor or drugs
- iii. Engagement in aviation or ballooning, speed contests or racing on any kind (other than on foot), bungee jumping, parasailing, parachuting, ski-diving, BASE jumping, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, solo climbing, ice climbing, ice canoeing, scuba diving, caving, cave diving, potholing, abseiling, snowboarding, waveski surfing, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and similar other hazardous activities or involving military, air force or naval operations, or whilst mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft, anywhere in the world, unless specifically covered and endorsed on the policy.
- iv. Directly or indirectly caused by venereal disease(s) or insanity
- v. Arising or resulting from insured committing breach of Law with criminal intent
- vi. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainments of people
- vii. Directly or indirectly caused by or arising from ionizing radiations or contamination by radioactivity from any nuclear fuel, nuclear weapon material, or from any nuclear waste from the combustion of nuclear fuel
- viii. Directly or indirectly caused by, contributed by, aggravated or prolonged by childbirth or from pregnancy or in consequence thereof.

III. LIFE HARDSHIP SURVIVAL BENEFIT PLAN

If during the Policy period, any Insured Person is diagnosed with any of the 11 Critical Illnesses defined hereunder and which results in admissibility of a claim under clause 1.2 A of the Policy, then a Survival Benefit as mentioned below, shall become payable to the Insured Person. However, this benefit shall not be available for the illness which the Insured Person is already suffering from (irrespective of the stage of the disease) at the time of opting for this cover for the first time.

Plan	Total amount payable	Amount payable on survival for 180 days and above from the date of discharge from the hospital (the first discharge date when more than one hospitalisation is involved).	Amount payable on survival for 270 days and above from the date of discharge from the hospital (the first discharge date when more than one hospitalisation is involved).
A	15 % of Sum Insured under the policy	5% of the Sum Insured	10% of the Sum Insured
B	25 % of Sum Insured under the policy	10% of the Sum Insured	15% of the Sum Insured

- i. Limits under this section indicate the aggregate liability of the Company for one or more claims under the Policy in respect of one or all the Insured Persons covered under the Policy.
- ii. Further, for a particular disease, the above benefit shall be paid only once during the lifetime of the Insured Person.

CRITICAL ILLNESSES COVERED:

1. CANCER OF SPECIFIED SEVERITY: A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukaemia, lymphoma and sarcoma.

The following are excluded -

- i. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- ii. Any skin cancer other than invasive malignant melanoma
- iii. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
- iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- v. Chronic lymphocytic leukaemia less than RAI stage 3
- vi. Microcarcinoma of the bladder
- vii. All tumours in the presence of HIV infection.

2. FIRST HEART ATTACK - OF SPECIFIED SEVERITY

I. The first occurrence of 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 this will be evidenced by all of the following criteria

- i. A history of typical clinical symptoms consistent with the diagnosis of Acute myocardial Infarction (for e.g typical chest pain)
- ii. New characteristic electrocardiogram changes
- iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

- i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of troponin I or T
- ii. Other acute Coronary Syndromes
- iii. Any type of angina pectoris.

3. OPEN CHEST CABG

I. The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

II. The following are excluded:

- i. Angioplasty and/or any other intra-arterial procedures
- ii. Any keyhole or laser surgery.

4. 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 technique including but not limited to, balloon valvotomy/valvulo plasty are excluded.

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all the following:

- i. No response to external stimuli continuously for atleast 96 hours.
- ii. Life support measures are necessary to sustain life; and
- iii. Permanent neurological deficit which must be assessed atleast 30 days after the onset of the coma.

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

6. 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 (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

7. 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 embolisation 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:

- i. Transient ischemic attack (TIA)
- ii. Traumatic injury of Brain

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iii. Vascular disease affecting only the eye or optic nerve or vestibular functions

8. MAJOR ORGAN/BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of

- i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner

II. The following are excluded:

- i. Other stem cell transplants
- ii. Where only islets of langerhans are transplanted

9. 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.

10. 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.

11. MULTIPLE SCLEROSIS WITH PERSISTENT SYMPTOMS

I. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following

- i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
- ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months; and
- iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

II. Other causes of neurological damage such as SIE and HIV are excluded.

2. OTHER MAJOR FEATURES:

- A. MINIMUM SUM INSURED:** Sum Insured of Rs.1lac and 1.5 lacs have been discontinued in Happy Family Floater Policy-2015. Minimum Sum Insured under the Policy is now Rs.2lacs. However,

- a. Those Insured Persons who were already covered for Rs.1lac Sum Insured under Happy Family Floater Policy are being offered two options:
 - i. They may opt for Sum Insured of Rs.2lacs and as a one-time benefit, Company will allow 25% discount on the total premium of Rs.2lacs Sum Insured (No discount is offered if the Insured opts for a Sum Insured above Rs.2lacs). This premium benefit is available only in case of first renewal into Happy Family Floater Policy-2015. No discount will be allowed on subsequent renewals.
 - ii. Those Insured Persons who wish to continue with the old Sum Insured of Rs.1lac, may continue with the same. However, no discount will be allowed if on subsequent renewal the Insured opts for a Sum Insured of Rs.2lacs.
- b. Those Insured Persons who were covered for a Sum Insured of Rs.1.5 lacs in Happy Family Floater Policy, are also being offered two options:
 - i. They may opt for Sum Insured of Rs.2lacs and as a one-time benefit, Company will allow 25% discount on the total premium of Rs.2lacs Sum Insured (No discount is offered if the Insured opts for a Sum Insured above Rs.2lacs). This premium benefit is available only in case of first renewal into Happy Family Floater Policy-2015. No discount will be allowed on subsequent renewals.
 - ii. If for any reason, the Insured is unwilling to move to higher Sum Insured, he will have the option to take the Sum Insured of Rs.1lac. However, no discount shall be available to the Insured in this case.

- B. MIDTERM INCLUSION:** Midterm inclusion of members is permitted under the Policy, on payment of pro-rata premium only for
- i. Newly wed spouse within 90days of marriage or at the time of renewal of the Policy.
 - ii. New Born Child from 91st day of birth or at the time of renewal of the Policy.

For members subsequently added, clauses 4.1, 4.2 and 4.3 shall apply from the date of their inclusion in the policy.

- C. NO CLAIM DISCOUNT / LOADING:** This is a one-time benefit for those Insured Persons covered under Happy Family Floater policy. Happy Family Floater Policy had the provision of No Claim Discount / Loading, which has been discontinued under Happy Family Floater Policy-2015. However,
- i. The discount on account of 'No Claim', which would have been earned by the Insured Person on renewal of the Happy Family Floater policy, would be allowed when the Policy is renewed for the first time, into Happy Family Floater Policy-2015. However, there will be no change in discount even if there are no claims reported under the subsequent Happy Family Floater Policy-2015 policy(ies). This discount shall continue till a claim is reported under the policy and upon reporting of a claim, any discount earned on account of 'No Claim' shall be forfeited. However, claim under PA section will not affect No Claim Discount earned thus far.
 - ii. The Insured Persons with claim loading(s) on their previous policies will not have any loading on the premium on renewal into Happy Family Floater Policy-2015, i.e loadings on account of claims are discontinued.

- D. ENHANCEMENT OF SUM INSURED:** Increase in Sum Insured under the Policy may be considered by the Company only at the time of Renewal. If at all allowed, increase shall be as given below:

- i. On Renewal, Sum Insured can be increased to the immediate higher slab.
- ii. If, on Renewal, the size of the family increases, Sum Insured can be increased to maximum two slabs higher.
- iii. If there are no claims reported in the two immediate preceding Policy Periods, change to the next Plan (Silver to Gold, Gold to Diamond) at the initial Sum Insured slab, or two steps higher from the current Sum Insured, whichever is more, is allowed.
- iv. Change of Plan is not allowed for a Policy covering any person above the age of 70years. However, Increase in Sum Insured within the same Plan is allowed as per above provisions.
- v. Notwithstanding above provisions, no increase in Sum Insured is allowed in policies where there are claims reported in two successive Policy Periods.

E. DISCOUNT ON OMP PREMIUM: A discount of 15% on the premium of Overseas Medclaim Policy would be allowed when an Insured Person covered under this Policy, takes the Overseas Medclaim Policy from the Company, provided this Policy is valid as on the date of taking the Overseas Medclaim Policy of the Company.

F. PRE -ACCEPTANCE MEDICAL CHECKUP: Any person above the age of 60 years proposing to take insurance cover for the first time under Silver or Gold Plan, and above the age of 55 years under Diamond Plan, has to submit following medical reports, or any other additional medical report(s) required by the Company, from listed Diagnostic Centres. Pre-Acceptance Medical Check-up is required in case of fresh proposals and in cases where there has been a break in the Policy Period.

Also, based on the information provided in the Proposal Form, the Company may require any proposed member, irrespective of his/her age, to undergo medical tests.

The list of Diagnostic centres is available with the underwriting office from where the Policy is intended to be taken. The cost shall be borne by the insured.

1	MEDICAL EXAMINATION
2	CBC WITH ESR
3	LIPID PROFILE
4	HbA1c
5	S.CREATININE
6	URINE-ROUTINE & MOLECULAR
7	ECG
8	TSH
9	X-RAY CHEST
10	USG
11	EYE EXAMINATION-FUNDUS & GLAUCOMA

In case of fresh proposals 50% cost of Medical Check up shall be reimbursed if the proposal has been accepted by the Company. This benefit will also be allowed in cases

where continuity benefits are not restored and the Policy is treated as fresh (and not as renewal) after the break in Policy Period.

Validity period of medical reports is upto 30 days from the date of proposal.

- G. MIGRATION:** Any person insured under our Individual/Group Health Policy may migrate into Happy Family Floater Policy-2015 at the time of renewal of his Policy. Upon such migration, the credits gained by the concerned Insured Person, for pre-existing conditions and time-bound exclusions shall be maintained under Happy Family Floater Policy-2015, provided there is no break in the Policy.

3. DEFINITIONS:

- 3.1 ACCIDENT:** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 3.2 AMBULANCE SERVICES:** means ambulance service charges reasonably and necessarily incurred in shifting the insured person from residence to hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the hospitalisation expenses are admissible under the policy.
- 3.3 ATTENDANT ALLOWANCE:** When an Insured Person above the age of 90 days and upto the age of 10 years is hospitalised and a claim is admitted under the GOLD or DIAMOND plan of the Policy, a sum as mentioned under 1.1(B) above will become payable under the Policy.
- 3.4 CASHLESS FACILITY:** means a facility extended by the insurer to the insured where the payments of the costs of the treatment undergone by the insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre- authorization approved.
- 3.5 CO-PAYMENT:** is a cost-sharing requirement under a health insurance policy that provides that the Policy holder/insured will bear a specified percentage of the admissible claim amount. A Co-payment does not reduce the Sum Insured.
- 3.6 DAILY HOSPITAL CASH ALLOWANCE:** When an Insured Person is hospitalized and a claim is admitted under the Policy, then the Insured Person shall be paid a Daily Hospital Cash Allowance as specified under 1.1B above.
- 3.7 DAY CARE CENTRE:** means any institution established for day care treatment of illness and / or injuries OR a medical set -up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-
- i has qualified nursing staff under its employment,
 - ii has qualified Medical Practitioner (s) in charge,
 - iii has a fully equipped operation theatre of its own, where surgical procedures are carried out
 - iv maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

3.8 DAY CARE TREATMENT: refers to medical treatment, and/or surgical procedure which is:

- i undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
- ii which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.9 DOMICILIARY HOSPITALISATION BENEFIT: means medical treatment for a period exceeding three days for such disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- i the medical condition of the patient is such that he/she is not in a position to be moved to a hospital, or
- ii the patient takes treatment at home on account of non availability of room in a hospital.

3.10 HOSPITAL/NURSING HOME: means any institution established for In- patient care and Day Care Treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- i has qualified nursing staff under its employment round the clock;
- ii has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and atleast 15 inpatient beds in all other places;
- iii has qualified Medical Practitioner (s) in charge round the clock;
- iv has a fully equipped operation theatre of its own where surgical procedures are carried out
- v maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

3.11 HOSPITALISATION : means admission in a Hospital for a minimum period of twenty four (24) in-patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

3.12 INSURED PERSON: Means Person(s) named on the schedule of the Policy.

3.13 MEDICAL PRACTITIONER: means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

3.14 NETWORK PROVIDER: means hospitals or healthcare providers enlisted by an insurer or by a TPA and insurer together, to provide medical services to an insured on payment, by a Cashless facility.

3.15 PRE-HOSPITALISATION EXPENSES: means Medical Expenses incurred during the period upto 30 days prior to the date of admission in the Hospital, provided that:

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

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

3.16 POST-HOSPITALISATION EXPENSES: means Medical Expenses incurred for a period upto 60 days from the date of discharge from the Hospital, provided that:

- i Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- ii The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.17. PRE EXISTING DISEASE: means any condition, ailment or injury or related condition(s) for which the insured person(s) had signs or symptoms, and / or was diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.

3.18 PORTABILITY: means transfer by an individual health insurance Policy holder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

3.19 QUALIFIED NURSE: means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.20 REASONABLE AND CUSTOMARY CHARGES : means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved .

3.21 THIRD PARTY ADMINISTRATOR (TPA): means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

3.22 UNPROVEN/EXPERIMENTAL TREATMENT: Treatment including drug experimental therapy which is not based on established medical practice in India.

4. GENERAL EXCLUSIONS: The Company shall not be liable to make any payment under this Policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

- 4.1** All Pre-existing Disease (whether treated / untreated, declared or not declared in the Proposal Form), which are excluded upto 48 months of the Policy being in force. Pre-existing Diseases shall be covered only after the Policy has been continuously in force for 48 months. For the purpose of applying this condition, the date of inception of the first indemnity based health Policy taken shall be considered, provided the Renewals have been continuous and without any break in period, subject to portability condition. This exclusion shall also apply to any complication(s) arising from Pre existing Diseases. Such complications will be considered as part of the Pre existing health condition or Disease.

- 4.2 Any disease other than those stated in clause 4.3, contracted by the Insured Person during the first 30 days from the inception date of fresh Policy. This shall, however, not apply in case the Insured Person is hospitalised for injuries suffered in an Accident, which occurred after inception of the Policy.
- 4.3 The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first Policy (subject to continuity being maintained), are not payable during the waiting period specified below.

Sl.	Ailment / Disease / Surgery	Waiting Period
i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
ii	Polycystic ovarian diseases.	1 year
iii	Surgery of hernia.	2 years
iv	Surgery of hydrocele.	2 years
v	Non infective Arthritis.	2 years
vi	Undescendent Testes.	2 Years
vii	Cataract.	2 Years
viii	Surgery of benign prostatic hypertrophy.	2 Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	2 Years
x	Fissure / Fistula in anus.	2 Years
xi	Piles.	2 Years
xii	Sinusitis and related disorders.	2 Years
xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
xiv	Surgery of genito urinary system excluding malignancy.	2 Years
xv	Pilonidal Sinus.	2 Years
xvi	Gout and Rheumatism.	2 Years
xvii	Hypertension.	2 Years
xviii	Diabetes.	2 Years
xix	Calculus diseases.	2 Years
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
xxi	Surgery of varicose veins and varicose ulcers.	2 Years
xxii	Congenital internal diseases.	2 Years
xxiii	Joint Replacement due to Degenerative condition.	4 Years
xxiv	Age related osteoarthritis and Osteoporosis.	4 Years

If the above diseases are pre-existing at the time of inception, clause.4.1 for Pre-existing Disease shall be applicable.

Note: If the continuity of the Renewal is not maintained then subsequent cover will be treated as fresh Policy and clauses 4.1, 4.2, 4.3 shall apply afresh, unless agreed by the Company and suitable endorsement passed on the Policy, by the duly authorised official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first Policy, clauses 4.1, 4.2 and 4.3 shall apply afresh on the enhanced portion of the Sum Insured.

- 4.4 Injury or disease directly or indirectly caused by or arising from or attributable to war, invasion, act of Foreign enemy, war like operations (whether war be declared or not) or by nuclear weapons / materials.

- 4.5 Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination (except as covered under 1.2 B(ii), inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- 4.6 Surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc.
- 4.7 Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, crowns, root canal treatment including treatment for wear and tear etc., unless arising from disease or injury and which requires hospitalisation for treatment.
- 4.8 Convalescence, general debility, "run down" condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to, and /or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc., any disease or injury as a result of committing or attempting to commit a breach of Law with criminal intent.
- 4.9 All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.
- 4.10 Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.
- 4.11 Expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.
- 4.12 Any treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy (not applicable in Diamond Plan to the extent given under clause 1.1B) except in the case of abdominal operation for extra uterine pregnancy (ectopic pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated.
- 4.13 Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine (other than Ayurveda, Siddha, Unani & Homeopathy as expressed in clause 1.2 A1) and related treatment including acupressure, acupuncture, magnetic and such other therapies.
- 4.14 Expenses for investigation/treatment irrelevant to the disease for which admitted or diagnosed. Private nursing charges, Referral fee to family doctors, Out station consultants / Surgeons fees etc.
- 4.15 Genetic disorders and stem cell implantation / surgery.

- 4.16 Cost of external and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps , splints, slings, braces, Stockings etc of any kind, Diabetic foot wear, Glucometer, Thermometer, Blood Pressure monitoring machine and similar related items and also any medical equipment which is subsequently used at home. Exhaustive list available on our website (www.orientalinsurance.org.in).
- 4.17 All non medical expenses including personal comfort and convenience items or services such as wi-fi/internet charges telephone, television, ayah / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc, guest services and similar incidental expenses or services etc.
- 4.18 Change of treatment from one system of medicine to another unless agreed / allowed and recommended by the consultant under whom the treatment is being taken.
- 4.19 Treatment for Age Related Macular Degeneration (ARMD), treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- 4.20 Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme, and similar services or supplies.
- 4.21 Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing and similar other activities, unless specifically agreed and endorsed on the policy.
- 4.22 Treatment taken in an Establishment which is a place for rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel, convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- 4.23 Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.
- 4.24 Out patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
- 4.25 Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.
- 4.26 Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the hospital.
- 4.27 Doctor's home visit charges, Attendant / Nursing charges during Pre and Post Hospitalisation period.
- 4.28 Pre and Post Hospitalisation expenses unrelated with disease / injury for which Hospitalisation claim has been admitted under the policy.

4.29 Compulsory Co-Payment: Under the SILVER plan the insured has to bear 10% of admissible claim amount in each and every claim.

5. CONDITIONS

5.1 FREE LOOK PERIOD: This Policy has a free look period. The free look period shall be applicable at the inception of the fresh Policy and the insured is allowed a period of 15 days from the 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 insurer on medical examination of the Insured Persons 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 policyholder, a deduction towards the proportionate risk premium for period on cover or
- iii. where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

As a one time option, the Insureds who have, upon renewal, got the Happy Family Floater Policy-2015, for the first time, will also get the option of Free look period as stated above.

5.2 PORTABILITY: In the event of the Insured Person porting to any other insurer, Insured Person must apply with details of the Policy and claims to the insurer where the Insured Person wants to port, atleast 45 days before the date of expiry of the Policy.

5.3 PAYMENT OF PREMIUM: The premium under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the Company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this Policy shall be valid, unless made in writing and signed by an authorised official of the Company.

5.4 NOTICE OF CLAIM: Immediate written notice of claim with particulars relating to Policy number, ID Card no., Name of insured person in respect of whom claim is made, nature of disease / illness / injury and name and address of the attending Medical Practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by fax, email. Such written notice should be given within 48 (forty eight) hours of admission or before discharge from Hospital / Nursing Home, whichever is earlier unless waived in writing.

5.5 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME:

- i. Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a network Hospital / Nursing Home and is subject to pre admission authorization.
- ii. The Company / TPA reserves the right to deny pre-authorization in case the Hospital / Insured Person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of liability.
- iii. Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorisation of Cashless facility may be withdrawn.

5.6 CLAIM DOCUMENTS: Final claim along with documents stated in the policy, should be submitted to the Company / TPA within 15 days of discharge from the Hospital / Nursing Home.

5.7 PAYMENT OF CLAIM: All medical treatment for the purpose of this insurance will have to be taken in India only (except where the policy has been extended to SAARC countries) and all claims shall be payable in Indian currency only. For the purpose of claims settlement, currency conversion rate on the date of admission to Hospital would apply.

5.8 RENEWAL OF POLICY: The Company shall not be responsible or liable for non-renewal of Policy due to non-receipt **or** delayed receipt (i.e. after the due date including the grace period of 30 days) of premium **or** the Proposal Form **or** of the Medical Practitioner's report wherever required or due to any other reason whatsoever.

5.9 REVISION IN PREMIUM / TERMS: The rates applied are valid only for the period of this Policy.

- i. The Company may revise the premium rates and / or the terms & conditions of the Policy, upon Renewal thereof, only after due approval from IRDAI. Renewal of this Policy is not automatic; premium due must be paid to the Company before the due date. Any revision or modification in the Policy will be notified to the policyholders three months in advance.
- ii. The Company shall not ordinarily deny the Renewal of this Policy unless on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the Insured.

5.10 REPUDIATION:

- i. The Company, shall repudiate the claim if not payable under the Policy. The Company / TPA shall mention the reasons for repudiation in writing to the Insured Person. The Insured Person shall have the right to appeal / approach Customer Service Department of the Company at its Policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002.
- ii. If the Insured is not satisfied with the reply of the Customer Service Department under 5.10 (i), he may approach the Insurance Ombudsman, established by the Central

Government for redressal of grievance. The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto Rs.20 lacs.

- 5.11 CANCELLATION CLAUSE:** Company may at any time, cancel this Policy (on grounds of fraud, moral hazard, misrepresentation or non-co-operation), by sending the Insured 30 (Thirty) days notice by registered post at the Insured's last known address; and in such an event, the Company shall refund to the Insured a pro-rata premium for un-expired Policy period only. However, no refund shall be made when cancellation is on grounds of fraud or moral hazard.

The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given below) provided no claim has occurred during the Policy period up to the date of Cancellation.

Period on Risk	Rate of premium to be charged
Upto 1 Month	1/4th of the annual rate
Upto 3 Months	1/2 of the annual rate
Upto 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

- 5.12 PRODUCT WITHDRAWAL:** This product may be withdrawn in future with due approval of IRDAI. However, in the event of withdrawal of the product, the insured shall be informed of the options available.
- 5.13 IT EXEMPTION:** The premium under the Policy is eligible for Income Tax exemption in accordance with the extant IT Act.
- 5.14 DISCLOSURE TO INFORMATION NORM:** The Policy shall be void in the event of misrepresentation, mis-description or non-disclosure of any material fact.
- 5.15 IRDAI REGULATION:** This Policy is subject to IRDAI (Protection of policy holders' interest) Regulation,2002 and IRDAI (Health Insurance) Regulations 2013 and Guidelines on Standardisation in Health Insurance as amended from time to time.
- 5.16 JURISDICTION:** All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and according to the Indian Laws.
- 5.17 HOW TO APPLY FOR INSURANCE:** The Proposer has to complete the Proposal Form and Enrolment Form in duplicate and submit Insured Person's details of each member. The proposer has to affix coloured stamp size photographs of each of the members to be insured on the Enrolment Form against the name of the person. These photographs will be utilised by Third Party Administrator for preparing ID card for each of the members insured.

The Prospectus contains salient features of the Policy. For details, reference is to be made to the Policy. In case of any difference between the Prospectus and the Policy, the terms and conditions of the Policy shall prevail.

The Prospectus and Proposal Form are part of the Policy. Hence please read the Prospectus carefully and sign the same. The Proposal Form is to be completed in all respects for each Insured Person. Both the Prospectus and the Proposal Form are to be submitted to the office or to the agent.

Name: _____ Signature _____

Address: _____

Place: _____ Date: _____

Note: For legal interpretation only English version will be valid.

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:

1. No person shall allow, or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of 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.

2. 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.

PREMIUM SCHEDULE - HAPPY FAMILY FLOATER POLICY-2015
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1	BASIC PREMIUM TABLE
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SI/AGE	91 days to 20 yrs	21-35 yrs	36-45 yrs	46-55 yrs	56-60 yrs	61-65 yrs	66-70 yrs	71-75 yrs	76-80 yrs	>80 yrs
SILVER PLAN										
100000	1029	1530	1716	2106	3810	4822	5302	5829	6409	7048
200000	1862	2051	2592	3497	5915	8175	8990	9887	10873	11957
300000	2249	2720	3552	4929	7986	11435	12576	13831	15211	16730
400000	2747	2944	4726	6465	10170	13127	14437	15878	17464	19207
500000	3406	3491	5767	7552	11626	14819	16299	17926	19716	21685
GOLD PLAN										
600000	4327	5326	6706	10780	16288	20841	22920	25207	27723	30490
700000	4729	5765	7906	12900	19428	25089	27593	30348	33377	36710
800000	5170	6241	9279	13631	20474	26336	28964	31856	35036	38535
900000	5652	6757	9752	14275	21397	27435	30174	33186	36499	40144
1000000	6180	7315	10176	14851	22222	28418	31255	34376	37808	41584
DIAMOND PLAN										
1200000	6885	8236	11683	16930	25121	32130	35309	38806	42652	46883
1500000	7323	9463	13564	19728	29181	37585	41303	45392	49891	54839
1800000	7694	10845	15526	22732	33550	43669	47988	52739	57966	63715
2000000	7914	11893	16922	24924	36745	48261	53035	58286	64063	70417

Full premium from the above Table to be charged on the two members of the highest age.

50% discount on the premium of member with third highest age will be given

60% discount on the premium of all other members will be given.

Total Basic Premium is the premium for all the Insured Persons covered under the policy

A RESTORATION OF SUM INSURED- ONLY FOR SI OF Rs.3lacs to Rs.10 lacs

Restoration Amount	Premium
50% of SI	15% of Total Basic Premium
100% of SI	25% of Total Basic Premium

B PERSONAL ACCIDENT

CSI AVAILABLE Rs.1lac to Rs.20 lacs, per Insured person.

Premium Rate-Rs.60 per lac per person

Family Discount of 10% if more than one member is covered under this section

C LIFE HARDSHIP SURVIVAL BENEFIT

Plan	Premium
Plan A	3% of Total Basic Premium
Plan B	5% of Total Basic Premium

Premium in the above tables is in Indian rupees.

Service Tax as applicable shall be extra.

Premium will be calculated on completed age.