THE ORIENTAL INSURANCE COMPANY LIMITED

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CIN No.U66010DL1947GOI007158

ORIENTAL CRITICAL ILLNESS POLICY

PROSPECTUS

We welcome You as Our Customer. This document explains how the **ORIENTAL CRITICAL ILLNESS POLICY** could provide value to your Health Care. In the document the word 'You', 'Your' means the Insured under the Policy. 'We', 'Our', 'Us', 'Company' means the Insurer i.e The Oriental Insurance Co. Ltd.

INTRODUCTION:

1. **ORIENTAL CRITICAL ILLNESS POLICY** is a benefit Policy. In the event of the insured person being first diagnosed as suffering from a Critical Illness, symptoms (and/or the treatment) of which were not present in such insured person at any time prior to inception of the Policy, the Company shall pay to the insured person the benefit defined below.

Critical Illness Benefit

The Company shall pay the full sum insured as mentioned in the schedule, provided:

i. The insured person is diagnosed with a critical illness specifically listed and defined in the policy; and

ii. the insured person survives such critical illness by number of days specified in the policy schedule as survival period or more, from the date of diagnosis/ date of undergoing the surgical procedure.

Notes:

a. for this benefit critical illness shall mean the illness/ surgical procedures specified under clause 2.B.1 to 2.B.22.

b. the company shall compensate the insured person, only once in respect of anyone or more of the covered diseases under the policy.

c. should a benefit paid in terms of this policy on behalf of an insured person the coverage for that person terminates under this policy and such person shall not be entitled to be covered by this policy or its renewal thereof.

Critical Illness includes the following illness/ surgeries, depending on the plan opted**.**

1. Cancer of specified severity
2. Myocardial infarction (first heart attack)
3. Open chest CABG
4. Open heart replacement or repair of heart valves
5. Coma of specified severity
6. Kidney failure requiring regulardialysis
7. Stroke resulting in permanent symptoms
8. Major organs/ bone marrow transplant
9. Permanent paralysis of limbs
10. Motor neuron disease with permanent symptoms

13. Benign brain tumour

14. Blindness
15. Deafness
16. End stage lung failure
17. End stage liver failure
18. Loss of speech
19. Loss of Limbs
20. Major Head trauma
21. Primary (ideopalhic) pulmonary hypertension
22. Third degree burns.

Medical Second Opinion Benefit

a. Medical Second Opinion Benefit up to 1% of Sum insured in a policy period subject to maximum of Rs.10000 for Sum Insured up to Rs. 20 lakhs and Rs.20000 for Sum Insured up to Rs.50 lakhs.

b. Claim under this clause would be admissible subject to the critical illness claim being admissible.

c. This expense is payable only once per illness per insured person during the lifetime of the insured person.

d. The second opinion benefit is valid only if critical illness policy is in force.

SALIENT FEATURES

Eligibility

i. Proposer should be between eighteen (18) years and sixty five (65) years.
ii. Maximum entry age of any family member is sixty five (65) years.
iii. Children between the age of eighteen (18) years and twenty five (25) years pursuing full time studies can be covered, provided bonafide certificate from educational institution is submitted as proof. Unmarried and/or unemployed female children can also be covered as dependents.
iv. Policy can be availed for self and the following family members
    a. Spouse
    b. Dependent legitimate or legally adopted children, up to twenty five (25) years of age
    c. Parents OR Parents in Law (either of them)
    d. Unmarried dependent siblings.

v. **Midterm inclusion** of family members at pro-rata premium is allowed only in case of spouse, within ninty days of marriage.
vi. (Members other than above may be included only at renewal. On inclusion of a new member, waiting period of 90 days shall apply).
vii. Dependent children have the option to port to similar health insurance product of the Company or any other insurer on completion of the specified exit age as mentioned.

Note: Only completed years to be considered for age calculation.

Plans - The Policy is available under two Plans:

Plan A - Covering 11 Critical Illnesses.
Plan B - Covering 22 Critical Illnesses (including plan A).
Each family member should opt for same plan.

Sum Insured (SI)

i. The SI available per insured person is **INR 2/4/6/8/10/12/14/16/18/20/25/30/35/40/45/50 Lakhs**.

ii. All SI slabs are available under both Plan A and Plan B.

iii. For fresh entrants at the age of 50 years and above, maximum sum insured available is restricted to INR 20 lakhs.

Change of Sum Insured

i. Sum Insured can be changed (increased/ decreased) only at the time of Renewal, subject to discretion of the Company.

ii. Increase in SI shall be allowed by one slab at a time.

iii. Increase in Sum Insured is allowed in policies where there are no claims reported in two successive policy years.

*** Mid term increase/decrease in SI is not allowed.**

Change of Plan

i. Change of Plan from Plan A to Plan B is allowed only at the time of renewal, subject to four years of continuous coverage with the Company and no claim reported under the Policy.

ii. For change of plan, medical reports are required to be submitted with respect to each insured person aged forty five years and above.

Policy Period

The policy period is available in two options, as under:-

a. Annual Policy - One year

b. Long Term Policy - Three years

* No short period policy is allowed i.e. policy period with less than one year duration.

DISCOUNTS :

a). Discount on direct On-line policies: A discount of 10% (subject to maximum upto Rs. 2000/-) 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 inany subsequent renewalthereof.

b). Family Discount : A flat discount of 10% on premium shall be given more than one member of a family are covered under a single policy.

i. Completion of Proposal Form

i. The proposal form is to be completed in all respects (including personal details, medical history of insured person) and to be submitted to the office or to the agent.

ii. Identity,age and address of the proposer must be supported by documentary proof.

iii. Person covered by any health insurance policy of any other non life insurance Company and wishing to port (switch) to the Policy, will have to submit the proposal form and portability form to the office or to the agent.

Proof of Identity and age must be submitted at the time of proposal, which could be any of the following document:

i. Passport
ii. Birth Certificate
iii. Driving License
iv. PAN Card
v. Class 10^{th}/12^{th}Certificate/School leaving Certificate
vi. Domicile Certificate (issued by Government of India)
vii. Adhaar Card

Pre-insurance Check Up

i. Pre policy checkup is required for all individual who are of age Forty five years and above.
ii. The Company shall reimburse 50% of the expenses incurred for pre policy checkup, if the proposal is accepted.
iii. Medical test reports to be submitted are as under:

1. Complete Blood count
2. Fasting Blood Sugar
3. ESR
4. Serum Creatinine
5. SGPT
6. Urine Routine
7. ECG
8. Medical Examination Report with BP recordings – By a medical practitioner.

In addition, from case to case, as per individual medical history, one might have to go for any other test as may be suggested by the Company.

The date of medical reports should not exceed thirty days prior to the date of proposal.

Buying the Policy

The Policy can be bought from the channels mentioned below:

✧ online from www.orientalinsurance.org.in, for policies where Pre insurance Checkup is not required.
✧ from our operatingoffices.
✧ from our agents/brokers.
✧ from POSP.
✧ Any other channel introduced by the Regulator from time to time

Payment of Premium

i. Premium is based on the Plan selected, SI opted and age of the insured person (in completed years).
ii. The premium under this Policy shall be paid inadvance.
iii. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of thecompany.
iv. The payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as these 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.
v. PAN details must be submitted to the Company.
vi. In case PAN is not available, Form 60 or Form 61 as per Rule 114B of the Income-tax Rule,1962 must be submitted
vii. No loadings shall apply on renewals based on individual claims experience.

Renewal of Policy

i. This Policy will be valid for the period mentioned in the Schedule.

ii. Policy can be renewed annually throughout the lifetime of the insured person.

iii. The Policy may be renewed by mutual consent before the expiry of the Policy.

iv. The Company is not bound to give notice that it is due for renewal

v. 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.

vi. 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.

vii. 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.

viii. If the Policy is renewed for enhanced Sum Insured then waiting period of 90 days for Critical Illness diagnosed as applicable to a fresh policy shall apply to additional Sum Insured.

Note: In case of revision including the premium, modification, or withdrawal of the Policy a notice, by suitable mode of communication, will be provided to insured 90 days before such revision, modification or withdrawal. Insured will have the option to migrate to similar Health Insurance Policy with Oriental Insuranceat the time of renewal with all the accrued continuity benefits such as waiver of waiting period etc. Provided the policy has been maintained without a break as per portability guidelines prescribed by IRDAI.

DEFINITION OF CRITICAL ILLNESSES COVERED :

CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded–

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 andCIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classificationT2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukemia less than RAI stage3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50HPFs;
ix. All tumors in the presence of HIV infection.

2.B.2. MYOCARDIAL INFARCTION
(First Heart Attack of specific severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

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.

III. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

OPEN CHESTCABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by acardiologist.

II. The following are excluded:

iv. Angioplasty and/or any other intra-arterialprocedures

OPEN HEART REPLACEMENT OR REPAIR OF HEARTVALVES

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. Thisdiagnosis must be supported by evidence of all of the following:
i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

KIDNEY FAILURE REQUIRING REGULARDIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extra cranial 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.

II. The following are excluded:

v. Transient ischemic attacks (TIA)
vi. Traumatic injury of the brain
vii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

MAJOR ORGAN /BONE MARROWTRANSPLANT

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 hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

viii. Other stem-cell transplants
ix. Where only islets of langerhans are transplanted

PERMANENT PARALYSIS OF LIMBS

I. 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.

MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. 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.

MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6months.

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

ANGIOPLASTY

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

BENIGN BRAIN TUMOR

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

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

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the braintumor.

III. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

BLINDNESS

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

II. The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;

ii. the field of vision being less than 10 degrees in both eyes.

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

DEAFNESS

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$);and

iv. Dyspnea at rest.

END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepaticenc ephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis mustbe supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

II. All psychiatric related causes are excluded.

LOSS OF LIMBS

I. The physical separation of **two** or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

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

PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialistin respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment

to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. **Class III:** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. **Class IV:** Unable to engage in any physical activity without discomfort. Symptoms may bepresent even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thrombo embolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

THIRD DEGREE BURNS

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

2. GENERAL DEFINITIONS

1. Accident:

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Any one illness:

Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

3. Break in Policy occurs at the end of the existing policy period when the premium due on a given Policy is not paid on or before the renewal date or within grace period.

4. Contract means prospectus, proposal, Policy, and the policy schedule. Any alteration with the mutual consent of the insured person and the company can be made by a duly signed and sealed endorsement on the Policy.

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

6. Congenital Anomaly:

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body.

7. Claim Free Year means coverage under the Oriental Critical Illness Policy for a period of a year during which, no claim is reported or paid or shall be payable under the terms and conditions of the

Policy in respect of any Insured Person.

8. Diagnosis:

Diagnosis means diagnosis by a medical practitioner, supported by clinical, radiological and histological and laboratory evidence, acceptable to the Company.

9. Disclosure to information norm:

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

10. Emergency Care:

Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long term impairment of the insured person's health.

11. Family: consists of the insured and/ or any one or more of the familymembers as mentioned below:

a) Legally wedded spouse.

b) Dependent Children (I.e. natural and adopted) between the age 18 years to 25 years. However male child can be covered up to the age until 25 years if he is a bonafide regular student and financially dependent. Female child can be covered until she is financially independent or married. Divorced or widowed daughter

is also eligible for coverage under the policy, irrespective of age.

c) Dependent Parents/ Parents-in-law (either of them).

d). Unmarried siblings, if financially dependent.

12. Grace Period:

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

13. Hospital:

A hospital means any institution established for *in-patient care* and *day care treatment* of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act **Or** complies with all minimum criteria asunder:

i) has qualified nursing staff under its employment round the clock;
ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
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 tothe insurance company's authorized personnel;

14. AYUSH Hospital: A healthcare facility wherein medical/surgical/parasurgical treatment proceduresand interventions are carried out by AYUSH medical practitioner(s) compromising of any of the following:

1. Central or State Government AYUSH Hospital, or
2. Teaching hospitals of AYUSH colleges recognized by Central Government/Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
3. AYUSH hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with the following criterion:

i. Has at least five in-patient beds.

ii. Having qualified AYUSH Medical Practitioner in charge round the clock.

iii. Having dedicated AYUSH therapy sessions as required and/or has equipped operation theatre where surgical procedures are to be carried out.

iv. Maintains daily records of patients and making them accessible to the insurance company's authorized representative.

15. Illness:

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests.
2. it needs ongoing or long-term control or relief of symptoms.
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it.
4. it continues indefinitely.
5. it recurs or is likely to recur.

16. Injury means accidental physical bodily harm excluding illness or disease solely and directly Caused by external, violent, visible and evident means which is verified and certified by a medical practitioner.

17. Inpatient Care:

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

18. Insured/ Insured Person: means person(s) named as Insured Person(s) in the schedule of the policy.

19. Intensive Care Unit:

Intensive care unit means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner(s),* and which is specially equipped for the continuous

monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

20. Maternity expenses:

Maternity expenses means;

a) medical treatment expenses traceable to childbirth (including complicated deliveriesand caesarean sections incurred during hospitalization);
b) expenses towards lawful medical termination of pregnancy during the policyperiod.

21. Medical Advice:

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

22. Medical Practitioner:

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

23. Migration:

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

24. Notification of Claim:

Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

25. Policy Period: means the period of coverages as mentioned in the schedule.

26. Policy schedule means a document forming part of the Policy, containing details including name of the insured person, age, relation of the insured person, sum insured, premium paid and the policy period.

27. Portability: Portability means, the right accorded to individual health insurance policyholders (includingall members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

28. Pre-Existing Disease:

Pre-Existing Disease means any condition, ailment or injury or disease:
a). That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or, its reinstatement.
b). for which medical advice or treatment was recommended by, or received from, a physician within 48

months prior to the effective date of the policy or, its reinstatement.

29. Renewal:

Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existingdiseases, time-bound exclusions and for all waiting periods.

30. Sum Insured means the amount of insurance in respect of each insured person, as mentioned in the schedule, payable in full by the Company in case of an admissible claim by the insured person during the policy period.

31. Surgery or Surgical Procedure:

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

32. Survival Period:

This is the period of time after the date of first diagnosis of a critical Illness that the policyholder has to survive to be eligible for availing the benefits under the Policy.

33. Unproven/Experimental treatment:

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

34. Waiting period means a period from the inception of this Policy during which the cover shall not be available i.e. Critical Illness diagnosed within 90 days of the inception date of this Policy. This exclusion does not apply for subsequent renewals with the Company without a break.

4. POLICY EXCLUSIONS:

The Company shall not be liable to make any payment for any claim caused by, based on, arising out of or howsoever attributable to any of the following:

A. Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portabilitynorms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Critical illness diagnosed within 3 months of the inception date of this policy. This exclusion does not apply for subsequent renewal with the Company without a break.

C. Any diseases causing the death of the Insured within the stipulated **Survival Period**, measured fromthe date of first diagnosis.

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

E. Breach of law

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

F. Excluded Providers:

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

G. Unproven Treatments:

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

H. Maternity and Pregnancy:

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization);

ii. Expenses towards miscarriage and lawful medical termination of pregnancy during the policy period.

I. Non Payable Conditions: Any Critical Illness resulting out of the following:-

i. Congenital external diseases, defects or anomalies, genetic disorders not resulting into specified critical Illnesses.

ii. Sterility, infertility/sub fertility, assisted conception procedures.

iii. The ingestion of drugs other than those prescribed by a medical practitioner.

iv. Treatment arising out of disease/ injury/ directly attributable to abuse of drugs/alcohol and intoxicating substances, and treatment thereof.

v. Intentional self-inflicted injury, attempted suicide.

J. War Group Perils:

Caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any governmentor public local authority.

K. Radioactivity:

Caused by or contributed by nuclear weapons/materials or arising from ionising

radiation or contamination by any nuclear fuel or from any nuclear waste or combustion of nuclear fuel.

5. GERNERAL CONDITIONS :

Entire Contract:

This Policy /Prospectus/ Proposal Form and declaration and medical report (if any) given by the insured constitute the complete contract. Insurer may alter the terms and conditions of this Policy/contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the Policy.

Condition Precedent to Admission of Liability

The due observance and fulfillment of the terms and conditions of the Policy, by the insured, shall be a condition precedent to any liability of the Company to make any payment under the Policy.

Waiting Period

A claim for critical illness shall be admissible under the policy, provided such critical illness is diagnosed after number of days specified in the policy schedule as waiting period i.e. Ninety (90) days from Inception of first policy/ certificate of insurance with us.

Survival Period

A claim shall be admissible under the Policy, provided the insured person survives the specified survival period i.e. thirty (30) days, after diagnosis of a Critical Illness or undergoing the procedure.

Communication:

Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the Policy issuing office / Third Party Administrator as shown in the Schedule.

6. CLAIM PROCEDURE:

Notification of Claim

i. The insured person or an authorized representative of insured person shall notify the Policy issuing office in writing regarding the occurrence of a Critical Illness that may give rise to a claim under the Policy, within 15 days of diagnosis or undergoing the procedure.
ii. The notification should contain full particulars like policy number, policy period, name of the insured person suffering Critical Illness, date of diagnosis or undergoing procedure, name of the Critical Illness suffered for the Policy issuing office to verify the records and register the claim.
iii. The underwriting office after registration of the claim shall supply a claim form, if required, which shall be filled in all respects, signed and submitted to the underwriting office along with the required documents.

Claim Documents:-

I. Policy number.

II. Duly filled Claim form

III. Photo ID and Age proof.

IV. Medical practitioner's certificate confirming diagnosis of the Critical Illness or undergoing the procedure along with the date of diagnosis or undergoing procedure.

V. Original/Attested copy of Discharge summary

VI. Original/ Attested copies of all diagnostic/ radiological/ Histopathological/ investigation reports

VII. Original/Attested copies of Indoor case papers(If needed)

VIII. Original/Attested copies of all the medical bills (If needed)

IX. Any other document (e.g. Disability Certificate, Dialysis records etc.) deemed necessary at the time of claim assessment for a specific Critical Illness condition

X. Copy of PAN Card and NEFT Details (to enable direct credit of claim amount in bank account) and a cancelled cheque.

XI. KYC (Identity proof with Address) of the proposer, where claim liability isabove

Rs. One lakh as per AML Guidelines.

XII. Legal heir/ succession certificate, where ever applicable.

Waiver

Waiver of delay in submission of claim documents may be considered in genuine cases of hardship, but only if it is proved to Company's satisfaction that it was not possible for insured or any other person to comply with the prescribed time-limit.

The Insured person shall give the Company/TPA any additional information and assistance as the TPA / Insurer may require.

Claim Settlement (provision for Penal Interest):

I. Any claim arising under the Policy will be processed and settled by the Company/TPA.

II. The Company shall settle or reject a claim, as the case may be, within 30 days fromthe date of receipt of last necessarydocument.

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

IV. However, where the circumstance of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later

than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

Payment of Claim

All claims under the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

Territorial Limit

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

Cessation of Cover

i. Upon occurrence of a Critical Illness and payment of the benefit amount to the insured person, the cover shall cease.
ii. In case a claim has been paid to any insured person for a Critical Illness, in subsequent renewals no claim shall be paid to that insured person.

Fraud

The Company shall not be liable to make any payment under the Policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

7. OTHER TERMS AND CONDITIONS

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:-

I. For policies with a period of one year :

PERIOD ON RISK	**Rate of premium to be charged**
Up to one month	25% of the annual rate
Up to three months	50% of the annual rate
Up to six months	75% of the annual rate
Exceeding six months	Full annual rate.

Ii. For Policies with 3 years term but cancelled within one year after the free look period:

Same as above table. The computation of the refund would be total premium received, excluding GST. Premium to be retained (short period rate applied on the premium payable for 1 year policy).

Iii. For Policies with 3 years term and cancelled after completion of 1 year:

The premium refunded would be on pro-rata basis computed asbelow:

Total premium received*No of days on risk / Total tenure of the policy in days.

** 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 fraud, moral hazard, misrepresentation, non-cooperation or non-disclosure by the insured, by giving 15 days written notice. There would be no refund of premium on cancellation on grounds of fraud, moral hazard, misrepresentation, non-cooperation or non-disclosure by the insured.

Free Look Period:

The free look period shall be applicable at the inception of the first Oriental Critical Illness Policy.

Insured will be allowed a period of fifteen (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 insured/s have not made any claim during the free look period, the insured shall be entitled to:

1. A refund of the premium paid less any expenses incurred by insurer on medical examination and the stamp duty charges or;

2. Where the risk has already commenced and the option of return of the policy is exercised by insured, a deduction towards the proportionate risk premium for period on cover.

Single policy: Proposer/Insured is not allowed to take multiple policies of Oriental Critical Illness Policy. This condition shall be applicable to all the Insured persons covered under Oriental Critical Illness Policy.

a Portability: This Policy is subject to Guidelines of IRDAI on Portability under Health Insurance Regulations 2016 and as amended from time to time.

Subject to the above Portability will be allowed only from any other Critical Illness or similar Critical Illness Policy offered by The Oriental Insurance company Limited or other companies. Porting will not be allowed from any other product.

7.4.b Migration: Migration will be not be allowed from any of our other products to this product.

Change of Address: Insured must informthe Company immediately in writing of any change in the address.

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. Ill the event of death of the policyholder, the Company willpay 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.

Disclaimer

If the Company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within 12 (twelve) calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

7.8.. 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.

ii. It is clearly agreed and understood that no difference or dispute shall be referable 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.

Territorial Jurisdiction

All disputes or differences under or in relation to the Policy shall be determined by a court in India in accordance to Indian law.

Protection Of Policy Holders Interest:

This policy is subject to IRDAI (Protection of Policyholders' Interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations2016 &Guidelines on Standardization in health insurance, as amended from time to time.

Grievance Redressal:

In case of any grievance the insured person may contact the company through

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

Customer Service Department
4th Floor, Agarwal House
Asaf Ali Road,
New Delhi-110002.

For updated details of grievance officer, kindly refer the link https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac-c613-ffc05d578a3e

Insurance Ombudsman –If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-III & revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

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 by the policyholder.

(**Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)**

DISCLAIMER

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.

7.14 INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:

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. Any person making default in complying with the provisions of this section shall be liablefor a penalty which may extend to INR Ten Lakhs.

Insurance is the subject matter of solicitation.

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