THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002
CIN No.U66010DL1947GOI007158

Policy Document

ORIENTAL HAPPY CASH – Nishchint Rahein !

1. WHEREAS the insured named in the Schedule hereto, has by a proposal and declaration, (which shall be the basis of this Contract and is deemed to be incorporated herein) applied to THE ORIENTAL INSURANCE COMPANY LIMITED (hereinafter called the **COMPANY**) for the insurance hereinafter set forth in respect of persons(s) named in the Schedule hereto (hereinafter called the **INSURED PERSON**(S)) and has paid premium to the **Company** as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called the **TPA**) or the **Company** as the case may be.

NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the **Company** undertakes that, if during the period of insurance stated in the Schedule any **insured** Person shall contract any disease or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require, upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') admission in a Hospital / Nursing home (as defined hereafter) for medical/surgical treatment at any Hospital/Nursing Home in India as herein defined (hereinafter called 'HOSPITAL'), the **Company** shall pay benefits as per the policy terms & conditions. In any case the liability of the **Company** shall be strictly in accordance with the period and amounts stated in the schedule.

2. COVERAGE: Subject to terms, conditions and exclusions herein contained or otherwise expressed herein, the policy pays to the insured, the following benefits:

a. HOSPITALISATION BENEFIT – In the event of the insured person getting hospitalised, a **Daily Cash Benefit** as mentioned in the schedule shall become payable, limited to the Daily Cash Benefit Period selected by the insured. For the purpose of calculating the number of days for which this benefit becomes payable, each continuous and completed period of 24 hours of hospitalisation shall only be considered. The Policy will pay for any number of hospitalisations, in a policy period, subject to any single hospitalisation not exceeding the Daily Cash Benefit Period selected by the Insured. However, in case of more than one hospitalisation for the same disease / accident, the aggregate number of days of hospitalisation payable in a policy period would be limited to Daily Cash Benefit Period (30/60 days) selected by the Insured.

NOTE: In case of Ayurvedic / Homeopathic / Unani treatment, this policy will pay only if Hospitalisation is in a Government Hospital or a hospital associated with a Medical College.

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel or a similar place.

b. CONVALESCENCE BENEFIT – If a single hospitalisation continues for a period exceeding the **Daily Cash Benefit Period** opted for (30/60days), a lumpsum amount is payable towards convalescence,

i. provided that there is an admissible claim under 'a' above.
ii. this benefit is payable only once per insured person during any one policy period.

Our liability shall be as mentioned in the schedule.
The payment under this benefit will be in addition to the payment under 'a' above.

3. DEFINITIONS: For the sake of clarity, the following words are put in **Bold** wherever they appear in the body of the policy. The meaning of these words should be taken from the definitions given hereunder.

3.1 ACCIDENT:is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 ALTERNATIVE TREATMENTS: are forms of treatments other than 'Allopathy', or 'modern medicine' and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

3.3 CONDITION PRECEDENT: means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

3.4 CONGENITAL ANOMALY: refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
a. Internal Congenital Anomaly: which is not in the visible and accessible parts of the body
b. External Congenital Anomaly: which is in the visible and accessible parts of the body.

3.5 BENEFITS: Daily Cash Benefit, Daily Cash Benefit Period and **Deductible** all together are referred to as **Benefits**.

3.6 DAILY CASH BENEFIT: means the per day (continuous and completed period of 24 hours of hospitalisation) benefit amount selected by the insured at the time of commencement of policy.

3.7 DAILY CASH BENEFIT PERIOD: means the maximum number of days for which the **Daily Cash Benefit** is payable under the policy in respect of any one hospitalisation in a policy period. The policy provides two options of either 30 days or 60 days period depending on insured's selection.

3.8 DEDUCTIBLE: A deductible is a cost-sharing arrangement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any Benefits are payable by the Insurer. A deductible does not reduce the Daily Cash Benefit Period.

3.9 FAMILY: consists of the proposer and 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 3months 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 on proposer. Female child can be covered until she gets married. Divorced and widowed daughters are also eligible for coverage under the policy, irrespective of her 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).

3.10 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.

3.11 HOSPITAL/NURSING HOME: means any institution established for in-patient care and day care treatment of disease 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 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.

3.12 HOSPITALISATION PERIOD: means the period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 hours.

3.13 **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.

3.14 INSURED PERSON : means person(s) named in the schedule of the policy

3.15 ILLNESS: means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

a. 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 and leads to full recovery.

b. Chronic condition - is a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation or to be specially trained to cope with it
iv. it continues indefinitely
v. it comes back or is likely to come back.

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

3.17 IN-PATIENT: means an Insured person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

3.18 MEDICAL ADVICE: means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

3.19 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.

3.20 NOTIFICATION OF CLAIM: is a process of notifying a claim to the Insurer or TPA by specifying the timelines as well as the address/telephone number, to which it should be notified.

3.21 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.

3.22 POLICY PERIOD : means the period of coverage as mentioned in the schedule.

3.23 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.

3.24 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.

3.25 RENEWAL: Renewal defines 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 all waiting periods.

3.26 THIRD PARTY ADMINISTRATOR (TPA): means any person who is licensed under the IRDA (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.

3.27 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 Hospitalisation of 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 hospital cash 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. To illustrate if a person is suffering from hypertension or diabetes or both hypertension and diabetes at the time of taking the policy, then policy shall be subject to following exclusions.

Diabetes	Hypertension	Diabetes & Hypertension
Diabetic Retinopathy	Cerebro Vascular accident	Diabetic Retinopathy
Diabetic Nephropathy	Hypertensive Nephropathy	Diabetic Nephropathy
Diabetic Foot /wound	Internal Bleed/ Haemorrhages	Diabetic Foot
Diabetic Angiopathy	Coronary Artery Disease	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper / Hypoglycaemic shocks		Hyper / Hypoglycaemic shocks

Coronary Artery Disease		Coronary Artery Disease
		Cerebro Vascular accident
		Hypertension Nephropathy
		Internal Bleeds/ Haemorrhages

4.2 Any disease 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.

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh policy and clauses 4.1and 4.2 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 **Daily Cash Benefit** is enhanced subsequent to the inception of the first policy, the exclusion 4.1 and 4.2 will apply afresh for the enhanced portion of the **Daily Cash Benefit**.

4.3 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.

4.4 Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination (other than dog-bite or bite of any rabid animal), inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

4.5 Surgery for correction of eye sight.

4.6 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 requires **hospitalisation** for treatment.

4.7 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.

4.8 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.

4.9 Treatment primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.

4.10 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 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.

4.11 Naturopathy treatment, unproven procedure or treatment, **experimental** or **alternative treatment** (other than Ayurveda, Unani & Homeopathy as mentioned in 2a above) and related treatment including acupressure, acupuncture, magnetic and such other therapies.

4.12 **Hospitalisation** for investigation or treatment irrelevant to the diseases diagnosed during **hospitalisation** or which was the primary reason for admission.

4.13 Treatment of Genetic disorders and stem cell implantation / surgery.

4.14 Change of treatment from one system of medicine to another unless agreed / allowed and recommended by the Medical Practitioner/Consultant under whom the treatment is being taken.

4.15 Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, and similar services or supplies.

4.16 Any treatment required because of Insured person'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.

4.17 Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.

4.18 Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.

4.19 Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.20 Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.

5 CONDITIONS

5.1 **ENTIRE CONTRACT:** This policy, alongwith the proposal form and declaration given by the insured person constitutes the complete contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

5.2 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 the case may be, as shown in the Schedule.

5.3 PAYMENT OF PREMIUM: The premium payable 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 in respect of 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 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 / 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 notice should be given within 48 hours of admission but before discharge from **Hospital / Nursing Home**, unless waived in writing.

5.5 CLAIM DOCUMENTS: Documents as listed below, alongwith duly filled in claim form, should be submitted to the **Company** / **TPA** within 15 days of discharge from the **Hospital** / **Nursing Home**.

a. Discharge certificate / card from the **Hospital**/ **Nursing Home**.
b. All documents pertaining to the illness, starting from the date it was first detected, i.e Doctor's consultations reports / history
c. Medical history of the patient recorded by the **Hospita**l, if required.
d. Pathological and other test reports from a pathologist / radiologist.
e. Attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis.
f. MLC/FIR/Post Mortem Report,(if applicable)
g. Details of previous policies, if the details are already not with **TPA**.
h. Any other information required by Company / **TPA**.

Photocopies of the above documents are accepted in case the hospitalisation expenses have been claimed from other sources (eg.Employer, Insurance Company, etc). However a written confirmation from such source of having received the claim documents, is required.

All documents must be duly attested by the insured person/claimant.

NOTE: Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured person was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.

Company shall settle claims including its rejection within 30 days of the receipt of the last 'necessary' document, except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms & conditions shall be deemed necessary.

5.6 MEDICAL RECORDS:

(i) The insured person hereby agrees to and authorises the disclosure, to the Company / **TPA** or any other person nominated by the Company, of any and all Medical records and information held by any Institution / **Hospital** or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by the Company / **TPA** in connection with any claim made under this policy or the Company's liability there under.

(ii) The Company / **TPA** agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use it in connection with any claim made under this policy or the Company's liability there under.

(iii) Any medical practitioner authorised by the Company / **TPA** shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring **Hospitalisation** when and so often as the same may reasonably be required on behalf of the Company / **TPA**.

5.7 PAYMENT OF CLAIM: All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only. Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In the cases of any delay in the payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

5.8 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 the Grievance Redressal Cell 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. or register the complaint on the grievance Portal available at our website www.orientalinsurance.org.in.

ii. If the insured is not satisfied with the reply of the Grievance Cell under 5.8 (i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The list of Offices of Ombudsman is available on the Company website (www.orientalinsurance.org.in).The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims upto Rs.20 lacs.

5.9 DISCLAIMER OF CLAIM: If the Company shall disclaim liability and communicate in writing (either through the **TPA** or by itself) to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.10 ARBITRATION CLAUSE: If any dispute or difference shall arise as to the quantum to be paid under 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; or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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.

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 this policy.

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

5.11 FRAUD / MISREPRESENTATION / CONCEALMENT: Non – disclosure, concealment or misrepresentation of material facts or making false statements in the Proposal Form and/ or in the Claim Form or any other document, shall render the policy null and void ab initio and the Company shall not be liable under this policy. The Company shall, also not be liable under the policy in respect of any claim, if such claim be in any manner- intentionally or fraudulently or otherwise misrepresented or concealed or involves making false statement or submitting false bills whether by the insured person or any Institution/ Organisation on his behalf. Company shall be at liberty to take suitable legal action against the Insured person/ Institution/ Organisation as per the laws.

5.12 CANCELLATION CLAUSE: Company may at any time, cancel this Policy (on grounds of lodging a fraudulent claim and such other intentional malicious acts of the insured / beneficiaries under the policy), by sending the Insured 30 (Thirty) days notice by registered post at the Insured's last known address; and in such an event no refund of premium shall be made.

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

6. BENEFITS AVAILABLE

- **i.** The Policy provides 4 options of **Daily Cash Benefit**- Rs.500 Rs.1000, Rs.2000 and Rs.3000. Different insured persons, under a policy, may opt for different **Daily Cash Benefits**. For females this **Daily Cash Benefit** automatically gets increased by 25% without any extra premium.
- **ii.** The Policy provides 2 options of **Daily Cash Benefit Period**- 30 days and 60 days per **hospitalisation**.
- **iii.** The Policy provides 3 options of **deductible**- no deductible, 1day & 2days **deductible**. The deductible is applicable per event.
- **iv.** It is mandatory for all the insured persons under a policy to have an identical **Daily Cash Benefit Period** and **Deductible** (ii & iii above).

v. Change in Benefit(s): The **Daily Cash Benefit**, the **Daily Cash Benefit period** and **Deductible** under the policy can be changed only at the time of renewal and at the discretion of the Company. For the said enhanced benefits, **pre-existing disease** clause 4.1 and clause 4.2 of the policy, shall apply afresh.

vi. Discounts

a. Family discount of 5% on premium is available if two members are covered and7.5% if more than 2 members are covered.

b. Loyalty Discount of 10% in premium is available for the persons who at the inception of this policy are covered under Oriental's health insurance policy (retail or bank-tie-up). To be eligible for this discount at renewals, such Health policy from Oriental has to be in force at the time of such renewal also.

c. Staff Discount of 33% on premium is available to the employees of Oriental Insurance Company Ltd.

7. FREE LOOK PERIOD: This policy shall have a free look period. The free look period shall be applicable at the inception of the fresh policy and the insured will be 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.

The free look period is not applicable in case of renewal of the policy.

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 practitioners report wherever required or due to any other reason whatsoever.

Notwithstanding this, however, the decision to accept or reject the coverage of any person upon renewal of this insurance shall rest solely with the Company. The Company, after obtaining due approval of the Authority, may revise the premium rates and / or the terms & conditions of the policy upon renewal thereof. Renewal of this policy is not automatic; premium due must be paid by the Insured to the Company before the due date. Any revision or modification in the policy will be notified to the policyholders three months in advance.

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.

9. GRACE PERIOD: In the event of delay in renewal of the policy, a **grace period** of 30 days is allowed. However, no coverage shall be available during the **grace period**

and any disease/injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

10. **PRODUCT WITHDRAWAL:** This product may be withdrawn in future. However, in such an event the policy holder shall be notified three months in advance and duly informed of the options available.

11. **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.

12. **CHANGE OF ADDRESS:** Insured must inform the Company immediately in writing of any change in the address.

13. **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.

14. **IRDA REGULATION :** This policy is subject to IRDA (Protection of policy holders' interest) Regulation and IRDA (Health Insurance) Regulations 2013 and Guidelines on Standardisation in health insurance as amended from time to time.

15. **DISCLOSURE TO INFORMATION NORM:** The policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

16. **PREMIUM TABLE :**

PREMIUM CHART - ORIENTAL HAPPY CASH-Nishchint Rahein!

A. DAILY CASH BENEFIT PERIOD - 30 DAYS

1	0 DAY DEDUCTIBLE			
	Premium			
AGE (in yrs)	DCB 500	DCB 1000	DCB 2000	DCB 3000
UPTO 45	260	515	1008	1481
46-60	589	1167	2287	3359
>60	1148	2273	4455	6545

2	1 DAY DEDUCTIBLE			
	Premium			
AGE (in yrs)	DCB 500	DCB 1000	DCB 2000	DCB 3000
UPTO 45	199	395	774	1137
46-60	452	896	1755	2578
>60	881	1745	3419	5023

3	2 DAYS DEDUCTIBLE			
	Premium			
AGE (in yrs)	DCB 500	DCB 1000	DCB 2000	DCB 3000
UPTO 45	151	299	587	862
46-60	343	679	1330	1955
>60	668	1323	2592	3808

B. DAILY CASH BENEFIT PERIOD - 60 DAYS

1	0 DAY DEDUCTIBLE			
	Premium			
AGE (in yrs)	DCB 500	DCB 1000	DCB 2000	DCB 3000
UPTO 45	289	572	1122	1648
46-60	656	1298	2544	3737
>60	1277	2529	4957	7282

2	1 DAY DEDUCTIBLE			
	Premium			
AGE (in yrs)	DCB 500	DCB 1000	DCB 2000	DCB 3000
UPTO 45	223	441	864	1269
46-60	505	1000	1959	2878
>60	984	1948	3817	5607

3	2 DAYS DEDUCTIBLE			
	Premium			
AGE (in yrs)	DCB 500	DCB 1000	DCB 2000	DCB 3000
UPTO 45	170	336	658	967
46-60	385	762	1492	2192
>60	749	1484	2907	4271

Premium and DCB (Daily Cash Benefit) - in INR

Service Tax as applicable will be extra

Premium will be calculated on completed years as on date of inception / renewal of the policy., eg. A person who has completed 45years & 364 days, will fall in the age band of upto 45 years and not in 46-60years.

P.S: Daily Cash Benefit (Rs.500,1000,2000 & 3000) given in the above Table will be 25% more (ie Rs.625, 1250, 2500, & 3750 respt) in case of female Insureds. However, Premium remains same.

Convalescence Benefit: (At no Extra premium) - Lumpsum amount payable if in a single hospitalisation, the number of days of hospitalisation exceeds the Daily Cash Benefit Period opted by the Insured.

CONVALESCENCE BENEFIT - in INR				
BENEFIT PERIOD / DCB	500	1000	2000	3000
30 DAYS	5000	5000	10000	10000
60 DAYS	10000	10000	20000	20000

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Following discounts are available

A. Family discount -

5%. If 2 members are covered

7.5%. If more than 2 members are covered

B. Loyalty discount - 10%

C. Staff discount -33%. However, in this case discounts at A&B are not allowed.

D. TPA discount - 5.5%, If TPA services are not opted for

The above discounts shall be applied successively and not on cumulative basis.