

## GROUP MEDICLAIM INSURANCE POLICY

1. WHEREAS the Insured designated in the Schedule hereto has by a proposal and declaration as stated in the Schedule which shall be the basis of this contract and is deemed to be incorporated herein, has applied to Reliance General Insurance Company Limited (hereinafter called the "Company") for the insurance hereinafter set forth in respect of Employees / Members (including family members) named in the Schedule hereto (hereinafter called the "Insured Person") and has paid premium as consideration for such insurance.

1.1 NOW THIS POLICY WITNESSETH 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 stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any disease or suffer from any illness (hereinafter called "Disease") or sustain any bodily injury through accident (hereinafter called "Injury") and if such disease or injury shall upon the advice of a duly qualified Medical Practitioner require any such Insured Person, to incur hospitalisation expenses at any Hospital/ Nursing Home in India (hereinafter called "Hospital") as an inpatient or domiciliary hospitalisation expenses in any of the circumstances mentioned hereunder, the Company will pay to the Insured Person the amount of such expenses/charges as would fall under different heads mentioned below and as are reasonably and necessarily incurred by or on behalf of such Insured Person but not exceeding the sum insured for the person in any one period of insurance as mentioned in the Schedule hereto

- A. Room, boarding expenses incurred at the hospital / nursing home.
- B. Nursing expenses.
- C. Medical Practitioner, Anesthetist, Consultants fees.
- D. Anesthesia, oxygen, blood, operation theatre charges, surgical appliances, medicine and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and cost of organs.

## 2 DEFINITIONS

2.1 "Domiciliary hospitalisation" means medical treatment for a period exceeding three days for disease/injury which in the normal course would require care and treatment at a hospital/nursing home but is actually taken whilst confined at home in India under any of the following circumstances namely :-

- i) the condition of the patient is such that he/she cannot be removed to Hospital/Nursing Home, or

- ii) the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

Domiciliary hospitalisation benefits shall be subject to the limit stated in the Schedule attached hereto and shall in no case cover:

- a) expenses incurred for pre and post hospital treatment and
- b) expenses incurred for treatment of any of the following diseases :
  - i. Asthma
  - ii. Bronchitis
  - iii. Chronic nephritis and nephritic syndrome
  - iv. Diarrhea and all types of dysenteries including gastroenteritis
  - 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 pharangitis
  - xii. Arthritis, gout and rheumatism

2.2 "Hospitalisation Benefits" mean expenses on hospitalisation for minimum period of 24 hours which are admissible. However, this time limit will not apply for specific treatments i.e. dialysis, chemotherapy, radiotherapy, eye surgery, dental surgery, lithotripsy (kidney stone removal) D & C, tonsillectomy taken in a Hospital / Nursing Home where the Insured Person is discharged on the same day in which case, the treatment will be considered to be taken under hospitalisation benefits.

2.3 "Hospital / Nursing Home" means any institution in India established for indoor care and treatment of disease and injury and which

- (a) is registered either as a Hospital or Nursing Home with the local authorities and is under the supervision of a registered Medical Practitioner, or
- (b) complies with minimum criteria of -
  - i. at least 15 in-patient beds;
  - ii. fully equipped operation theatre of its own where surgical operations are carried out;
  - iii. fully qualified nursing staff under employment round the clock;
  - iv. qualified doctor(s) in-charge round the clock.

(N.B. In class "C" towns, condition of number of beds shall stand reduced to 10)

but shall not include any 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 similar place.

- 2.4 "Maternity Benefits" mean expenses for treatment taken in Hospital / Nursing Home arising from or traceable to pregnancy, childbirth including normal caesarean section. (This is an optional benefit available on payment of additional premium. When benefits under a policy are extended to include maternity benefits exclusion 4.11 in the policy shall stand deleted).
- 2.5 "Medical Practitioner" means a person who holds a degree/diploma of a recognised institution and is registered with the Medical Council in respective states of India. The term Medical Practitioner includes a physician, specialist and surgeon.
- 2.6 "Qualified Nurse" means a person who holds a certificate of a recognised Nursing Council and is employed on recommendation of the attending Medical Practitioner.
- 2.7 "Surgical Operation" means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life.

### 3 PRE AND POST HOSPITALISATION EXPENSES

#### 3.1 Pre hospitalisation

Relevant medical expenses incurred during a period upto 30 days prior to hospitalisation / domiciliary hospitalisation on disease / injury sustained will be considered as part of claim.

#### 3.2 Post hospitalisation

Relevant medical expenses incurred during a period upto 60 days after hospitalisation / domiciliary hospitalisation on disease / injury sustained will be considered as part of claim.

### 4 EXCLUSIONS

The Company shall not be liable to make payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

- 4.1 All diseases/injuries which are pre-existing when the cover incepts for the first time.
- 4.2 Any disease other than those stated in exclusion 4.3 hereunder, contracted by an Insured Person during the first 30 days from the date of commencement of the policy. Provided that the above exclusion shall not apply -

- a) if in the opinion of a panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company; or
  - b) in case of the Insured Person having been covered under this scheme or a group insurance scheme with any of the Insurance Companies in India for a continuous period of preceding 12 months without any break.
- 4.3 During the first year of operation of the insurance cover, expenses on treatment of diseases such as cataract, benign prostatic hypertrophy, hysterectomy or menorrhagia or fibromyoma, hernia, hydrocele, congenital internal diseases, fistula in anus, piles, sinusitis and related disorders are not payable. Provided that the exclusion shall not apply in case of the Insured Person having been covered under this scheme or a group insurance scheme with any of the Insurance Companies in India for a continuous period of preceding 12 months without any break. However, if these diseases are pre-existing at the time of proposal, they will not be covered even during period of subsequent renewals.
- 4.4 Circumcision unless necessary for treatment of a disease not excluded hereinabove or as may be necessitated due to an accident, vaccination or 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.
- 4.5 Cost of spectacles, contact lenses and hearing aids.
- 4.6 Dental treatment or surgery of any kind unless requiring hospitalisation.
- 4.7 Convalescence, general debility, 'run-down' condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury and use of intoxicating drugs/alcohol.
- 4.8 All expenses arising out of any condition, directly or indirectly, caused to or associated with human T-Cell Lymphotropic Virus type III (HTLV III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.
- 4.9 Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home or at home under domiciliary hospitalisation as defined.

- 4.10 Expenses on vitamins and tonics unless forming part of treatment for disease or injury as certified by the medical practitioner.
- 4.11 Treatment arising from or traceable to pregnancy, childbirth including caesarean section. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.
- 4.12 Naturopathy treatment.
- 4.13 Disease or injury directly or indirectly caused by or arising from attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not).
- 4.14 Disease or injury directly or indirectly caused by or contributed to by nuclear weapons/materials.

## 5 CONDITIONS

- 5.1 Any one illness:  
Any one illness will mean continuous period of illness and includes relapse within 45 days from the date of last consultation at the Hospital/Nursing Home where treatment was taken. Occurrence of same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.
- 5.2 Every notice and communication to the Company required by this policy shall be in writing and be addressed to the nearest office of the Company.
- 5.3 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 authorised official of the Company. Payment of premium and the due observance and fulfillment of the terms, provisions, conditions and endorsements on this policy by the Insured / Insured Person in so far as they relate to anything to be done or complied with by the Insured / Insured Person shall be a condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements on this policy shall be valid unless made in writing and signed by an authorised official of the Company.
- 5.4 Upon the happening of any event, which may give rise to a claim under this policy, notice with full particulars shall be sent to the nearest office of the Company within 7 days from the date of hospitalisation.

5.5 A claim must be filed within 30 days from the date of discharge from the hospital.

Note: Waiver of conditions 5.4 and 5.5 hereinabove, 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 notice or file a claim within the prescribed time limits.

5.5 The Insured Person shall obtain and furnish to the Company all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require for dealing with the claim.

5.6 Any medical practitioner authorised by the Company shall be allowed to examine the Insured Person in case of any disease or injury requiring hospitalisation when and so often as the same may reasonably be required on behalf of the Company.

5.7 The Company shall not be liable to make any payment under this 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.

5.8 If at the time when any claim arises under this policy, there is in existence any other insurance (other than Cancer Insurance Policy in collaboration with Indian Cancer Society) whether it be effected by or on behalf of any Insured Person in respect of whom the claim may have arisen covering the same loss, liability, compensation, cost or expenses, the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation, costs or expenses. The benefits under this policy shall be in excess of the benefits available under Cancer Insurance Policy.

5.9 The Policy may be renewed by mutual consent. The Company shall not however be bound to give notice that it is due for renewal and the Company may at any time cancel this policy by sending the Insured 30 days notice by registered letter at the Insured's last known address and in such event the Company shall refund to the Insured a pro rata premium for the unexpired period of insurance. The Company shall, however, remain liable for any claim which may have arisen prior to the date of cancellation. 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 here below), provided no claim has occurred upto the date of cancellation.

PERIOD ON RISK

RATE OF PREMIUM  
TO BE CHARGED

Upto one month	1/4 <sup>th</sup> of the annual rate
Upto three months	1/2 <sup>th</sup> of the annual rate.
Upto six months	3/4 <sup>th</sup> of the annual rate.
Exceeding six months	Full annual rate

- 5.10 If any difference or dispute shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall be referred to arbitration in accordance with the provisions of the Arbitration and Conciliation Act, 1996 as amended from time to time and for the time being in force. 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.
- 5.11 If the Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 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.
- 5.12 All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.
- 5.13 **LOW CLAIM RATIO DISCOUNT (BONUS)**  
 Low claim ratio discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claims ratio for the entire group insured under any Group Medclaim Insurance policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal. Where the Group Medclaim Insurance policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims ratio under the Group Policy	Discount %
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	35
Not exceeding 25%	40

- 5.14 **HIGH CLAIM RATIO LOADING (MALUS)**  
 The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under any Group Medclaim Insurance policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal. Where the Group Medclaim policy has not been in force for 3 completed years,

such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurring Claim ratio under the Group Policy	Loading %
Between 80% and 100%	25
Between 101% and 125%	55
Between 126% and 150%	90
Between 151% and 175%	120
Between 176% and 200%	150
Over 200%	Cover to be reviewed

Note:

Incurring claim means claims paid plus claims outstanding at the end of the policy period minus the claims outstanding at the beginning of the policy period in respect of the entire group insured under the policy.

5.15 Special conditions applicable to Maternity Benefits extension (where applicable):

- a. These benefits are applicable only if the expenses are incurred in Hospital/Nursing Home as an in-patient.
- b. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, mis-carriage or abortion induced by accident or other medical emergency.
- c. Claim in respect of delivery for only first two children and/or operations associated therewith will be considered in respect of any one Insured Person covered under the policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.
- d. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.
- e. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.