Enhance your group coverage with our

ICICI Pru

GROUP NON-LINKED CRITICAL ILLNESS RIDER

A Non-linked, Non-Participating Group Renewable Health Insurance Rider

ICICI PRUDENTIAL LIFE INSURANCE

ICICI Pru Group Non-Linked Critical Illness Rider is an extra layer of protection offered to employer-employee groups as well as non-employer-employee groups, in addition to their underlying group policy. The coverage may be voluntary or compulsory.

This Rider serves as an additional layer of protection, offering coverage in the event of diagnosis of critical illnesses as outlined in the policy. In the event of diagnosis of any one of the critical illnesses covered, the sum assured of the respective benefit option and package as chosen by the Member/ Master Policyholder is payable subject to the terms and conditions of the Rider as provided in the Rider documents/Certificate of Insurance. The Rider will be attached to the Master Base policy /Member Base policy and it will provide the sum assured as a lump-sum as per the Benefit Option chosen to give you that extra comfort of safety.

Salient features that make

ICICI Pru Group Non-Linked Critical Illness Rider

suitable for you?

Protection against 33 Critical Illness depending upon the Package chosen

Option to accelerate the base cover on diagnosis of listed Critical Illnesses based on the Benefit Option chosen.

Option to add the Rider Benefit Option to Master Base policy /Member Base policy at inception or at any subsequent Master Base policy/Member Base policy renewal

Flexibility to pay premiums in single pay, yearly (annual), half-yearly, quarterly or monthly mode

Plan at a glance - Eligibility Criteria to buy the Rider

Plan options

This rider offers two Benefit options^ as given below:

- Accelerated Critical Illness Benefit Option
- Additional Critical Illness Benefit Option

Min/Max Entry Age

Minimum – 18 years
Maximum – 69 years

Min/Max Coverage Term offered

Minimum - 1 month

Maximum - 1 year

Any one of the Benefit option(s) and one package under the Rider can be attached to an applicable Member cover at the inception of such Master Base policy or at any subsequent Master Base policy renewal, subject to the age restrictions mentioned.

The coverage term of the Master Base policy and Rider will be the same.

Min/Max Premium Payment Term

Minimum – 1 month

Maximum – 1 year

In the case of one-year renewable rider, the premium payment term will be set to 1 year, same as that of the base one-year renewable policy.

In the case of Master Base policy term less than one year, the balance premium payment term for rider will be same as the Master Base policy.

Mode of Premium Payment Offered

One year Policy Term- Yearly/ Half-yearly / Quarterly/ Monthly

Policy Term less than One year- Single Premium/ Quarterly/ Monthly

Modes of premium payment should be same as that of the master base policy.

Min/Max Annualized Premium

Minimum- Based on minimum sum assured under the respective benefit options.

Maximum- Based on the maximum sum assured under the respective benefit options.

The premium pertaining to any of the benefit options shall not exceed 100% of premium under the base member cover.

Min/Max Basic Sum Insured (in INR)

Minimum – ₹ 5,000

Maximum - The maximum Sum Assured under each benefit option will be as per Board-approved Underwriting Policy (BAUP), but not exceeding the Sum Assured on Death at inception for the member cover of base policy.

*Applicable Goods and Services Tax will be charged separately, as per applicable rates. The tax laws are subject to amendments from time to time.

^Under this Rider, the Master Policyholder has the option to choose only one Benefit Option and one Package. Only the Benefit Option and Package chosen by the Master Policyholder shall be made available to the Members.
The Benefit Option and Package once chosen cannot be changed during the Coverage term.

Benefits in detail

This Rider offers two Benefit Options as given below:

- Accelerated Critical Illness Benefit Option
- Additional Critical Illness Benefit Option

In addition to the Benefit Options, this Rider also offers four packages based on the number of Critical Illnesses covered. The Master Policyholder will have to choose the Package at Rider inception along with the Benefit Option. The packages offered under this Rider are as follows:

- Basic – Covers 4 Critical Illnesses (CI)
- Essential – Covers 7 Critical Illnesses (CI)
- Classic – Covers 19 Critical Illnesses (CI)
- Comprehensive – Covers 33 Critical Illnesses (CI)

List of CI conditions under four different CI Options

S.No.	Critical Illness	Basic	Essential	Classic	Comprehensive
1	Cancer of Specified Severity	✓	✓	✓	✓
2	Myocardial Infraction (First Heart Attack of Specified Severity)	✓	✓	✓	✓
3	Open Chest CABG	✓	✓	✓	✓
4	Stroke resulting in permanent symptoms	✓	✓	✓	✓
5	Kidney Failure Requiring Regular Dialysis		✓	✓	✓
6	Major Organ/ Bone Marrow Transplant		✓	✓	✓
7	Loss of Independent Existence		✓	✓	✓
8	Blindness			✓	✓
9	Multiple Sclerosis with Persisting Symptoms			✓	✓
10	Alzheimer's Disease			✓	✓

S.No.	Critical Illness	Basic	Essential	Classic	Comprehensive
11	Open Heart Replacement or Repair of Heart Valves			✓	✓
12	Deafness			✓	✓
13	Apallic Syndrome			✓	✓
14	Benign Brain Tumour			✓	✓
15	Brain Surgery			✓	✓
16	Coma of Specified Severity			✓	✓
17	Major Head Trauma			✓	✓
18	Permanent Paralysis of Limbs			✓	✓
19	Third Degree Burns			✓	✓
20	Motor Neurone Disease with Permanent Symptoms				✓
21	Aorta Graft Surgery				✓
22	End Stage Lung Failure				✓
23	End Stage Liver Failure				✓
24	Parkinson's Disease				✓
25	Cardiomyopathy				✓
26	Loss of Limbs				✓
27	Primary (Idiopathic) Pulmonary Hypertension				✓
28	Loss of Speech				✓
29	Systemic Lupus Erythematosus with Lupus Nephritis				✓
30	Aplastic Anaemia				✓
31	Muscular Dystrophy				✓
32	Poliomyelitis				✓
33	Medullary Cystic Disease				✓

Since this is a Critical Illness Rider, we have defined 'Critical Illness ' as any illness, medical event or surgical procedure as specifically defined in below in "CI definitions" whose signs or symptoms first commence post the specified waiting period after the inception of Rider period. Diagnosis of the critical illness must be confirmed by a specialist.

Benefit options:

The following Benefit Options are available under this Rider. At the time of Rider inception, the Master Policyholder must choose one of the two available Benefit options. The Benefit Option chosen by the Master Policyholder and made available to the Members is as mentioned in the Riders schedule and Certificate of Insurance.

a. Accelerated Critical Illness (ACI) benefit option:

Under this Benefit Option, upon confirmatory diagnosis of any of the covered Critical Illness, the ACI Sum Assured of the Member prevailing at the time of diagnosis will be paid to the claimant provided the Rider is in force. Upon payment of the Accelerated Critical Illness Sum Assured to the Claimant by the Company, the Rider shall terminate for the Member.

- If ACI Sum Assured is less than the Base Sum Assured then the Member Base Policy will continue with Base Sum Assured reduced to the extent of ACI Sum Assured payout.
- If ACI Sum Assured is equal to the Base Sum Assured then the Member Base Policy as well as this Member Rider will terminate upon payment of this benefit.

Claim payment will only be made with confirmatory diagnosis of the conditions covered while the insured is alive (i.e. a claim would not be admitted if the diagnosis is made post-mortem)

b. Additional Critical Illness benefit option:

Under this Benefit Option, upon confirmatory diagnosis of any of the covered Critical Illness, the Additional Critical Illness Sum Assured of the Member prevailing at the time of diagnosis will be paid to the Claimant, provided the Rider is in force. Upon payment of the Additional Critical Illness Sum Assured to the Claimant by the Company, the Rider shall terminate for the Member and the Base Sum Assured under the Base Member Policy remains unchanged.

Claim payment will be made only if the member has survived for a minimum period of 30 days after the date of first diagnosis of the Critical Illness.

c. The Critical Illness benefit under this Rider is payable only if the Member is diagnosed with any of the covered Critical Illness during the respective Coverage Term (i.e. before Date of Termination of Cover).

d. The date of diagnosis will be considered for processing a claim.

e. If the Member is diagnosed with a Critical Illness within the Coverage Term, and however the Survival Period goes beyond the Coverage Term, then the claim shall be honored by the Company as per the applicable terms and conditions.

Critical Illness definitions

1. Cancer of Specified Severity

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.

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 and CIN-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 classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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 5/50 HPFs;

2. Myocardial Infarction – (FIRST HEART ATTACK – OF SPECIFIED 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.

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.

3. Open Chest CABG

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 a cardiologist.

Excluded are:

Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement Or Repair Of Heart Valves

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

5. Coma of specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis 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.

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

6. Kidney Failure Requiring Regular Dialysis

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

7. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Major Organ /Bone Marrow Transplant

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.

The following are excluded:

i. Other stem-cell transplants

ii. Where only Islets of Langerhans are transplanted

9. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a Specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. Multiple Sclerosis with Persisting Symptoms

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 6 months.

Other causes of neurological damage such as SLE is excluded.

12. Benign Brain Tumor

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.

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 brain tumor.

The following conditions are excluded:

a. 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.

13. Blindness

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

The Blindness is evidenced by:

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

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

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

14. 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 90decibels across all frequencies of hearing” in both ears.

15. End stage lung Failure

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 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 (PaO2 < 55mmHg); and
iv. Dyspnea at rest.

16. End stage liver failure

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

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

17. Loss of Speech

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 must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

18. Major Head Trauma

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.

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.

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 ability to 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 vice versa;
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.

The following are excluded:

a. Spinal cord injury.

19. Primary (Idiopathic) Pulmonary hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in 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.

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 be present even at rest.

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

20. Third degree burns

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.

21. Aorta Graft Surgery

The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta. Minimally invasive procedures like endovascular repair are covered under this definition. The surgery must be determined to be medically necessary by a Consultant Surgeon and supported by imaging findings.

For the above definition, the following are not covered:

1. Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts)
2. Surgery of the aorta related to hereditary connective tissue disorders (e.g., Marfan syndrome, Ehlers–Danlos syndrome)
3. Surgery following traumatic injury to the aorta.

22. Apallic Syndrome or Persistent Vegetative State (PVS)

A vegetative state is absence of responsiveness and awareness due to dysfunction of the cerebral hemispheres, with the brain stem, controlling respiration and cardiac functions, remaining intact. The definite diagnosis must be evidenced by all of the following:

1. Complete unawareness of the self and the environment
2. Inability to communicate with others.
3. No evidence of sustained or reproducible behavioral responses to external stimuli

4. Preserved brain stem functions.
5. Exclusion of other treatable neurological or psychiatric disorders with appropriate neurophysiological or neuropsychological tests or imaging procedures.
6. The diagnosis must be confirmed by a Consultant Neurologist and the condition mustbe medically documented for at least one month without any clinical improvement.

23. Alzheimer's Disease

A definite diagnosis of Alzheimer's disease evidenced by all of the following:

1. Loss of intellectual capacity involving impairment of memory and executive functions (sequencing, organizing, abstracting, and planning), which results in a significant reduction in mental and social functioning.
2. Personality change
3. Gradual onset and continuing decline of cognitive functions
4. No disturbance of consciousness
5. Typical neuropsychological and neuroimaging findings (e.g., CT scan)

The disease must require constant supervision (24 hours daily) [before age 65]. The diagnosis and the need for supervision must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

- Other forms of dementia due to brain or systemic disorders or psychiatric conditions

24. Parkinson's disease

A definite diagnosis of primary idiopathic Parkinson's disease, which is evidenced by at least two out of the following clinical manifestations:

1. Muscle rigidity
2. Tremor
3. Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses)

Idiopathic Parkinson's disease must cause neurological deficit resulting [before age 65] in the permanent and irreversible inability of the Life Assured to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 6 months despite adequate drug treatment.

Activities of Daily Living are:

1. 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.
2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again

The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

1. Secondary parkinsonism (including drug- or toxin-induced parkinsonism)
2. Essential tremor
3. Parkinsonism related to other neurodegenerative disorders.

25. Aplastic Anaemia

A definite diagnosis of Aplastic anaemia resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition must be treated with blood transfusions and, in addition, with at least one of the following:

1. Bone marrow stimulating agents.
2. Immunosuppressant

3. Bone marrow transplantation

The diagnosis must be confirmed by a Consultant Haematologist and evidenced by bone marrow histology.

Temporary or reversible aplastic anemia is excluded and not covered in this Policy.

26. Loss of independent Existence (cover up to Insurance age 74)

Inability to perform at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor.

Only Life assured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

Activities of daily living:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;

ii. Dressing: the ability to 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 lying position in a bed to a sitting position in an upright chair or wheelchair and vice versa; The ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

27. Brain Surgery

The actual undergoing of surgery to the brain under general anesthesia during which a Craniotomy with removal of bone flap to access the brain is performed.

The following are excluded:

a. Burr hole procedures, trans-phenoidal procedures and other minimally invasive procedures such as irradiation by gamma knife or endovascular embolisations, thrombolysis and stereotactic biopsy, and,

b. brain surgery as a result of an accident.

The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

28. Cardiomyopathy

A definite diagnosis of one of the following primary cardiomyopathies:

1. Dilated Cardiomyopathy
2. Hypertrophic Cardiomyopathy (obstructive or non-obstructive)
3. Restrictive Cardiomyopathy
4. Arrhythmogenic Right Ventricular Cardiomyopathy

The disease must result in at least one of the following:

1. Left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months.
2. Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness, or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months.
3. Implantation of an Implantable Cardioverter Defibrillator (ICD) for the prevention of sudden cardiac death

The diagnosis must be confirmed by a Consultant Cardiologist and supported by echocardiogram or cardiac MRI. The implantation of an Implantable Cardioverter Defibrillator (ICD) must be determined by a Consultant Cardiologist.

For the above definition, the following are not covered:

1. Secondary (ischaemic, valvular, metabolic, toxic, or hypertensive) cardiomyopathy
2. Transient reduction of left ventricular function due to myocarditis.
3. Cardiomyopathy due to systemic diseases
4. Implantation of an Implantable Cardioverter Defibrillator (ICD) due to primary arrhythmias (e.g., Brugada or Long-QT-Syndrome)

29. Loss of Limbs

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.

30. Muscular Dystrophy – Resulting in Permanent loss of Physical abilities

A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle without involvement of the nervous system.

The diagnosis must be confirmed by a company appointed Registered Medical Practitioner who is a neurologist based on all the following conditions:

1. Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction.
2. Characteristic Electromyogram; or
3. Clinical suspicion confirmed by muscle biopsy.

The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

1. 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.
2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by electromyography (EMG) and muscle biopsy findings

31. Poliomyelitis

A definite diagnosis of acute poliovirus infection resulting in paralysis of the limb muscles or respiratory muscles. The paralysis must be medically documented for at least 3 months from the date of diagnosis.

The diagnosis must be confirmed by a Consultant Neurologist and supported by laboratory tests proving the presence of the poliovirus.

For the above definition, the following are not covered:

- Poliovirus infections without paralysis
- Other enterovirus infections
- Guillain-Barré syndrome or transverse myelitis

32. Medullary Cystic Disease

A definite diagnosis of medullary cystic disease evidenced by all of the following:

1. Ultrasound, MRI or CT scan showing multiple cysts in the medulla and corticomedullary region of both kidneys.
2. Typical histological findings with tubular atrophy, basement membrane thickening and cyst formation in the corticomedullary junction.
3. Glomerular filtration rate (GFR) of less than 40 ml/min (MDRD formula)
4. The diagnosis must be confirmed by a Consultant Nephrologists.

For the above definition, the following are not covered:

1. Polycystic kidney disease
2. Multisystem renal dysplasia and medullary sponge kidney
3. Any other cystic kidney disease

33. SLE with Lupus Nephritis (Systematic lupus Eryth. with Renal Involvement)

The Systemic Lupus Erythematosus (SLE) is a systemic autoimmune disease. It can affect any part of the body. The immune system erroneously attacks the body´s cells and tissue resulting in inflammation and damage. It can be diagnosed by typical laboratory findings and associated symptoms, the so-called butterfly rash being the most known, and has to be treated with corticosteroids or other immunosuppressants.

A definite diagnosis of systemic lupus erythematosus evidenced by all of the following:

1. Typical laboratory findings, such as presence of antinuclear antibodies (ANA) or anti-dsDNA antibodies
2. Symptoms associated with lupus erythematosus (butterfly rash, photosensitivity, serositis)
3. Continuous treatment with corticosteroids or other immunosuppressants

Additionally, one of the following organ involvements must be diagnosed:

1. Lupus nephritis with proteinuria of at least 0.5 g/day and a Glomerular filtration rate of less than 60 ml/min (MDRD formula)
2. Libman-Sacks endocarditis or myocarditis
3. Neurological deficits or seizures over a period of at least 3 months and supported by cerebrospinal fluid or EEG findings. Headaches, cognitive and psychiatric abnormalities are specifically excluded.

The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologists.

The other form of lupus erythematosus the Discoid lupus erythematosus or subacute cutaneous lupus erythematosus or a lupus erythematosus that is drug-induced are not covered.

What are the exclusions?

a. No claim shall be payable in respect of any Critical Illness that a Member is diagnosed with or for which care, treatment or advice was recommended by or received from a physician, or which first manifested itself or was contracted within 90 days from the Date of Commencement of Cover (i.e. during the Waiting Period). In the event of occurrence of any of the scenarios mentioned above, or in case of a claim, where it is established that the Member was diagnosed with any one of the covered Critical Illness during the Waiting Period for which a critical illness claim could have been made, 100% of the premiums will be refunded and the Member Rider policy will terminate.

b. If the Member is covered under the Additional Critical Illness Benefit Option and dies within 30 days of the diagnosis of the covered Critical Illness i.e before the end of the Survival Period no claim will be payable However,100% of the premium will be refunded and the Member Rider policy will terminate.

c. Pre-Existing Disease: Pre-existing Disease means any condition, ailment, injury or disease:

   i. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of this Rider issued by the insurer or

ii. For which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of this Rider or its reinstatement.

d. If the Critical Illness for which the claims is raised is due to any intentional self-inflicted injury, suicide or attempted suicide.

e. If any Critical Illness suffered by the Member was caused directly or indirectly by influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescriptions of a registered medical practitioner.

f. If the Critical Illness for which the claim is raised is due to engaging in or taking part in hazardous activities, including but not limited to, diving or riding or any kind of race; martial arts; hunting; mountaineering; parachuting; bungee-jumping; underwater activities involving the use of breathing apparatus or not.

g. If the Critical Illness for which the claim is raised is on account of the Member participating in any criminal or unlawful act

h. For any Critical Illness arising out of nuclear contamination; the radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

i. For any Critical Illness arising either as a result of war, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, terrorism, military or usurped power, riot or civil commotion, strikes or participation in any naval, military or air force operation during peace time.

j. For any Critical Illness arising from participation by the Member in any flying activity, except as a bona fide, fare-paying passenger and aviation industry employee like pilot or cabin crew of a recognized airline on regular routes and on a scheduled timetable.

k. Any Critical Illness which is due to an external congenital anomaly which is not as a consequence of a genetic disorder.

l. Failure to seek medical advice or treatment by a medical practitioner leading to occurrence of the Critical Illness.

Apart from these permanent exclusions, there are exclusions with respect to each Critical Illness which are listed in CI definitions above.

Additional Feature

Sum Assured Reset Benefit-This benefit is applicable only if specifically chosen by the Master Policyholder. The Sum Assured for chosen benefit option for each Member can be increased or decreased by the Master Policyholder/ Member during the term of the Rider Policy, subject to underwriting, provided that the life cover for the Member is in force and the Sum Assured for chosen Benefit Option does not exceed the Member's Base Sum Assured. The increase or decrease of the Sum Assured of the chosen benefit option shall be mutually agreed between the Company and the Master Policyholder and there is no deviation from agreed benefit option chosen at the inception of Master Rider tenure.

If the Base Sum Assured for any member is decreased by the Master Policyholder/Member during the term of the Member Base policy, the Sum Assured of chosen benefit option would be reset to base sum assured, if necessary, such that it does not exceed the member base sum assured, subject to underwriting. The decrease of the Sum Assured of the chosen Benefit Option shall be mutually agreed between the Company and the Master Policyholder provided that there is no deviation from agreed Benefit Option chosen at the inception of Master Rider tenure.

Policy Surrender / Withdrawal Benefit:

a. In case the Master Policyholder surrenders the Master Rider, the Members of the Group will be given the option to continue Rider cover till the end of the Coverage Term. The option to continue the cover will be applicable only to those schemes where the premium is paid by the members provided the Member Base Policy is in force.

b. If the Member chooses to continue the Cover upon Surrender of the Master Rider by the Master Policyholder, then this has to be specifically communicated to the Company by the Master Policyholder/ or the Member and will be effective only upon acceptance of the same by the Company.

c. In the event, the chooses Members not to continue the Cover upon Surrender of the Master Base policy along with the Master Rider chosen or on surrender of the Master Rider only, then the Unexpired risk premium value, if any, will be payable to the Master Policyholder

d. For lender borrower groups, on foreclosure of loan or transfer of loan to another financial institution by the Member, the Member has the option to continue or discontinue the Rider. If the member chooses to continue the cover post foreclosure or transfer then this has to be specifically communicated to the company and will be effective only upon acceptance of the same by the company.

Unexpired risk premium value for respective benefit options will be calculated as below:

Unexpired risk premium value = 75% X [Outstanding Coverage Term in days / (Total Coverage Term in days at the time of attachment)] X Premiums paid less actual stamp duty paid less medical costs incurred in issuance of the Policy

Where, Outstanding Coverage Term in days = Total Coverage Term in days at the time of attachment minus Number of completed coverage term in days at the time of exit.

Withdrawal Benefit:

On Member withdrawal by the Master Policyholder, the withdrawal benefit payable is the premium paid towards the Member pro-rated to reflect the Rider cover not yet provided. The Withdrawal Benefit will be paid to the Master Policyholder by the Company.

Withdrawal benefit = 75% * [Outstanding coverage term in days / (Total Coverage Term in days)] X Premiums paid

Renewal

The Master Policyholder has the option to modify the Policy Renewal Date. The applicable premium for the period up to the original Policy Renewal Date will be calculated on a pro-rata basis and will be refunded to the Master Policyholder. Premium applicable on the modified Policy Renewal Date will be calculated based on the latest data provided.

In case there is a break in cover on account of any reason, Waiting Period will be applicable from the date of commencement of cover post the break in cover.

The Master Policyholder can renew the Rider only with the renewal of the Master Base Policy to which the Rider is attached.

Cancellation/Termination of the Rider

The Rider shall be terminated by the Company on the occurrence of any of the below mentioned conditions:

i. When the Member Base policy to which the Rider is attached terminates upon payment of death benefit due to any reason whatsoever.

ii. When the coverage under the Master Base Policy/ Member Base policy (as applicable) to which the Master Rider/ member level Rider is attached expires due to cancellation or surrender or termination due to any other reason.

iii. When the coverage under the Master Base Policy/ Member Base policy to which the Rider is attached lapses on account of non-payment of premiums.

iv. Upon expiry of the Coverage Term for each of benefit option(s) chosen.

v. On cancellation of the Rider by the Company for any reason whatsoever

vi. On payment of free look cancellation proceeds.

vii. If the Member ceases to satisfy any of the eligibility criteria as mentioned in Clause 4 of Terms and conditions and chooses to expressly discontinue the cover when he/she ceases to be a Member of the group;

viii. Upon payment of Critical Illness benefit under this Rider by the Company to the Claimant.

Tax Benefits

Premiums and the benefits under the policy, will be subject to the taxes and other statutory levies as may be applicable from time to time.

The Master Policyholder/Member will be required to pay goods and services tax, cess or any other form of taxes or charges or levies as per the prevailing laws, regulations and other

financial enactments as may exist from time to time, wherever applicable.

All benefits payable under the policy are subject to the tax laws and other financial enactments as they exist from time to time.

All provisions stated in this Policy are subject to the current guidelines issued by the Regulator as on date. All future guidelines that may be issued by the Regulator from time to time may also be applicable to this Policy.

Claim Payment

a. For lender-borrower groups, in case of a Regulated Entity, subject to the Master Policyholder providing the Company a letter of authorization from the member, authorizing the Company to make payment to the extent of Outstanding loan amount in favor of the Master Policyholder, the claim amount to the extent of Outstanding loan amount shall be paid to the Master Policyholder after deduction of the same from the claim proceeds payable on the happening of the contingent event covered under this policy. The balance amount, if any, shall be payable to the Claimant. In the absence of Letter of Authorization or in case of Other Entities, in the event of a claim arising under the policy, the claim payment will be made to the Claimant.

Regulated Entities and Other Entities have been defined as follows

- **Regulated Entity** shall mean to include the following:
  1. Reserve Bank of India ("RBI") Regulated Scheduled Commercial Banks (including Co-operative Banks).
  2. NBFCs having Certificate of Registration from RBI.
  3. National Housing Bank ("NHB") Regulated Housing Finance Companies.
  4. National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies.
  5. Small Finance Banks regulated by RBI
  6. Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies.
  7. Microfinance companies registered under section 8 of the Companies Act, 2013.
  8. Any other category as approved by the Authority.

- **Other Entities** shall mean to include the entities other than Regulated Entities.

Before payment of any claim under this Rider the Company shall require the delivery to it of the following documents establishing the right of the claimant or claimants to receive payment.

i. Duly filed claim form; and

ii. Bank details of the claimant (cancelled cheque copy with printed name/ passbook); and

iii. Medical reports or special reports by registered physician/doctor relevant to the Critical Illness and its treatment which may be further validated by a physician/doctor appointed by the Company; and

iv. Current and previous medical records for last 5 years, if any (First and all consultation papers with all investigation reports, discharge summary, Indoor case papers, follow up papers since onset of critical illness); and

v. Any other document/ information that the Insurer may decide in the circumstances of a particular case.

vi. The Company reserves the right to call for additional information, documents, or particulars, in such form and manner as the Company would prescribe, and the Benefits would be paid only after receipt of such additional information, documents or particulars.

b. For non-lender borrower groups, in the event of a claim arising under the policy, the member / nominee / legal heir to whom benefits are payable shall be intimated to the Company, through Master Policyholder, in writing. Before payment of any claim under this Master Policy, the Company shall require the delivery to it of the following documents establishing the right of the claimant or claimants to receive payment.

i. Completed claim form (including NEFT details and bank account proof as specified in the claim form; and

ii. Medical reports or special reports by registered physician/doctor relevant to the Critical Illness and its treatment which may be further validated by a physician/doctor appointed by the Company; and

iii. A cancelled personalised cheque with account no. and IFSC code. Where the cheque is not personalised, a latest bank statement (not more than 3 months old) or copy of passbook (where account number and IFSC code is mentioned).

iv. Any other document/ information that the Insurer may decide in the circumstances of a particular case.

v. First and all consultation papers with all investigation reports, discharge summary, Indoor case papers, follow up papers since onset of critical illness; and

vi. Current and previous medical records for last 5 years, if any

vii. The Company reserves the right to call for additional information, documents, or particulars, in such form and manner as the Company would prescribe, and the Benefits would be paid only after receipt of such additional information, documents or particulars.

c. All claim payments shall be made in Indian Currency only in accordance with the prevailing Exchange control regulations and other relevant laws and regulations in India.

d. The settlement of claim is subject to correct information provided by the member related to his/her personal information & in declaration of good health, if applicable. The Company reserves the right to reject the claim of a member in case incorrect information related to member is provided for the Cover. The decision of the Company regarding the settlement of the Cover shall be binding on the Master Policyholder/ Member.

e. A death claim under a life insurance policy shall be paid or be rejected or repudiated giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and required clarifications. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate the same at the earliest and complete such investigation expeditiously, in any case not later than 90 days from the date of receipt of claim intimation and the claim shall be settled within 30 days thereafter.

f. If there is delay on the part of Insurer beyond the timelines as mentioned above, the insurer shall pay interest at a rate, which is 2% above bank rate from the date of receipt of last necessary document.

Terms & Conditions

1. **Grace Period:**

   The Grace Period for monthly mode of payment is 15 days, and 30 days for quarterly and half-yearly mode of premium payment, commencing from the premium due date. The member's cover continues during the Grace Period. In case the insured event occurs during the Grace Period, then We will pay the benefit under the appli cable Benefit Option(s) subject to terms and conditions of this Rider as outlined in Clauses "Benefits in detail" and "What are the exclusions" above.

   Grace Period corresponding to the premium payment frequency shall be available at the time of renewal of Rider contract and claims arising during this period will be settled subject to renewal of the Master Rider/ Master Base Policy/Member Based Policy.

   If any premium instalment for the benefit option(s) along with the Member Base policy /Master Base policy is not paid by the Member/Master Policyholder within the Grace Period, then the benefit option(s) shall lapse and the cover will cease.

   The Company is liable for any claim if the Premiums in respect of the concerned Member is received by the Master Policyholder, subject to the Claimant/Master Policyholder proving that the Member has paid the Premi um within the Grace Period and has secured a proper receipt that he was duly insured.

   The Company shall be responsible to honour any valid claims brought under this Rider in instances wherein the Master Policyholder has collected/ deducted the Premium but has failed to pay the same to the Company within the Grace Period due to administrative reasons.

2. **Free look period:** The Master Policyholder/Member have the option to review the Rider following receipt of the certificate of insurance/Rider document, respectively. If the Master Policyholder/Member is not satisfied with the terms and conditions of the Rider, the Rider document/Certificate of Insurance needs to be returned to the Company with reasons for cancellation within within 30 days from the date of receipt of the certificate of insurance/rider document.

   On cancellation of the Rider /Member's cover during the free look period, We will return the premium paid subject to the deduction of:

   - Stamp duty under the policy,
   - Expenses borne by the Company on medical examination, if any
   - Proportionate risk premium for the period of cover

   Thereafter this Master Rider /Member's cover shall terminate and all rights, benefits and interests under this Master Rider/ Member's Cover shall be extinguished. In case the Master Base policy/Member Base policy is cancelled within free-look period, the Rider/ Member's Cover will also be automatically cancelled.

3. **Waiting Period:**

   1. A waiting period of 90 days will be applicable under both Accelerated Critical Illness and Additional Critical Illness benefit options. In case the Member is diagnosed with any of the covered Critical Illness during this

period, no benefit shall be payable. The Company shall refund the premium applicable and the Member Rider policy will terminate with all rights and benefits thereunder.

2. No waiting period applies for Critical Illness claims arising solely due to an accident.
3. Waiting Period will not be applicable on consecutive renewal of the Rider Cover for the Member with the Company.
4. Waiting Period can be waived off to the extent of waiting period already served, in case wherein the Master Policyholder is transferring the covered Members from other policy with CI cover to this Master Rider Policy.
5. In case there is a break in cover on account of any reason, waiting period will be applicable from the date of commencement of cover, post the break in cover.

4. Eligibility for Membership

a. Persons who are of at least the minimum age at entry (last birthday) and not more than the maximum age at entry (last birthday) as on the Rider Commencement Date will be eligible for Membership of the Scheme.

b. Persons who join the Group after the Date of Commencement of cover shall be eligible for Membership of the Scheme, subject to them being within the age limits specified above.

c. The eligibility of a Member to join the scheme as specified in (a) and (b) above is subject to the Company receiving the Member Data, an intimation of eligibility of the Member and premium amount preferably within 45 days of the Member becoming eligible provided this is within the Coverage term and subject to underwriting.

5. In case of any contradiction between the terms and conditions of the Master Base Policy Document and this Master Rider Document, then:

- For the benefits payable under the Rider, the Rider Terms and Conditions shall prevail; and
- For the benefits payable under the Master Base Policy, the Master Base Policy Terms and conditions shall prevail

6. Premium loadings: The premium loadings for non-annual premium payment modes with one year term are as given below:

Premium paying frequency	Modal loading (as a % of annual premium)
Half-yearly	2%
Quarterly	3%
Monthly	4%

Terms & Conditions

Premiums under the rider can be paid in yearly, half-yearly, quarterly or monthly mode, same as chosen under the Master Base policy. The Master Policyholder may choose to opt for a change of premium paying mode other than Yearly and Single Pay during the policy term, subject to the premium payment frequency of the Rider being same as that of the Master Base policy. The excess/deficit of premium would be payable to/payable by the Master Policyholder.

The premium payable on renewal of the Master Policy may vary and shall be quoted on application for such renewal. Premiums are payable within a Grace Period starting from the Premium due date and on the Policy Renewal Date, as applicable.

7. **Nomination:** Nomination shall be as per Section 39 of the Insurance Act, 1938 as amended from time to time. Details of nomination will be as mentioned for the Master Base Policy. For more details on this section, please refer to our website.
8. **Assignment:** Assignment shall be as per Section 38 of the Insurance Act, 1938 as amended from time to time. For more details on this section, please refer to our website.
9. **Section 41 of the Insurance Act, 1938 as amended from time to time:** In accordance with Section 41 of the Insurance Act, 1938 as amended from time to time, no person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take 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 prospectuses or tables of the insurer.
10. **Section 45 of the Insurance Act, 1938, as amended from time to time:** 1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later. 2) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based. 3) Notwithstanding anything contained in sub-section (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer: Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive 25. 4) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made

is based: Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation. 5) Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the Life Insured was incorrectly stated in the proposal.

In case of fraud or misstatement, the policy shall be cancelled immediately by paying the unexpired risk premium value, subject to the fraud or misstatement being established by the Company in accordance with Section 45 of the Insurance Act, 1938 as amended from time to time.

11. For further details, please refer to the Rider document.

12. In case of withdrawal of the product due to any reason by Us, we shall provide the following option to the master policyholder for the existing covered members:

(i) A one-time option to renew the existing product, if renewal falls within the 90 days from the date of withdrawal of the product; or

(ii) Migrate to any other suitable product (any other existing product or modified version of the withdrawn product) as per the choice of the master policyholder.

13. Policy Servicing and Grievance Handling Mechanism: For any clarification or assistance, You may contact Our advisor or call Our customer service representative (between 10.00 a.m. to 7.00 p.m, Monday to Saturday; excluding national holidays) on the numbers mentioned on the reverse of the Policy folder or on Our website: www.iciciprulife.com. For updated contact details, We request You to regularly check Our website. If You do not receive any resolution from Us or if You are not satisfied with Our resolution, You may get in touch with Our designated grievance redressal officer (GRO) at gro@iciciprulife.com or 1860 266 7766.

Address:

ICICI Prudential Life Insurance Company Limited,

Ground Floor & Upper Basement, Unit No. 1A & 2A,

Raheja Tipco Plaza Rani Sati Marg,

Malad (East) Mumbai-400097 .

The concerns of senior citizens will be resolved on priority ensuring there is a speedy disposal of the grievances.

For more details, please refer to the “Grievance Redressal” section on www.iciciprulife.com. If You do not receive any resolution or if You are not satisfied with the resolution provided by the GRO, You may escalate the matter to Our internal grievance redressal committee at the address mentioned below:

Terms & Conditions

ICICI Prudential Life Insurance Co. Ltd.

Ground Floor & Upper Basement Unit No. 1A & 2A,

Raheja Tipco Plaza, Rani Sati Marg,

Malad (East), Mumbai- 40009, Maharashtra.

If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach Policyholders' Protection and Grievance Redressal Department, the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

IRDAI Grievance Call Centre (BIMA BHAROSA SHIKAYAT NIVARAN KENDRA)

155255 (or) 1800 4254 732

Email ID: complaints@irdai.gov.in

Address for communication for complaints by fax/paper:

Policyholders' Protection and Grievance Redressal Department – Grievance Redressal Cell

Insurance Regulatory and Development Authority of India

Survey No. 115/1, Financial District, Nanakramguda, Gachibowli,

Hyderabad, Telangana State – 500032

You can also register your complaint online at bimabharosa.irdai.gov.in.

About ICICI Prudential Life Insurance

ICICI Prudential Life Insurance Company Limited is a joint venture between ICICI Bank Limited and Prudential Corporation Holdings Limited, a part of the Prudential group. ICICI Prudential began its operations in Fiscal 2001 after receiving approval from Insurance Regulatory Development Authority of India (IRDAI) in November 2000.

ICICI Prudential Life Insurance has maintained its focus on offering a wide range of savings and protection products that meet the different life stage requirements of customers.

ICICI PRUDENTIAL LIFE INSURANCE

For More Information:

Customers calling from anywhere in India, please dial 1860 266 7766

Do not prefix this number with “+” or “91” or “00” (local charges apply)

Call Centre Timings: 10.00 am to 7.00 pm

Monday to Saturday, except National Holidays.

To know more, please visit www.iciciprulife.com

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IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums.
Public receiving such phone calls are requested to lodge a police complaint.