# A comprehensive plan to secure the future of your loved ones

ICICI Pru
SUPER PROTECT LIFE

A Non-Participating Non-Linked Life Group Pure Risk Product

ICICI PRUDENTIAL LIFE INSURANCE

ICICI Pru Super Protect – Life, a plan that offers insurance protection at affordable cost to the members of your group in case of their unfortunate death. The plan offers wider coverage through optional benefits. It also offers the flexibility to customise the benefits and payout options as per the needs of the members.

## Benefits

Wide coverage with optional benefits

- Accelerated Terminal Illness Benefit
- Accidental Death Benefit
- Accelerated Accidental Total and Permanent Disability Benefit
- Accelerated Critical Illness Benefit
- Additional Critical Illness Benefit
- Cancer Protect Benefit
- Hospitalisation Benefit
- Waiver of Premium on Critical Illness or Accidental Total and Permenant Disability

**Need based benefit payout**

Choose to receive the benefit amount as a lump sum or as monthly income or a combination of both

**Choice to offer coverage**

To spouse

**Convenient Premium Payment options**

Flexibility to pay premiums in monthly, half-yearly or yearly mode

**Choice of Premium Payment terms**

Flexibility to pay premiums only once or regularly for the coverage term

# ICICI Pru Super Protect Life at a glance

| | |
|---|---|
| Premium Payment Term | Single Pay/ Regular Pay |
| Minimum / Maximum Age at Entry (Age completed birthday) | Single Pay: 18 years / 70 years<br>Regular Pay: 18 years / 70 years |
| Minimum / Maximum Age at Maturity (Age completed birthday) | 20 years / 80 years |
| Minimum/ Maximum Coverage Term | Single Pay: 2 years / 30 years<br>Regular Pay: 5 years / 30 years |
| Minimum Sum Assured for each benefit | ₹10,000 per member |
| Maximum Sum Assured for each benefit | As per Board Approved Underwriting Policy |
| Premium Payment mode for RP | Yearly, Half-Yearly, and Monthly |

| Benefit Options | Minimum Coverage Term | | Maximum Coverage Term | |
|---|---|---|---|---|
| | SP | RP | SP | RP |
| TI Benefit | 2 years | 5 years | 30 years | 30 years |
| ADB Benefit | 2 years | 5 years | 30 years | 30 years |
| ATPD Benefit | 2 years | 5 years | 30 years | 30 years |
| ACI Benefit | 2 years | 5 years | 15 years | 15 years |
| CI Benefit | 2 years | 5 years | 15 years | 15 years |
| CP Benefit | 2 years | 5 years | 5 years | 5 years |
| Hospitalisation Benefit | 2 years | 5 years | 5 years | 5 years |

Maximum term for waiver of premium on diagnosis of critical illness or occurrence of accidental total and permanent disability benefit in case of regular pay option shall be as per the maximum coverage term of each benefit to which it applies. Premium and Benefits will vary depending upon the cover option chosen.

## How does the plan work?

The Master Policyholder shall

1

Choose the benefit options depending on the members' need. Along with Death Benefit, other Benefits can be chosen by the Member and Member's spouse, only at the inception of the cover, provided the Benefits have been opted for by the Master Policyholder.

2

Choose the Premium Payment Term options and Premium Payment Modes. Premium Payment Term options and Premium Payment Modes can be chosen by the Member, only at the inception of the cover, provided the options have been opted for by the Master Policyholder. Premium will vary based on the benefits chosen.

3

Receive the Master Policy.

4

Certificate of Insurance is issued to all covered Members. The Certificate of Insurance, issued at the inception of the Cover, will specify the member details as well as the amount payable on the occurrence of an event giving rise to a claim for a member will be sent to the respective members.

## Benefits

Death Benefit: This benefit is payable on the death of the covered member before the end of the member's coverage term. Death Benefit is equal to base Death Sum Assured chosen by the member at cover inception. In the event of death of the Member on the Date of Termination of Cover or Terminal Date, then death benefit shall not be payable. The Member Cover shall terminate with all rights and benefits thereunder

Accelerated Terminal Illness (TI) Benefit: If this benefit is chosen, on the member being diagnosed with Terminal Illness, an amount equal to the base Death Sum Assured will be payable. This is an accelerated benefit and not an additional benefit, which means payment through this benefit will not be in addition to the Death Benefit. In case the member has chosen both TI Benefit and Additional CI benefit, and condition leading to TI is the one covered under CI, the member shall get both the benefits. In case of Single Pay option, only one benefit out of ATPD Benefit, TI Benefit and ACI Benefit can be chosen. In the event the Member is diagnosed with Terminal Illness on the Date of Termination of Benefit or Terminal Date, then this benefit shall not be payable. The Member Cover shall terminate with all rights and benefits thereunder.

Accelerated Accidental Total and Permanent Disability (ATPD) Benefit: If this benefit is chosen, on the member being regarded as Totally and Permanently Disabled due to an accident, during the ATPD Benefit coverage term, ATPD Benefit will be payable. This is an accelerated benefit and not an additional benefit, which means, on payment of this benefit, member's Death Benefit and TI Benefit (if chosen), will be reduced by the extent of the ATPD Benefit payment made. ACI Benefit if chosen, and is more than the reduced Death Benefit, ACI Benefit will decrease to the amount of reduced Death Benefit, else will remain unchanged. ATPD Benefit can be less than or equal to base Death Sum Assured. In case of Regular Pay option, the future premiums for Death, ATPD and ACI Benefits will reduce proportionately. In cases where ATPD Benefit is equal to Death Benefit, the member's life cover will cease. ATPD Benefit can be chosen for a period of 2 to 30 years subject to Member's coverage term. In case of Single Pay option, only one benefit out of ATPD Benefit, TI Benefit and ACI Benefit can be chosen. In the event of an accident on the Date of Termination of Benefit or Terminal Date; whichever is earlier resulting in the total and permanent disability of the Member, then this benefit shall not be payable.

Accidental Death (AD) Benefit: If this benefit is chosen, on the death of the member due to an accident during the AD Benefit coverage term, AD Benefit will be payable in addition to Death Benefit. AD Benefit chosen by the member can be less than or equal to base Death Sum Assured. AD Benefit can be chosen for a period of 2 to 30 years subject to Member's coverage term. In the event of an accident on the Date of Termination of Benefit or Terminal Date; whichever is earlier resulting in the death of the Member, then this benefit shall not be payable. The Member Cover shall terminate with all rights and benefits thereunder.

Cancer Protect (CP) Benefit: If this benefit is chosen, on the member being diagnosed with the first ever occurrence of any of the listed conditions during the lifetime of the member and within the CP Benefit coverage term, CP benefit will be payable as below:

| Level and Covered Conditions | Payout (as % of Cancer Protect Benefit) |
|---|---|
| Minor conditions:<br>1. Carcinoma-in-Situ 2. Early stage cancer | 25% |
| Major condition:<br>1. Cancer of specified Severity | 100% less earlier Minor condition claim payouts, if any |

Multiple claims for minor conditions can be made, as long as the total payout does not exceed 100% of the Cancer Protect Benefit. This is an additional benefit. Cancer Protect Benefit can be less than or equal to the base Death Sum Assured. In case the member has chosen both CP benefit and ACI or CI benefit, then, on being diagnosed with cancer of specified severity, both the benefits payouts will be made. CP Benefit can be chosen for a period of 2 to 5 years subject to Member's coverage term. In the event the Member is diagnosed with a Minor or Major Condition (Cancer) on the Date of Termination of Benefit or Terminal Date; whichever is earlier, then this benefit shall not be payable

Hospitalisation Benefit: Hospitalisation Benefit is payable, if the Member on the recommendation of a medical practitioner is hospitalised for the required continuous number of days in a policy year, during the Hospitalisation Benefit coverage term. There is an option to choose either 7 continuous days of hospitalization or 15 continuous days of hospitalization in a policy year. A member will be able to choose only one option out of 7 days or 15 days hospitalization benefit. Hospitalisation Benefit can be claimed once every policy year. This is an additional benefit. Annual Hospitalisation Benefit can be less than or equal to the base Death Sum Assured and can be chosen for a period of 2 to 5 years subject to Member's coverage term.

Accelerated Critical Illness (ACI) Benefit: If this benefit is chosen, ACI Benefit will be payable on the member being diagnosed with the first ever occurrence of any of the covered Critical Illness during the lifetime of the member and within the ACI coverage term. There is a choice between any one of Essential/ Classic/ Comprehensive ACI packages which cover 7, 19 and 33 Critical Illnesses respectively as given in the table below point 10. This is an accelerated benefit. It means, on payment of this benefit, member's Death Benefit and TI Benefit (if chosen) will be reduced by the extent of the payment made. ATPD

Benefit if chosen, and is more than the reduced Death Benefit, then ATPD Benefit will decrease to the amount of reduced Death Benefit, else will remain unchanged. In case of Regular Pay option, the future premiums for Death, ATPD and TI Benefits will reduce proportionately. In cases where ACI Benefit is equal to Death Benefit, the member's life cover will cease. ACI Benefit can be chosen for a period of 2 to 15 years subject to Member's coverage term. In case of Single Pay option, only one benefit out of ATPD Benefit, TI Benefit and ACI Benefit can be chosen. In case the member has chosen both CP benefit and ACI, then, on being diagnosed with cancer of specified severity, payouts will be made for both the benefits. In the event the Member is diagnosed with any of the covered Critical Illnesses on the Date of Termination of Benefit or Terminal Date; whichever is earlier, then this benefit shall not be payable.

Additional Critical Illness (CI) Benefit: If this benefit is chosen, CI Benefit will be payable on the member being diagnosed with the first ever occurrence of any of the covered Critical Illness during the lifetime of the member and within the CI coverage term. This is an additional benefit. There is a choice between any one of Essential/ Classic/ Comprehensive CI packages which cover 7, 19 and 33 Critical Illnesses respectively as given in the table below point 9. CI Benefit will be payable only if the member survives for a period of 14 days from the date of diagnosis of any of the covered Critical Illnesses. CI Benefit can be less than or equal to the base Death Sum Assured and can be chosen for a period of 2 to 15 years subject to Member's coverage term. Only one of either ACI Benefit or CI Benefit can be chosen. In case the member has chosen both TI Benefit and Additional CI Benefit, and condition leading to TI is the one covered under CI, the member shall get both the benefits. In case the member has chosen both CP benefit and CI benefit, then, on being diagnosed with cancer of specified severity, payouts will be made for both the benefits. In the event the Member is diagnosed with any of the covered Critical Illnesses on the Date of Termination of Benefit or Terminal Date; whichever is earlier, then this benefit shall not be payable.

Waiver of Premium on Critical Illness or Accidental Total and Permenant Disability (WoP) Benefit: If this benefit is chosen, the Member on being diagnosed to be suffering from any of the 33 Critical Illnesses covered under Comprehensive package as given in the table below or in the event of the Member being regarded as Totally and Permanently Disabled due to an accident, future premiums for all Benefits mentioned in the Member's Certificate of Insurance will be waived. The subsequent premiums payable for this benefit shall reduce when any of the benefit is exhausted and/or reduced. The Member's benefits will continue for the remaining coverage term. This Benefit cannot be chosen if ATPD Benefit or ACI Benefit is chosen and is equal to Death Benefit. This is applicable for Regular Pay option.

## List of Critical Illnesses covered under Essential, Classic and Comprehensive packages

| Critical Illness Coverage Package | Sr No. | List of Critical Illnesses covered |
|---|---|---|
| Comprehensive, Classic, Essential | 1 | Cancer of Specified Severity |
| Comprehensive, Classic, Essential | 2 | First Heart Attack of Specified Severity |
| Comprehensive, Classic, Essential | 3 | Open Chest CABG |
| Comprehensive, Classic, Essential | 4 | Stroke resulting in permanent symptoms |
| Comprehensive, Classic, Essential | 5 | Kidney Failure Requiring Regular Dialysis |
| Comprehensive, Classic, Essential | 6 | Major Organ/ Bone Marrow Transplant |
| Comprehensive, Classic, Essential | 7 | Loss of Independent Existence |
| Comprehensive, Classic, Essential | 8 | Blindness |
| Comprehensive, Classic, Essential | 9 | Multiple Sclerosis with Persisting Symptoms |
| Comprehensive, Classic, Essential | 10 | Alzheimer's Disease |
| Comprehensive, Classic, Essential | 11 | Heart Valve Surgery (Open Heart Replacement or Repair of Heart Valves) |
| Comprehensive, Classic, Essential | 12 | Deafness |
| Comprehensive, Classic, Essential | 13 | Apallic Syndrome |
| Comprehensive, Classic, Essential | 14 | Benign Brain Tumour |
| Comprehensive, Classic, Essential | 15 | Brain Surgery |
| Comprehensive, Classic, Essential | 16 | Coma of Specified Severity |
| Comprehensive, Classic, Essential | 17 | Major Head Trauma |
| Comprehensive, Classic, Essential | 18 | Permanent Paralysis of Limbs |
| Comprehensive, Classic, Essential | 19 | Major Burns |
| Comprehensive, Classic, Essential | 20 | Motor Neurone Disease with Permanent Symptoms |
| Comprehensive, Classic, Essential | 21 | Surgery to aorta |
| Comprehensive, Classic, Essential | 22 | Chronic Lung Disease |
| Comprehensive, Classic, Essential | 23 | Chronic Liver Disease |
| Comprehensive, Classic, Essential | 24 | Parkinson's Disease |
| Comprehensive, Classic, Essential | 25 | Cardiomyopathy |
| Comprehensive, Classic, Essential | 26 | Loss of Limbs |
| Comprehensive, Classic, Essential | 27 | Primary Pulmonary hypertension |
| Comprehensive, Classic, Essential | 28 | Loss of Speech |
| Comprehensive, Classic, Essential | 29 | Systematic lupus Eryth. with Renal Involvement |
| Comprehensive, Classic, Essential | 30 | Aplastic Anaemia |
| Comprehensive, Classic, Essential | 31 | Muscular Dystrophy |
| Comprehensive, Classic, Essential | 32 | Poliomyelitis |
| Comprehensive, Classic, Essential | 33 | Medullary Cystic Disease |

## Sample Illustration for Benefit payouts

| Scenario 1: Benefits chosen by the member | Death Benefit | ACI Benefit |
|---|---|---|
| Sum Assured | 50,00,000 | 20,00,000 |
| On occurrence of a covered critical illness claim | | |
| Payout Amount | | 20,00,000 |
| After Claim policy continues with Sum Assured of | 30,00,000 | |

| Scenario 2: Benefits chosen by the member | Death Benefit | AD Benefit | Cancer Protect Benefit |
|---|---|---|---|
| Sum Assured | 50,00,000 | 50,00,000 | 10,00,000 |
| On occurrence of major cancer claim | | | |
| Payout Amount | | | 10,00,000 |
| After Claim policy continues with | 50,00,000 | 50,00,000 | |
| On occurrence of an accidental death claim | | | |
| Payout Amount | 50,00,000 | 50,00,000 | |
| After Claim | Policy terminates | | |

Payout Options: The Death Benefit, TI Benefit, AD Benefit and ATPD Benefits will payable as per one of the below options chosen by the Member at the inception of the coverage and as mentioned in the Member's Certificate of Insurance.All the other benefits will be paid out as Lump sum.

Lump Sum: Entire benefit amount is payable as lump sum.

Income: The Benefit amount will be payable in equal monthly installments in advance over a period of 1 to 10 years, as chosen by the Master Policyholder/ Member. The payout period has to be selected at outset of the Policy /commencement of cover. The total amount of benefit paid out over the selected period shall be equal to the Base Death Sum Assured and Benefit Amount (if applicable).

Monthly income as a percentage of the Benefit amount will be paid out as below:

| Payout period (number of years) | Percentage of Benefit to compute monthly income |
|---|---|
| 1 | 8.33333% |
| 2 | 4.16667% |
| 3 | 2.77778% |
| 4 | 2.08333% |
| 5 | 1.66667% |
| 6 | 1.38889% |
| 7 | 1.19048% |
| 8 | 1.04167% |
| 9 | 0.92593% |
| 10 | 0.83333% |

Income + Lump sum: The part of the Base Death Sum Assured and Benefit amount (if applicable) shall be paid out as lump sum is chosen at inception. The balance amount will be paid out in equal monthly instalments as per the table above in advance from 1 to 10 years as chosen by Master Policyholder/ Member at inception.

At the claim stage and at any time after the start of monthly income, the beneficiary will have the option to convert the outstanding monthly income into lump sum pay out and the Member's cover will terminate after the lump sum payout. The lump sum amount will be the present value of future payouts calculated at a discount rate as given below:

At the claim stage 4% p.a.

At any time after the payment of first monthly income: Higher of 4% and 10-year Government Securities yield, rounded to nearest 0.25%. The yield on 10-year Government Securities will be sourced from www.bloomberg.com. This discount rate will be reviewed twice every year on 1st of June and 1st of December.

The benefit payout option that can be chosen for various benefits are as follows:

| Benefit Type | Payout Option |
|---|---|
| Death, AD, TI and ATPD | Lump Sum, Income or Income + Lump sum |
| ACI, CI, CP, Hospitalisation Benefit | Lump Sum |

Maturity Benefit: No Maturity Benefit shall be payable under the plan.

Benefit on Policy Surrender: In case of surrender of the Master Policy by the Master Policyholder or foreclosure of loan by the insured Member or transfer of loan to another company by the insured Members, the Members shall have an option to continue the cover till the end of the Coverage Term. Such Cover shall continue with the same terms and conditions as the original cover. In the event the Member decides to continue the cover, then the same needs to be communicated to the Company by the Master Policyholder/ Member (as applicable).

For Members who opt to Surrender their cover or do not choose to continue the cover upon (a). Surrender of the Master Policy by the Master Policyholder; or (b). foreclosure of the loan or transfer of loan to another company by the Members, then the Surrender value equal to unexpired risk premium value shall be payable by the Company.

Surrender Value for the member will be the sum of Surrender Value for each of the chosen benefits.

On payment of the Surrender Value, the Member's cover for all benefits will terminate and all rights, benefits and interests of the Member under the Policy will stand extinguished. URPV for each benefit is mentioned in the terms and conditions below.

## Terms & Conditions

1. Suicide Clause: In case of death due to suicide within 12 months from the risk commencement date of the member cover or from the date of revival of the member cover, as applicable, the nominee or beneficiary of the Life Assured shall be entitled to an amount which is 80% of the total premiums paid till the date of death, provided the member cover is in force.

   On the above payment, the member's cover will terminate and all rights, benefits and interests of the member will stand extinguished. The same treatment will be applicable in case of death of Member's spouse, if he/she is covered under the policy.

This clause is not applicable to:

- Compulsory employer-employee groups.
- Existing members of groups renewing their coverage. The suicide claim provision shall apply to new members of such groups.

2. Free look period: If the Master Policyholder/member is not satisfied with the terms and conditions of this policy, then the policy document / original Certificate of Insurance can be returned to the Company with reasons for cancellation within 30 days from the date of receipt of the Policy Document/Certificate of Insurance.

   Policies will not be issued electronically to the Master Policyholder.

   On cancellation of the Policy/Member cover during the free look period, We will return the premium paid subject to the following deductions:

i. Stamp duty charges

ii. Expenses incurred by the Company on medical examination, if any

iii. Proportionate risk premium for the period of cover

   The policy/member's cover will terminate on payment of this amount and all rights, benefits and interests will stand extinguished.

3. Grace period: For Regular Pay - a grace period of 15 days from the premium due date is allowed for payment of premium for monthly frequencies and 30 days is allowed for other frequencies. In case the due premium is not paid before the end of the grace period, member's cover under the policy will terminate. The member's cover continues during the grace period.

   The Insurer is liable for any claim if the Premiums in respect of the concerned Member are received by the Master Policyholder, subject to the Member proving that he/she has paid the Premium and has secured a proper receipt that he/she was duly insured.

   The Company shall be responsible to honour any valid claims brought under this policy 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.

4. Revival:

- For Regular Pay - Member can make an application for revival of cover through the Master Policyholder within 5 years from the due date of the first unpaid premium and before the end of the coverage term.
- Revival will be based on the prevailing Board approved underwriting policy and guidelines framed thereunder.
- The Member furnishes, at his own expense, satisfactory evidence of health as required by the prevailing Board approved underwriting policy.

- The arrears of premiums together with interest at such rate as the Company may charge for late payment of premiums are paid. Revival interest rates will be set monthly and is equal to 150 basis points in addition to the prevailing yield on 10 year Government Securities. The yield on 10 year Government Securities will be sourced from www.bloomberg.com. The revival interest rate applicable for November 2024 is 8.36% p.a. compoundedhalf yearly.

  The revival of the Member cover may be on terms different from those applicable to the Member before premiums were discontinued; for example, extra mortality premiums or charges may be applicable. The Company reserves the right to refuse to revive the Member cover. The revival will take effect only if it is specifically communicated by the Company to the Master Policyholder and Member. Any change in revival conditions will be as per permissible regulatory provisions set out by IRDAI and will be disclosed to members.

  On revival of a lapsed member cover/ policy, the lower of the Sum Assured as applicable on the date of premium discontinuance or as approved during revival (following Board Approved Underwriting policy) shall be restored.

5. Lapsation: If any premium instalment is not paid within the grace period, then the Member Cover/ Master Ppolicy shall lapse, and the Member Cover/ Master Policy will cease. If the Member Cover/ Master Ppolicy is not revived within the revival period, then the Member Cover/ Master Policy shall foreclose without any value and all rights and benefits under the Member Cover/ Master Policy shall be extinguished.
6. Unexpires Risk Premium Value (URPV) or Surrender Value:

   URPV for the member will be the sum of URPV for each of the chosen benefits.

   On payment of URPV, the Member's cover will terminate and all rights, benefits and interests of the Member under the Policy will stand extinguished.

   URPV or Surrender Value for each benefit is as follows:

   - Single Pay:

   URPV = 60% x Single Premium x Unexpired coverage term (in complete months)/ Original coverage term (in months)

   - Regular Pay:

   No URPV is payable.

   The bases for computing the URPV will be reviewed from time to time and any change in the factors applicable to existing business will be as per permissible regulatory provisions set out by IRDAI and will be disclosed to policyholders
7. Claims:

   For Death Benefit, ATPD Benefit, ACI Benefit and TI Benefit, the Insurer will make payment to the extent of outstanding loan amount in favour of the Master Policyholder and the residual benefit amount, if any, shall be paid to the member/beneficiary. For all other benefits, the claim amount payable on the happening of the contingent event covered under this policy, shall be paid to the Master Policyholder in line with the IRDAI framework and to the extent of outstanding loan amount. The payment of benefits to the Master Policyholder to the extent of outstanding loan amount shall be done by the Company provided a valid assignment has been made by the Member in favor of the Master Policyholder. Any residual benefit shall be paid to the beneficiary. In the absence of a valid assignment, the claim payment will be made to the beneficiary.

   The Master Policyholder will raise claims to avail Benefits with the following documents:

- Duly filled and signed Claimant Statement FormRecent photograph of the claimant
- Original Certificate of Insurance

- Certificate from the Master Policyholder confirming the status of the loan, for which cover is taken, if applicable.Death certificate of member issued by the local authority in case of death claim.
- Signed copy of photo identity proof of the claimant

  Current Address proof of the claimant (Any one of the following: Aadhar Card, Valid Passport or Driver's License, Voters ID are considered as proofs).
- Copy of cancelled cheque / bank statement / passbook of the bank account of the claimant where payment needs to be transferred
- In case of natural death/ death due to illness - cause of death and Medical records (i.e. Admission notes, Discharge / Death summary, test reports, etc.) if any is required.
- In case of accidental death - FIR, Panchnama, Inquest report, Post mortem report and Driving licence is required.
- All reports, including but not limited to all medical reports, case histories, investigation reports, treatment papers, discharge summaries. In case of Terminal illness - Definition Fulfilment documents are required. Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the claim.

All claims payments will be made in Indian currency in accordance with the prevailing exchange control regulations and other relevant laws and regulations in India.

8. Conditions, Definitions and Exclusions:

In order to understand the Accelerated Terminal Illness Benefit, it is important that you understand the following terminologies:

A member shall be regarded as Terminally ill only if that member is diagnosed as suffering from a condition which, in the opinion of two independent medical practitioners specializing in the treatment of such illness, is highly likely to lead to death within 6 months. The Terminal Illness must be diagnosed and confirmed by independent medical practitioners registered with the Indian Medical Association and approved by the Company. The Company reserves the right for independent assessment.

The definition of medical practitioner is as defined below:

“A Medical Practitioner is 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. The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage nor share the same residence as the Member.”

In order to understand the ATPD Benefit, it is important that you understand the following terminologies:

ATPD Benefit will be payable/ applicable if the Member has become totally and irreversibly disabled as a result of accident. It includes:

1. The total and permanent loss of use of both hands, or both feet, or both eyes, or a combination of any two, will also result in the Member being regarded as totally and permanently disabled, or,
2. To be regarded as totally and permanently disabled, the Member must be totally incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit, or,
3. To be regarded as totally and permanently disabled, the Member must be unable to perform (whether aided or unaided) at least 3 of the following 6 “Activities of Daily Work”

a) Mobility: The ability to walk a distance of 200 meters on flat ground.

b) Bending: The ability to bend or kneel to touch the floor and straighten up again and the ability to get into a standard saloon car, and out again.

c) Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.

d) Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.

e) Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

f) Blindness – permanent and irreversible - Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids,vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

4. The disability should have lasted for at least 180 days without interruption and must be deemed permanent by a Company empanelled medical practitioner.

5. TPD due to accident should not be caused by the following:

a) Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Member is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or

b) Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or

c) The Member with criminal intent, committing any breach of law; or

d) Due to war, whether declared or not or civil commotion; or

e) Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

6. TPD due to accident wherein an accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

7. The accident shall result in bodily injury or injuries to the Member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the TPD of the Member. In the event ofTPD of the Member after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit. The benefit is payable even if the ATPD occurs beyond the Benefit Coverage Term but within 180 days from the date of Accident, provided the Accident occurs within the Benefit Coverage Term, and the disability should have lasted for at least 180 days without interruption and must be deemed permanent by a Company empanelled medical practitioner

8. The member's cover must be in-force at the time of accident.

9. The Company shall not be liable to pay this benefit in case the accident that resulted in TPD of the Member occurs on or after the Date of Termination of the Benefitcover.

In order to understand the Accidental Death Benefit, it is important that you understand the following terminologies:

1. Death due to accident should not be caused by the following:

a) Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Member is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or

b) Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or

c) The Member with criminal intent, committing any breach of law; or

d) Due to war, whether declared or not, or civil commotion; or

e) Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

2. Death caused due to accident wherein an accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

3. The accident shall result in bodily injury or injuries to the Member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the death of the Member. In the event of the death of the Member after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit. The benefit is payable if the Accidental Death occurs beyond the Benefit Coverage Term but within 180 days from the date of Accident, provided the Accident occurs within the Benefit Coverage Term.

4. The member's cover must be in-force at the time of accident.

5. The Company shall not be liable to pay this benefit in case accident that resulted in accidental death of the Member occurs on or after the date of termination of the Benefit cover.

6. Exclusions for AD Benefit will only apply to AD Benefit and death benefit will be paid on death due to accident.

In order to understand the Hospitalisation Benefit, it is important that you understand the following terminologies:

Hospitalization: Hospitalization means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Medically Necessary: Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii) must have been prescribed by a medical practitioner;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

A hospital means any institution established for in – patient care and day care treatment of sickness and/or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

Surgery or Surgical Procedure means manual and/or operative procedure(s) required for treatment of an illness or injury,

correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care center by a medical practitioner.

In order to understand the Cancer Protect Benefit it is important that you understand the following terminologies:

1. Cancer of Specified Severity: A malignant tumor characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded

i. All tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3;

ii. Any non-melanoma skin cancer unless there is evidence of metastases or 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 lymphocyctic leukaemia less than RAI stage 3;

vii. Non-invasive papillary cancer of the bladder histologically described as T1N0M0 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. Carcinoma-in-Situ of any organ (except skin)

i. Carcinoma in situ (CIS) means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane.

ii. The diagnosis of the Carcinoma in situ must always be supported by a histopathological report.

iii. Furthermore, the diagnosis of Carcinoma in situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.

iv. In the case of the cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy or colposcopy with the cervical biopsy report clearly indicating presence of CIS.

v. Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, and CIN II (where there is severe dysplasia without carcinoma in situ) does not meet the required definition and are specifically excluded.

vi. All CIS of the skin are specifically excluded.

vii. This coverage is available to the first occurrence of CIS of same organ. Multiple claims from same organ will not be admissible.

3. Early stage Cancers

Early Stage Cancer shall mean first ever diagnosis during the lifetime of the member and within the CP Benefit coverage term, with the presence of one of the following malignant conditions:

i. Any malignant tumor of the thyroid, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue, which is histologically classified as T1N0M0 according to the

TNM classification system, or another equivalent classification

ii. Prostate tumor should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent classification.

iii. Chronic lymphocytic leukaemia classified as RAI Stage I or II;

iv. Basal cell and Squamous skin cancer that has spread to distant organs beyond the skin,

v. Hodgkin's lymphoma Stage I by the Cotswold's classification staging system.

vi. All tumors of the urinary bladder histologically classified as T1N0M0 (TNM Classification)

The Diagnosis must be based on histopathological features and confirmed by a Pathologist.

Pre-malignant lesions and conditions, unless listed above, are excluded.

For the multiple minor conditions claims to be admissible for an individual member, there needs to be a period of at least 6 months between the date of diagnosis of a minor condition claim and date of diagnosis of subsequent minor condition claim. However this requirement of 6 months is not applicable in case of diagnosis of a major condition claim following a minor condition claim.

Multiple minor condition claims from the same organ will not be admissible. For the purpose of claim under Cancer Protect Benefit, each group of the following sites are treated as one organ.

i. Basal cell and squamous skin cancer

ii. Corpus uteri, vagina, fallopian tubes, cervix uteri, ovary

iii. Colon and rectum

iv. Penis, testis

v. Stomach and esophagus

In order to understand the ACI Benefit and CI Benefit it is important that you understand the following terminologies:

1. Cancer of Specified Severity: As defined in the section "In order to understand the Cancer Protect Benefit it is important that you understand the following terminologies" above.

2. First Heart Attack of Specified Severity:

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

a) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

b) New characteristic electrocardiogram changes

c) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

a) Other acute Coronary Syndromes

b) Any type of angina pectoris.

c) 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 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.

The following are excluded:

a) Angioplasty and/or any other intra-arterial procedures

4. Stroke resulting in permanent symptoms

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

The following are excluded:

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

5. 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.

6. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

1. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

2. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

3. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

7. Loss of Independent Existence

The insured person is physically incapable of performing 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, signifying a permanent and irreversible 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 Who is a specialist.

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

Activities of Daily Living:

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. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

8. 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. the 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.

9. 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.

10. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.

The disease must result in a permanent inability to perform three or more Activities of daily living with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days.

The following conditions are however not covered:

a. neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease

b. alcohol related brain damage; and

c. any other type of irreversible organic disorder/dementia not associated with Alzheimer's Disease

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.

### 11. 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.

### 12. Deafness

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

### 13.Apallic Syndrome

Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

The definition of approved hospital will be in line with Guidelines on Standardization in Health Insurance and as defined below:

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

a) has qualified nursing staff under its employment round the clock;

b) has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

c) has qualified medical practitioner (s) in charge round the clock;

d) has a fully equipped operation theatre of its own where surgical procedures are carried out

e) Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

### 14. Benign Brain Tumour

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:

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.

### 15. Brain Surgery

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

### 16. 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:

a) no response to external stimuli continuously for at least 96 hours;

b) life support measures are necessary to sustain life; and

c) 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 directly from alcohol or drug abuse is excluded.

### 17. 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:

i. Spinal cord injury;

### 18. 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.

### 19. Major 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.

### 20. Motor Neurone Disease with Permanent Symptoms

Motor neurone 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.

### 21. Surgery of Aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

### 22. Chronic Lung Disease

End stage lung disease causing chronic respiratory failure, where all of the following criteria are met:

1. Permanent oxygen therapy is required;
2. A consistent forced expiratory volume (FEV1) test value of less than one (1) liter (during the first second of a forced exhalation);
3. Baseline arterial blood gas analysis showing arterial partial oxygen pressure at a level of fifty-five (55) mmHg or less; and
4. Dyspnea at rest.

The diagnosis must be confirmed by a respiratory physician.

### 23. Chronic Liver Disease

End Stage liver failure as evidenced by all of the following:

(a) Permanent jaundice;

(b) Ascites; and

(c) Hepatic encephalopathy.

(d) Esophageal or Gastric Varices and Portal Hypertension

Irrespective of the above, liver failure due or related to alcohol or drug abuse is excluded.

### 24. Parkinson's Disease

Unequivocal Diagnosis of Parkinson's Disease by a Registered Medical Practitioner who is a neurologist where the condition:

(a) cannot be controlled with medication;

(b) shows signs of progressive impairment; and

(c) Activities of Daily Living assessment confirms the inability of the Insured to perform at least three (3) of the Activities of Daily Living as defined in the Policy, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

Drug-induced or toxic causes of Parkinson's disease are excluded.

### 25. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class III or Class IV, or its equivalent, based on the following classification criteria:

Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure.

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

### 26. 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.

### 27. 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:

1. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
2. 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.

28. 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.

29. Systematic lupus Eryth. with Renal Involvement

Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

Abbreviated ISN/RPS classification of lupus nephritis (2003):

Class I - Minimal mesangial lupus nephritis

Class II - Mesangial proliferative lupus nephritis

Class III - Focal lupus nephritis

Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis

Class V - Membranous lupus nephritis

Class VI - Advanced sclerosing lupus nephritis the final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

30. Aplastic Anaemia

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2)
of the following:

(a) Blood product transfusion;

(b) Marrow stimulating agents;

(c) Immunosuppressive agents; or

(d) Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

31. Muscular Dystrophy

Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:

(a) Family history of other affected individuals;

(b) Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;

(c) Characteristic electromyogram; or

(d) Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Member to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living' as defined, for a continuous period of at least six (6) months.

32. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

1. Poliovirus is identified as the cause and is proved by Stool Analysis,

2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

33. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

1. The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;

2. Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and

3. The Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

For the purpose of ACI Benefit and CI Benefit following exclusions shall apply:

No CI or ACI Benefit will be payable/ applicable in respect of any listed condition arising directly or indirectly from, though, in consequence of or aggravated by any of the following:

1. Pre-Existing Conditions or conditions connected to a Pre-Existing Condition will be excluded. 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 the policy issued by the Company or its reinstatement
    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 the policy or its reinstatement
2. Existence of any Sexually Transmitted Disease (STD) and its related complications
3. Self-inflicted injury, suicide, insanity and deliberate participation of the Member in an illegal or criminal act with criminal intent.
4. Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner.
5. War – whether declared or not, civil commotion, invasion, hostilities (whether war is declared or not), rebellion, revolution, military or usurped power or wilful participation in acts of violence.
6. Aviation other than as a fare paying passenger or crew in a commercial licensed aircraft.
7. Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate exposure to exceptional danger.
8. Radioactive contamination due to nuclear accident.
9. Any treatment of a donor for the replacement of an organ.

10. Any illness due to a congenital defect or disease which has manifested or was diagnosed before the inception of the policy.

For the purpose of Cancer Protect Benefit the following exclusions shall apply:

No Cancer Protect Benefit will be payable in respect of any listed condition arising directly or indirectly from, though, in consequence of or aggravated by any of the following:

1. Pre-Existing Diseases are not covered. Pre-Existing Disease means any Cancer condition (primary or metastatic); pre-cancerous condition or related condition(s):
    - that is/are diagnosed by a physician not more than 36 months prior to the date of commencement the policy issued by the Company or its reinstatemen
    - 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 the policy or its reinstatement
2. Diagnosis or evidence of any covered condition first occurred / detected during the waiting period.
3. Existence of any Sexually transmitted diseases and its related complications.
4. Self-inflicted injuries, suicide, insanity, and deliberate participation of the Member in an illegal or criminal act with criminal intent.
5. Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner.
6. Radioactive contamination due to nuclear accident.
7. Any illness due to a congenital defect or disease which has manifested or was diagnosed before the inception of the policy.

For the purpose of Hospitalisation Benefit following exclusions shall apply:

No Hospitalisation Benefit shall be payable with respect to any period of hospital confinement/ICU stay unless the entire confinement/ICU stay and all the hospital services rendered and performed there had been recommended by a Medical Practitioner and are in accordance with the diagnosis and treatment of the condition for which the hospitalisation was required.

No Hospitalisation Benefit shall be payable under the policy if a claim or event suffered by the Member is directly or indirectly caused by or exacerbated as a result of any of the following:

1. Pre-Existing Conditions or conditions connected to a Pre-Existing Condition. Pre-Existing Disease means any condition, ailment, injury or disease:
    - that is/are diagnosed by a physician not more than 36 months prior to the date of commencement the policy issued by the Company or its reinstatement
    - 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 the policy or its reinstatement
2. Hospitalization/treatment within the waiting period except for hospitalization/treatment due to accidental injuries.
3. Routine Eye tests, refractive errors of eyes, refractive surgery, ear examination
4. Any treatment due to any congenital defect or disease which has manifested or was diagnosed before the inception of the policy.
5. Any dental surgery, extraction of impacted tooth/teeth, orthodontics or orthographic surgery, or Temporo-Mandibular Joint Disorder except as necessitated by an accidental injury.
6. Treatment arising from or traceable to pregnancy which shall include childbirth, infertility, miscarriage, abortion,

sterilization and contraception including complications relating thereto / treatment to assist reproduction including IVF treatment.

7. Hospitalisation primarily for investigatory purpose, diagnosis, X-ray examination, general physical or routine medical examination; preventive treatments or medicines, treatments/examinations specifically for weight management regardless whether the same is caused (directly or indirectly) by a medical condition, or any treatment or study related to sleep disorder or sleep apnoea syndrome.
8. Convalescence, general debility, custodial, sanitaria, rehabilitation centre, nature care clinics, or respite care; or long term nursing care.
9. Stem cell implantation or surgery, harvesting/storage/any other treatment using stem cells, or any type of hormone replacement therapy.
10. Any form of plastic surgery except to the extent that such surgery is necessary for the treatment of cancer, burns or accidental injuries happened during the contract period ; Cosmetic or aesthetic treatments of any description, treatment or surgery for change of life/gender
11. Treatment of xanthelasma, syringoma, acne and alopecia.
12. Circumcision unless necessary for treatment of a disease or necessitated due to an accident.
13. Hospitalisation and treatment of any kind not actually performed, necessary or reasonable, or any kind of elective surgery or treatment which is not medically necessary
14. Any treatment for any Sexually Transmitted Disease (STD) and its related complications ; treatment of any sexual problem including impotence (irrespective of the cause) and sex changes/gender reassignments or erectile dysfunction.
15. Treatment for or arising from any injury that is intentionally self-inflicted, including attempted suicide.
16. Hospitalisation due to use or abuse of any substance, drug (not prescribed by any registered Medical Practitioner) or alcohol or treatment for de-addiction / smoking cessation programs or taking of poison.
17. War or hostilities (whether declared or not), civil commotion, invasion, rebellion, revolution, military or usurped power or nuclear weapons/materials, chemical /biological weapons or radiation of any kind or wilful participation in acts of violence or in illegal or criminal act.
18. Any treatment related to donor screening or treatment including surgery to remove organs of a donor for the replacement of an organ (where Member is donor).
19. Ayurvedic, Homeopathy, Unani, Yoga and naturopathy, Siddha, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, Rolfing, massage therapy, aroma therapy or any other treatments other than Allopathy / western medicines.
20. Any treatment received outside India
21. The following diseases/surgeries & any complications arising out of them will not be covered during the first 2 years from policy issuance date or revival date in case the revival is after 60 days from the date of first unpaid premium.

a) Deviated Nasal Septum/ Nasal & Paranasal Sinus Disorders

b) Diseases of Tonsils / Adenoids

c) Surgery of Thyroid Gland excluding Malignancy

d) All types of Hernia

e) Hydrocele /Varicocele / Spermatocele

f) Piles / Fissure / Fistula-in-Ano / Rectal Prolapse

g) Benign Prostatic Hypertrophy

h) Menstrual Irregularities, Dysfunctional Uterine Bleeding

i) Hysterectomy with or without Bilateral Salpingo-oophorectomy excluding Malignancy

j) Uterine Fibroid

k) Calculus Diseases

l) Prolapsed Intervertebral Disc

m) Retinopathy / Retinal Detachment

n) Peripheral Vascular Disease due to Diabetes / Diabetic Foot

o) Renal Failure due to Diabetes

p) Osteoporosis / Pathological Fracture

q) Cataract

r) Joint Replacements except due to an accident (one Knee or one Hip Replacement in a Policy Year)

s) Congenital Internal Disease or Anomalies or Disorder

8.Waiting period

No waiting period / pre-existing condition will apply for death benefit, TI Benefit, ADB or ATPD benefit.

180 days Waiting Period for CI Benefit, ACI Benefit and Cancer Protect

i. The benefit shall not apply or be payable in respect of any listed conditions for which the symptoms have occurred or for which care, treatment or advice was recommended by or received from a Medical Practitioner, or which first manifested itself or which was contracted during the first 180 days for Accelerated Critical Illness Benefit, Additional Critical Illness Benefit and Cancer Protect Benefit from the date of commencement or revival of cover of the member, where the cover has lapsed for more than 60 days. In the event of occurrence of any of the scenarios mentioned above, the Company will refund the premiums for that benefit of the member and member's cover for ACI benefit, CI benefit and CP Benefit will terminate with immediate effect.

ii. No waiting period applies where the condition manifests due to accident.

iii. Applicability of the waiting period for existing Members of a group already covered in previous Group Policy issued by any insurer for similar benefits, will be subject to Board Approved Underwriting Guidelines, provided there is no unbroken period between such previous Group Policy and this Policy. Waiting period applies for new Members of the group.

45 days Waiting Period for Hospitalisation Benefit

i. The benefit shall not apply or be payable in respect of hospitalisation during the first 45 days from the date of commencement of cover or date of revival of cover of the Member, where the cover has lapsed for more than 60 days.

ii. No waiting period applies where the condition manifests due to accident.

10. Survival Period for Additional CI Benefit

A survival period is a defined as a period of 14 days commencing from the date of diagnosis of the covered Critical Illness under the Additional CI benefit that the Member has to survive to be eligible for receiving the applicable benefit amount.

11. Nomination Requirements: Nomination in the Master Policy will be governed by Section 39 of the Insurance Act,1938, as amended from time to time. For more details on this section, please refer to our website.
12. Assignment Requirements: Assignment in the Master Policy will be governed by Section 38 of the Insurance Act,1938, as amended from time to time. For more details on this section, please refer to our website.
13. The Company does not express itself upon the validity of or accepts any responsibility for the assignment or nomination in recording the assignment or registering the nomination or change in nomination.
14. Section 41: In accordance to the 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.
    Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.
15. Fraud and Misstatement: Treatment will be as per Section 45 of the Insurance Act, 1938 as amended from time to time.
16. 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.
    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 in the proposal or other document on the basis of which the policy was issued or revived or rider issued: 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 to repudiate the policy of life insurance 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.

16. Tax Benefits: Tax benefits may be available as per the prevailing Tax laws. We recommend that you seek professional advice for applicability of tax benefit on premium paid and benefits received.

17. Recovery: We reserve the right to recover the amount from the Master Policyholder or the Member or any other person, if it is found that the Benefits are erroneously paid due to the fault of the Master Policyholder. In case we are not in a position to recover such amounts from the Member or any other person, the Master Policyholder will be liable to pay the said amount to the Company within 15 days from the date of its demand. However, the Master Policyholder will not be liable or responsible for any wrong payments made by the Company without any fault on the part of the Master Policyholder.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 1800-2660

- 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 .

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:
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.

This is subject to change from time to time.
Refer https://www.iciciprulife.com/services/grievance-redressal.html for more details

## About ICICI Prudential Life Insurance

ICICI Prudential Life Insurance Company Limited is a joint venture between ICICI Bank Limited and Prudential Corporation Holdings Limited, apart of the Prudential group. ICICI Prudential began its operations in Fiscal 2001after receiving approval from Insurance RegulatoryDevelopment 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 any where in India, please dial 1800 2660
Do not prefix this number with “+” or “91” or “00”

Call Centre Timings: 10:00 A.M. to 7:00 P.M.
Monday to Saturday, except National Holidays
To know more, please visit www.iciciprulife.com

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ICICI Prudential Life Insurance Company Limited. IRDAI Regn. No. 105. CIN: L66010MH2000PLC127837.

Registered Office: ICICI Prudential Life Insurance Company Limited, ICICI PruLife Towers, 1089, Appasaheb Marathe Marg, Prabhadevi, Mumbai 400 025. For more details on the risk factors, term and conditions please read the sales brochure carefully before concluding the sale. The product brochure is indicative of terms & conditions, warranties & exceptions contained in the insurance policy. The information contained here must be read in conjunction with the policy document of ICICI Pru Super Protect Life product. In the event of conflict, if any between the terms & conditions contained in this brochure and those contained in the policy documents, the terms & conditions contained in the policy document of ICICI Pru Super Protect Life shall prevail. ICICI Pru Super Protect Life UIN:105N180V02. Advt No.:L/II/1564/2024-25.