TATA AIG MediCare PLUS

TATA AIG INSURANCE WITH YOU ALWAYS

Prospectus

1. Suitability:

a. This policy covers persons in the age group of 5 years onwards (Dependent children between 91 days and 5 years can be insured only when both parents are getting insured). The minimum entry age for adults is 18 years and maximum entry age is 65 years.

b. There is no maximum cover ceasing age under this policy.

c. The policy will be issued for a period 1/2/3 years.

d. This policy can be issued to an individual and/or family.

e. The family includes spouse and economically dependent children and dependent parents.

f. The policy offers coverage on family floater basis.

g. Maximum 7 members of a family are covered in one Individual Plan Policy (Self, spouse, 3 dependent children and 2 dependent parents).

h. Maximum 7 members are covered in one Family Floater Plan policy (Self, spouse, 3 dependent children (Up to the age of 25 Years) and 2 dependent parents. In case of family floater, where age of the dependent child is crossing 25 years, the child can be covered under a separate policy with eligible continuity benefit.

2. Key Benefits:

a. **Range of benefits:** Indemnity based health insurance cover with range of benefits without any sub-limit unless otherwise mentioned.

b. **Network of hospitals:** We are equipped to offer you health care with our network of 4000+ hospitals across India.

c. **Lifelong renewal:** We offer you a lifelong renewal for your policy provided premium is paid without any break. Your premiums will be basis the age, sum insured, deductible and plan. Your renewal premium will be basis your age on renewal and there will be no extra loadings based on your individual claim.

d. **Global Cover (Optional Cover):** We will cover Medical Expenses of the Insured Person incurred outside India, upto the sum insured in excess of deductible provided that the diagnosis was made in India and the insured travels abroad for treatment.

e. **Consumables Benefit:** We will pay for expenses incurred, for specified consumables listed in 'Annexure I – List I as Optional Items (Consumables Benefit)' Items which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I-Optional items are available on our website (www.tataaig.com).

f. **Cumulative bonus/No Claim Discount:** You have the option to choose between Cumulative Bonus and No Claim Discount. If you choose Cumulative Bonus, sum insured will increase by 50% for every claim free policy year subject to maximum of 100% of sum insured. In case a claim is made during the policy year, the cumulative bonus would reduce by 50% in the following year. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year. If you Choose No Claim Discount, We will allow 1% discount on renewal premium for every claim free Policy Year, provided that the Policy is renewed with Us without break.

g. **Tax Benefit:** The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

h. **Aggregate Deductible:** All claims under the policy benefits shall be payable only if the aggregate of covered medical expenses, in respect to hospitalizations in a policy year is in excess of deductible specified in policy schedule. In case of family floater policy, the deductible shall be per policy per year and in case of individual policy, the deductible shall be per insured person per year

3. Discounts on premium:

a. 10% long term discount on premium in case insured opts policy term of 3 years

b. 5% long term discount on premium in case insured opts policy term of 2 years

c. Family floater discount on premium:

- 2 members -20%
- 3 members -28%
- > 3 members-32%

4. Salient Features:

1. **In-patient Treatment:** We will cover expenses for hospitalization due to disease/illness/Injury during the policy period that requires an Insured Person's admission in a hospital as an inpatient. Medical expenses directly related to the hospitalization would be payable

2. **Pre-Hospitalisation:** We will cover for expenses for Pre-Hospitalization consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital.

3. **Post-Hospitalisation:** We will cover for expenses for Post-Hospitalization consultations, investigations and medicines incurred upto 90 days after discharge from the hospital.

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4. **Day Care Procedures:** We will cover expenses for listed Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. The list of such day care procedures covered is available on our website (www.tataaig.com)
5. **Organ Donor:** We will cover for Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient.
6. **Domiciliary Treatment:** The Medical Expenses incurred by an Insured Person for availing medical treatment at his home which would otherwise have required Hospitalisation. We will also cover pre and post hospitalization expenses in case of domiciliary hospitalization.
7. **In-patient Dental Treatment**- We will cover for medical expenses incurred towards hospitalization for dental treatment under anesthesia necessitated due to an accident/injury/illness.
8. **AYUSH benefit** - Medical Expenses incurred for In-patient/Day care treatment taken in an AYUSH hospital/AYUSH day care centre, including pre and post hospitalization expenses.
9. **Ambulance cover**– We will cover for expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency or from one hospital to another hospital for better medical facilities and treatment, subject to Rs. 3000 per Hospitalization.
10. **Health Check-up**- Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured subject to a maximum of Rs. 10,000/- per policy once in block of every two continuous claim free policy years with us.
11. **Second Opinion**- We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with the listed Illnesses in policy during the Policy Period.
12. **Consumables Benefit**- We will pay for expenses incurred, for specified consumables listed in Annexure I – List I as Optional Items (Consumables Benefit) which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I – List I as Optional Items (Consumables Benefit) are available on our website (www.tataaig.com).
13. **Global Cover (Optional Cover):** We will cover Medical Expenses of the Insured Person incurred outside India, upto the sum insured in excess of provided that the diagnosis was made in India and the insured travels abroad for treatment. The Medical Expenses payable shall be limited to Inpatient and daycare Hospitalization only on reimbursement basis.

5. Sum Insured options: (in Rs.)

- 3 Lacs
- 5 Lacs
- 10 Lacs
- 15 Lacs
- 20 Lacs
- 25 Lacs
- 50 Lacs
- 1 Crore

6. Deductible options: (in Rs.)

- 2 Lacs
- 3 Lacs
- 5 Lacs
- 10 Lacs
- 15 Lacs
- 20 Lacs

7. Renewal Incentives:

a. **Cumulative Bonus** - We will offer Cumulative Bonus of 50% of the Sum Insured for every claim free year accumulating up to 100% of sum insured. In the event of a claim, the cumulative bonus shall be reduced by 50% at the time of renewal. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year

b. **Health Check-up**- Expenses for a Preventive Health Check-up upto 1% of previous year policy sum insured subject to a maximum of Rs. 10,000/- per policy once in block of every two continuous claim free policy years with us.

8. Portability:

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy, as applicable.

For Detailed Guidelines on **Portability**, kindly refer Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and their subsequent amendments thereof.

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9. Free Look Period:

The insured person shall be provided a free look period of thirty days beginning from the date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid subject to deduction of proportionate risk premium for the period of cover and the expenses, if any, incurred by Us on medical examination of the proposer and stamp duty charges.

10. Waiting Period:

i. 30 days Waiting Period (Code- Excl 03):

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

ii. Specified Disease/Procedure Waiting Period (Code- Excl 02):

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

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

c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of Specific Diseases/procedures as furnished below:

I. Tumors, Cysts, polyps including breast lumps (benign)
II. Polycystic ovarian disease
III. Fibromyoma
IV. Adenomyosis
V. Endometriosis
VI. Prolapsed Uterus
VII. Non-infective arthritis
VIII. Gout and Rheumatism
IX. Osteoporosis
X. Ligament, Tendon or Meniscal tear (due to injury or otherwise)
XI. Prolapsed Inter Vertebral Disc (due to injury or otherwise)
XII. Cholelithiasis
XIII. Pancreatitis
XIV. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
XV. Ulcer & erosion of stomach & duodenum
XVI. Gastro Esophageal Reflux Disorder (GERD)
XVII. Liver Cirrhosis
XVIII. Perineal Abscesses
XIX. Perianal / Anal Abscesses
XX. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.
XXI. Benign Hyperplasia of prostate
XXII. Varicocele
XXIII. Cataract
XXIV. Retinal detachment

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XXV. Glaucoma

XXVI. Congenital Internal Diseases

The following treatments are covered after a waiting period of two years irrespective of the illness for which it is done:

XXVII. Adenoidectomy

XXVIII. Mastoidectomy

XXIX. Tonsillectomy

XXX. Tympanoplasty

XXXI. Surgery for nasal septum deviation

XXXII. Nasal concha resection

XXXIII. Surgery for Turbinate hypertrophy

XXXIV. Hysterectomy

XXXV. Joint replacement surgeries Eg: Knee replacement, Hip replacement

XXXVI. Cholecystectomy

XXXVII. Hernioplasty or Herniorraphy

XXXVIII. Surgery/procedure for Benign prostate enlargement

XXXIX. Surgery for Hydrocele/ Rectocele

XL. Surgery of varicose veins and varicose ulcers

iii. Pre-existing Diseases Waiting Period(Code- Excl 01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

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

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

d. Coverage under the policy after the expiry of 36 months for any pre -existing disease is subject to the same being declared at the time of application and accepted by us

11. General Exclusions:

We will neither be liable nor make any payment for any claim in respect of any Insured Person which is caused by, arising from or in any way attributable to any of the following exclusions, unless expressly stated to the contrary in this Policy.

1. Medical Exclusions

i. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Code- Excl 12).

ii. Alcoholic pancreatitis

iii. Obesity/ Weight Control(Code- Excl 06)

Expenses related to surgical treatment of obesity that does not fulfil the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

i. greater than or equal to 40 or

ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity-related cardiomyopathy

2. Coronary heart disease

3. Severe Sleep Apnea

4. Uncontrolled Type2 Diabetes

iv. Congenital External Diseases, defects or anomalies

v. Stem cell therapy; however hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under benefit B1 or B4 of this policy

vi. Growth hormone therapy;

vii. Sleep-apnoea

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viii. Admission primarily for administration of Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid

ix. Investigation and evaluation (Code- Excl 04):

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

x. Venereal disease, sexually transmitted disease or illness;

xi. Sterility and Infertility (Code- Excl 17):

Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

xii. Refractive error (Code - Excl 15):

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

xiii. Change-of-Gender treatments: (Code- Excl 07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

xiv. Cosmetic or Plastic Surgery (Code- Excl 08):

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

xv. Rest cure, rehabilitation and respite care (Code- Excl 05):

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

xvi. All preventive care, vaccination including inoculation and immunisations ;

xvii. Unproven treatments (Code - Excl 16):

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

xviii. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization & any dental treatment other than specified in 'Inpatient Treatment – Dental'

xix. Maternity (Code - Excl 18) :

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

xx. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Code -Excl13)

xxi. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. (Code -Excl14)

xxii. Any existing disease specifically mentioned as Permanent exclusion in the Policy Schedule

2. Non-Medical Exclusions

i. War or any act of war, invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.

ii. Any Insured Person's participation or involvement in naval, military or air force operation.

iii. Hazardous or Adventure Sports (Code- Excl 09):

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

iv. Breach of law (Code- Excl 10):

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

v. Intentional self-injury or attempted suicide while sane or insane.

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vi. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service

vii. Treatment rendered by a Medical Practitioner which is outside his discipline

viii. Doctor's fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family.

ix. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy

x. Any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

xi. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.

xii. Crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively and explicitly stated and covered in the policy).

xiii. Any illness diagnosed or injury sustained or where there is change in health status of the member after date of proposal and before commencement of policy and the same is not communicated and accepted by us.

xiv. Excluded Providers: (Code-Excl 11)

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

xv. Any claim within the deductible limit as specified in the policy schedule.

12. Claim Procedure:

The final decision on all claims is taken by TATA AIG General Insurance Company Limited.

a. Intimation & Assistance:

Please contact our designated TPA/Us atleast 48 hours prior to an event which might give rise to a claim. For any emergency situations, kindly contact us within 24 hours of the event.

b. Claim Related Information:

For any claim related query, intimation of claim and submission of claim related documents, You can contact us through:

Claim Servicing Details	
Name	TAGIC Health Claims
Claims Administrator Address	TATA AIG General Insurance Company Limited, 5th and 6th Floor, Imperial Towers, H.No 7-1-6-617/A, GHMC No - 615,616, Ameerpet, Hyderabad – 500016, Telangana, Phone-040-66864900
Email	healthclaimsupport@tataaig.com
Toll Free	1800 266 7780 or 1800 229 966 (For Senior Citizens)
Website	www.tataaig.com

c. Procedure for reimbursement claims:

- Our TPA/We must be informed within 7 days of completion of such treatment, consultation or procedure and send all the claim related documents to our TPA/Us within 15 days of the occurrence of the Incident.
- On receipt of the complete set of claim documents, We will send the payment for the admissible amount, along with a settlement statement within 30 days.

d. Procedure for availing cashless facility:

- For any emergency Hospitalisation, our TPA/We must be informed within 24 hours after hospitalization and in case of planned hospitalization, cashless authorization to be sought atleast 48 hours prior to the hospitalization.
- On receipt of complete claim documents, TPA/We shall communicate our decision to the hospital.

e. Claim settlement (provision for Penal Interest) Procedure:

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

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

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to be reviewed

13. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of established fraud, non-disclosure and/or misrepresentation by the Insured person.

I. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iii. Single premium payment mode Policy can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period after the end of the policy period. If not renewed under the Grace Period, the Policy shall terminate at the end of the Grace period.

iv. The grace period for payment of the premium during the Policy Period, for instalment premium shall be fifteen days where premium payment mode is monthly and thirty days in all other cases (Annually/Half-Yearly/Quarterly/Limited Premium Paying Term).

v. Coverage during such grace period (in case of instalment premium):

   a. Within the policy period - coverage will be available from the due date of instalment premium till the date of receipt of premium by Company within the grace period.

   b. At the end of the policy period - the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period after the end of the policy period.

vi. The insured person will get the accrued continuity benefit to the extent of Sum Insured, No Claim Bonus, Specified Waiting Periods, waiting periods for pre-existing diseases, Moratorium period, as applicable, in the event of payment of premium within the stipulated grace Period.

vii. No loading shall apply on renewals based on individual claims experience

14. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

15. Sum Insured Enhancement

- Sum Insured can be enhanced only at the time of renewal subject to underwriting guidelines of the company.
- In case of increase in the Sum Insured waiting period and exclusions will apply afresh in relation to the amount by which the Sum Insured has been enhanced. However, the acceptance of Sum Insured enhancement request & quantum of increase shall be as per Our underwriting guidelines. For claims arising in respect of accident, injury or illness contracted or suffered during a preceding Policy period, liability of the Company shall be only to the extent of the Sum Insured under the Policy in force at the time when it was contracted or suffered.

16. Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines . If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy, as applicable.

For Detailed Guidelines on Migration, kindly refer Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and subsequent amendments thereof.

17. Withdrawal of the policy:

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

18. Moratorium Period

After completion of five continuous years of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This continuous period of five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of five continuous years would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

19. Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

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20. Requirement:

- Completed proposal form,
- Supporting Medical papers (wherever applicable),
- Previous policy copies, IRDAI portability form (as applicable)

21. Pre-policy medical calling (Tele-MER):

Pre-Policy medical calling would be done based upon the age and/or total of Sum Insured and Deductible. The Tele MER(Tele Medical Examination Report)expenses incurred per insured person will be payable by TATA AIG for all proposals. Based on the type of medical conditions disclosed to us at the time of Tele MER, we may call for additional medical tests, if required. In such cases, additional medical test expenses incurred per insured person will be payable by TATA AIG only on accepatance of proposal as per the grid below :

Policy Tenure(in years)	Additional Medical Test Expenses to be borne by TATA AIG
1	50%
2	100%
3	100%

Pre-policy Tele MER gird:

Age(in years)/ Sum Insured	Upto 50 lacs	> 50 Lacs
Upto age 45	No PPC	Tele MER
46- 65	Tele MER	Tele MER
	Tele MER	Tele MER
	Tele MER	Tele MER
	Tele MER	Tele MER

22. Premium Rates*:

a. The premium will be charged on the completed age of the Insured Person.

b. Premium rates are subject to change.

c. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.

d. For family floater, premium is calculated by adding the premium of respective individual members and applying family floater discount.

e. In case the insured person opts for Global Cover, additional 10% premium loading shall be applicable for each insured person.

f. Monthly instalment option would be allowed and following loadings shall be applicable:

Term of Policy	Loading%
1 year Policy	5%
2 year Policy	9%
3 year Policy	13%

If the insured person has opted for Payment of Premium on an installment basis i.e. Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

I. Grace Period of 15 days would be given to pay the installment premium due for the policy, during the policy period.

II. During such grace period, coverage shall be available from the due date of installment premium till the date of receipt of premium by Company.

III. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

IV. No interest will be charged If the installment premium is not paid on due date

V. In case of installment premium due not received within the grace period, the policy will get cancelled.

VI. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

VII. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

*Annexure enclosed

23. Loadings:

i. We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance).

ii. The maximum risk loading applicable for an individual shall not exceed 100% of premium per diagnosis / medical condition and an overall risk loading of over 150% of premium per person.

TATA AIG GENERAL INSURANCE COMPANY LIMITED

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G. K. Marg, Off Senapati Bapat Road, Lower Parel, Mumbai - 400 013.
24x7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens) | Email: customersupport@tataaig.com
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iii. The loading shall only be applied basis an outcome of Our medical underwriting.

iv. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

a. We will inform You about the applicable risk loading through a counter offer letter.

b. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.

c. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 10 days subject to deduction of the Pre-Policy Check up charges, as applicable.

v. Please note that We will issue Policy only after getting Your consent.

24. Cancellation:

The policyholder may cancel this **Policy** by giving 7 days written notice and in such an event, the Company shall refund proportionate premium for unexpired policy period. No refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit under this **Policy** has been availed by the **Insured Person**.

The Company may cancel the policy at any time on grounds of established fraud, misrepresentation and/or non-disclosure of material facts by the Policyholder/Insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud, misrepresentation and/or nondisclosure of material facts.

25. Redressal of Grievance:

At TATA AIG, we strive to provide the best service to our customers. If you're not satisfied and wish to lodge a complaint, please call our 24/7 toll-free number **022 6489 8282/1800 22 9966 (For Senior Citizens)** or **022-66939500** (toll charges apply), or email us at **customersupport@tataaig.com**. We will investigate and respond within the regulatory turnaround time (TAT).

Escalation Level 1

If you do not receive a response or are not satisfied with the resolution, please contact us at **manager.customersupport@tataaig.com**.

Escalation Level 2

If you still need assistance, reach out to the Head of Customer Services at **head.customerservices@tataaig.com**. We will provide our final response within the regulatory TAT.

If you're still not satisfied after this process, you may approach the Insurance Ombudsman of concerned jurisdiction. You can also lodge a grievance on the Bima Bharosa Grievance Redressal Portal: https://bimabharosa.irdai.gov.in. The name and address of the Insurance Ombudsman of competent jurisdiction is provided under Annexure A of this **Policy**.

26. Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

IRDAI REGULATION: This policy is subject to Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024

Note: Policy Term and Conditions & Premium rates are subject.

Disclaimer: This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of your insurance advisor if you require any further information or clarification.

"Insurance is the subject matter of the solicitation". For more details on benefits, exclusions, limitations, terms & conditions, please refer sales brochure/ policy wordings carefully, before concluding a sale."

Commencement of risk cover under the policy is subject to receipt of premium by TATA AIG General Insurance Company Limited.

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Benefit Illustration in respect of Policies offered on Individual and Family Floater basis

Age of the members insured (in years)	Coverage opted on individual basis covering each member of the family separately(at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy(Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured(only one sum insured is available for entire family)			
	Premium(`)	Sum Insured(`)*	Premium (`)	Discount if any	Premium after Discount(`)	Sum Insured(`)*	Premium or consolidated premium for all members of the family(`)	Floater discount if any	Premium after discount(`)	Sum Insured (`)*
42	1441	5,00,000	1441	0%	1441	5,00,000	1441	32%	980	5,00,000
37	1441	5,00,000	1441	0%	1441	5,00,000	1441		980	
19	1177	5,00,000	1177	0%	1177	5,00,000	1177		800	
15	1010	5,00,000	1010	0%	1010	5,00,000	1010		687	
	Total Premium for all members of the family is ` 5069 when each member is covered separately		Total Premium for all members of the family is ` 5069 when they are covered under a single policy				Total Premium when policy is opted on floater basis is ` 3447			
	Sum Insured available for each individual is ` 5,00,000		Sum Insured available for each family member is ` 5,00,000				Sum Insured of ` 5,00,000 is available for the entire family			

Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading.Also, the premium rates shall be exclusive of taxes applicable

*Sum Insured is with a Aggregate Deductible of 5,00,000

Benefit Name	Coverage Limit
In-patient Treatment	Upto sum insured
Pre-hospitalization expenses	Upto 60 days
Post-hospitalization expenses	Upto 90 days
Day Care Procedures	Upto sum insured
Organ Donor	Upto sum insured
Domiciliary Treatment	Upto sum insured
AYUSH Benefit	Upto sum insured
Ambulance Cover	Upto Rs. 3000 per Hospitalization
Health Checkup	Upto 1% of previous sum insured; max. upto Rs.10,000 per policy
Consumables Benefit	Upto sum insured
In-Patient Treatment – Dental	Upto sum insured
Second Opinion	Upto sum insured
Global cover, if opted	Upto sum insured
Cumulative Bonus	I. 50% increase in cumulative bonus for every claim free year. In the case a claim is made during the policy year, the cumulative bonus would reduce by 50% in the following year. Cumulative Bonus shall be provided only if No Claim Discount has not been availed for the claim free previous Policy Year. ii. Alternately, No Claim Discount in premium can be opted, in which case policy will not be entitled for Cumulative Bonus.

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