Health Companion

Prospectus and Sales Literature (for Health Companion Variant 2022 and Variant 2023

Health Companion – Start a healthy relationship

Heath Companion from Niva Bupa is a comprehensive health insurance cover for you and your family. It gives you the flexibility to choose just the right cover for your needs. Apart from giving you a comprehensive health insurance cover to suit your needs, we are also committed to provide you one of the best quality service when you need it the most.

Why Niva Bupa is the Healthier Health Insurance for you and your family:

- You talk to us directly, not through any third parties. We will be there for you when you need us. Because you should concentrate on getting healthier, not chasing your claims.
- You can access our cashless facility at the hospitals of your city which are part of our partner network.
- To build a relationship that lasts a lifetime, we make all efforts to understand your health profile during enrollment, so that when you need us, we can provide speedy and efficient support.
- We assure you renewability of your policy for lifetime, if you pay renewal premium within the grace period. You should renew on or before the renewal date of the policy to ensure you have continued medical insurance cover even during the grace period.
- As with all health insurance policies, you may save tax under Section 80D of the Income Tax Act when you buy a Niva Bupa health insurance policy. (Tax benefits are subject to changes in the tax laws, so please consult your tax advisor for more details)

Policy Design

- Niva Bupa's 'Health Companion' variant 2022 can be issued to individual customer(s) or to a family with up to 4 children (refer to as family floater).
- This policy covers persons in the age group 91 days and above. The minimum entry age for adult is 18 years and for dependent child is 91 days. There is no maximum entry age limit for adults in this product. The maximum entry age allowed for dependent child is 25 years.
- There is no maximum cover ceasing age on renewals.
- In an Individual policy, maximum up to 6 members (maximum of 4 adults and a maximum of 5 children can be included in a single policy. The 4 adults can be a combination of self, spouse, father, father in law, mother or mother in law). 10% discount on premium if 2 or more members are covered under an individual policy.
- The family floater policy is available in any of the following combinations:
    - 1 Adult + 1 Child
    - 1 Adult + 2 Children
    - 1 Adult + 3 Children
    - 1 Adult + 4 Children
    - 2 Adults
    - 2 Adults + 1 Child
    - 2 Adults + 2 Children
    - 2 Adults + 3 Children
    - 2 Adults + 4 Children

- Relationship allowed for adults in a family floater policy is / are self, spouse, father, father in law, mother or mother in law).
- The premium for family floater policies depends on the age of the eldest insured person.
- Please note if any Insured Person who is a child and has completed 26 years at the time of Renewal, then such Insured Person will have to take a separate policy based on our underwriting guidelines, as he/she will no longer be eligible to be covered under a family floater policy. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.
- **Term discount:** The default policy term for all plans is one year. Two year and three year policy term options are also available under the product. The level of discount is as below:
  - 2 year term:7.5% on the premium for second policy year
  - 3 year term: 15% on the premium for third policy year + 7.5% on the premium for second policy year

  Term Discount is not applicable if premium is paid via Monthly, Half Yearly or Quarterly Instalments.
- **Staff discount:** A staff discount of 15% on the policy premium will be given for the first policy year and on every renewal of such policy.
- **Standing Instruction discount:** 2.5% discount on premium if standing instruction for renewal is provided and the policy is renewed using the same.
- **Doctor discount:** 5% discount on premium if an Insured Person is a certified Medical Practitioner.
- **No-Claim Discount:** In case a consumer is receiving No Claim Bonus at the time of renewal, as specified in the policy wordings, we will offer a flat discount of INR 49 to the policy. This discount is applicable only at Renewals on the renewal premium and will not be offered if No Claim Bonus is not offered in a particular policy period. The discount will be offered for each policy period where there is No Claim Bonus including the policy that has reached its maximum limit of No Claim Bonus
- The premium rates for the plans offered are annexed hereto with the prospectus.
- For the purpose of calculating premium, the country has been divided into the following 3 zones:
  - Zone 1: Delhi, Gurgaon, Faridabad, Gautam Buddha Nagar, Ghaziabad, Noida, Surat, Kolkata, Mumbai, Thane
  - Zone 2: Pune, Nasik, Ludhiana, Jaipur, Baghpat, Bulandshahr, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Rohtak and Sonipat
  - Zone 3: Rest of India

Coverage Options

Health Companion variant 2022 has sum insured options from Rs.3 Lac to 1crore. The details of the benefits are specified in the product benefit table (Annexure I).

Benefits

No treatments or benefits other than outlines in the following section are covered under this product. 1.1.

1. Expenses to reach hospital **(Ambulance)**

   By road, maximum Rs.2,000 & by air maximum Rs.2,50,000 per hospitalization. Applies **ONLY** when Hospital admission claim is paid.

   IMPORTANT: You **MUST** use a registered ambulance / air ambulance provider. Air ambulance is available only for **Emergency care.**

2. Expenses during hospitalization **(Hospital admission)**

   a. We will pay the expenses incurred by you on treatment (Naturally this excludes expenses not linked to treatment like food, beverage, toiletries and cosmetics) if you were:

      - Admitted for 2 hours or more

NOTE: minimum 24 hours admission in AYUSH Hospital MUST for **AYUSH treatment**

- You had Dialysis (Hemo / Peritoneal), Radiotherapy or Chemotherapy for cancer

NOTE:

- **Admission in a hospital happens in what is called wards or rooms of various categories, ICUs, CCUs, NICU etc or in Day care.**
- **For Variant 2023 there is a room type capping up to Shared Room. 20% co-payment will apply in case of higher room category**

IMPORTANT:

i. **We will NOT pay, even if you were admitted, if there was no treatment and only investigations were done. Example: Admission only for investigations like MRI, CT Scan, Endoscopy, Colonoscopy etc.**

ii. **We will NOT pay for Automation machine for peritoneal dialysis**

iii. **We will pay for Angiography even though it is an investigation**

b. We pay for Modern treatments as specified below:

1. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	2. Immunotherapy- Monoclonal Antibody to be given as injection	3. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	4. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions
5. Balloon Sinuplasty	6. Oral Chemotherapy	7. Robotic surgeries	8. Stereotactic radio Surgeries
9. Deep Brain stimulation	10. Intra vitreal injections	11. Bronchical Thermoplasty	12. IONM - (Intra Operative Neuro Monitoring)

3. Expenses before and after hospitalization **(Pre & Post hospitalization)**

   We will pay expenses incurred on consultations, medicines, physiotherapy, diagnostic tests 60 days before date of admission and 180 days after date of discharge **IF these are related** to the condition for which hospital admission claim is paid.

4. Organ donor

   If you ever undergo an organ transplant, we will pay the hospitalization expenses of the donor for harvesting the organ **ONLY** when your **Hospital admission** claim is paid.

   If you donate any of your organs, we will pay for the expenses for harvesting the organ from you. We respect this noble deed. Remember, organ donation saves many lives.

5. No Claim Bonus (NCB)

   For every claim free year, we will add 20% of expiring policy base sum insured as NCB, maximum up to 100%.

   NOTE:

   IMPORTANT: Below points apply for changes made within the same product. Change in product is called **Migration** in which you **CAN NOT** carry NCB.

   a. NCB applies the same way as the policy sum insured type. If policy is floater, NCB is floater & if policy is individual sum insured, NCB too is individual basis.

   b. Individual NCB can be carried to any policy with individual sum insured as long as sum insured is NOT reduced.

   c. If two or more policies merge into a floater policy, the lowest of the NCB among all policies will be carried to the new merged floater policy.

d. In case You change individual sum insured policy to Floater, the lowest of the NCB of members in previous policy will be carried to floater policy.

e. If Floater policy is converted to individual sum insured policy, NCB of previous policy will be given to each of previously insured member on individual basis as long as sum insured is NOT reduced.

f. If any one reduces base sum insured, same percentage of NCB will be given as was the previous NCB of the previous base sum insured.

Example:

Base Sum Insured	Accumulated NCB	Base Sum Insured is reduced to 5 Lac	Revised Base Sum Insured	Revised Accumulated NCB
10 Lac	10 Lac (after 5 claim free years)		5 Lac	5 Lac

g. The sub-limits applicable to any benefit will remain the same and shall NOT increase with NCB.

6. Refill

We will add an amount equal to the base sum insured, after the first claim is paid. This will be added even at partial utilization of base sum insured.

NOTE:

a. Benefit applies **ONLY** once in a policy year.

b. Benefit applies for any illness (same or different).

Illustration

Base Sum Insured	1st paid Claim		Balance Base Sum Insured	Refill Benefit	2nd payable claim	Claim amount paid	Balance Base Sum Insured	Balance Refill Benefit	3rd Payable claim	Claim amount paid
10 Lac	7 Lac	Refill benefit is triggered	3 Lac	10 Lac	12 Lac	12 Lac (3 Lac from base SI and 9 Lac from Refill)	Nil	1 Lac	3 Lac	1 Lac from Refill

7. Health Checkup

Available once every Policy Year, from day 1 of the policy. You can choose any test(s) from the list specified below up to your eligibility limit. The tests MUST be booked through our digital assets (e.g. Mobile App). This benefit is available ONLY on cashless and no re-imbursement is allowed

List of tests covered:		
Complete blood count	Complete Physical Examination by Physician	Serum Electrolytes
Urine Routine	Post prandial/lunch blood sugar (PPBS / PLBS)	HbA1C
Erythrocyte Sedimentation Rate (ESR)	Uric Acid	Thyroid profile (TSH)
Fasting Blood Glucose	Lipid Profile	Liver Function Test (LFT)
Electrocardiogram	Kidney function test	Treadmill test (TMT)
S Cholesterol	Serum Vitamin D	Ultrasound test

Note: If you undergo multiple tests, make sure that all these are done within 7 days

8. **Vaccination for Animal Bite**

   Vaccination required post an animal bite is covered up to Rs. 5,000.

9. **Home Care / Domiciliary Treatment**

   Home Care Treatment means treatment availed by the insured person at home which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

   a. The medical practitioner advices the insured person to undergo treatment at home.

   b. There is continuous active line of treatment with monitoring of health status by a medical practitioner for each day through the duration of the home care treatment.

   c. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

   Note: We will pay for Pre & Post hospitalization benefit as per section 3 for Home Care / Domiciliary Treatment.

Optional Benefits:

10. **Hospital Cash**

    We will pay a fixed amount as specified in your Product Benefit Table (Annexure 1) for each day (continuous period of 24 hours) of Hospitalization, maximum up to 30 days for an insured person.

    Note: Benefit applies ONLY when admitted in a Hospital for 48 hours or more continuously and such claim is paid by us.

11. **Personal Accident**

    11.1 **Accidental Death (AD)**

    In event of unfortunate demise of the insured within 365 days from the date of the Accident, within the Policy Period, we will pay the Sum Insured.

    The Personal accident benefit will terminate after the Accidental Death benefit is paid for.

11.2 **Permanent Total Disability**

If the Insured Person suffers Permanent Total Disability, within 365 days from the date of the Accident, within the Policy Period, we will pay the benefit as per the below Table

Condition for Permanent Total Disability	% of Accidental Death Sum Insured
Complete & Irrecoverable loss of : • Any 2 Limbs • Sight of both eyes • Speech & hearing of both Ears • Combination of One Limb & Sight of One Eye	125%
Complete & Irrecoverable loss of : • 1 Limb • Sight of 1 Eye	50%

Complete & Irrecoverable loss of limb means physical separation or complete loss of functionality of the limb, within 365 days from the date of the Accident. This will include Paralysis including Paraplegia, Quadriplegia with loss of functional use of limb.

The Personal accident benefit will terminate after the Permanent Total Disability benefit is paid for.

11.3 **Permanent Partial Disability**

a. If the Insured Person suffers a Permanent Partial Disability, within 365 days from the date of the Accident, within the Policy Period, we will pay the benefit as per the below Table.

Condition for Permanent Partial Disability	% of Accidental Death Sum Insured
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	50%
Each hand at the wrist	50%
Each Thumb	20%
Each Index Finger	10%
Each other Finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%

b. If a Permanent Partial Disability loss is not mentioned in the table above, then we will internally assess the degree of disablement and determine the amount of payment to be made.

If there is more than one Permanent Partial Disability loss, then the total claim amount put together for all losses will not exceed the total Accidental Death Sum Insured opted. Once Total Sum Insured is paid, the policy will lapse.

Claim cost sharing option:

12 **Annual Aggregate Deductible**

This is an aggregate amount in a year that is incurred by you on Hospital admission, which we will **NOT** pay. Once the total expense exceeds this amount, balance we will pay. The deductible options available are INR 10,000, 20,000, 30,000. 50,000, 1 lac, 2 lac, 3 lac, 4 lac, 5 lac and 10 lac.

Note:

a. Deductible amount borne by you should also be payable as per policy terms and conditions.

b. Deductible will **NOT** apply to Health Check-up, Vaccination for Animal Bite and Hospital Cash benefits.

Exclusions

Standard Exclusions

I. **Pre-existing Diseases (Code–Excl01):**

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.

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 (Insurance Products) Regulations, 2024, 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.

II. **Specified disease/procedure waiting period (Code- Excl02)**

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. This exclusion shall not be applicable for claims arising due to an Accident (covered from day 1) or Cancer (covered after 30-day waiting period).

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:

i. Pancreatitis and stones in biliary and urinary system

ii. Cataract, glaucoma and retinal detachment

iii. Hyperplasia of prostate, hydrocele and spermatocele

iv. Prolapse uterus and cervix, endometriosis, Fibroids, PCOD, hysterectomy (unless necessitated by Malignancy)

v. Hemorrhoids, fissure or fistula or abscess of anal and rectal region

vi. Hernia of all sites,

vii. Osteoarthritis, joint replacement, osteoporosis, systemic connective tissue disorders, inflammatory polyarthropathies, Rheumatoid Arthritis, gout, intervertebral disc disorders, arthroscopic surgeries for ligament repair

viii. Varicose veins of lower extremities

ix. All internal or external benign or neoplasms/ tumours, cyst, sinus, polyp, nodules, mass or lump

x. Ulcer, erosion and varices of gastro intestinal tract

xi. Surgical treatment for diseases of middle ear and mastoid (including otitis media, cholesteatoma, perforation of tympanic membrane), Tonsils and adenoids, nasal septum and nasal sinuses

III. **30-day waiting period (Code- Excl03):**

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.

IV. **Investigation & Evaluation (Code-Excl04**)

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.

V. **Rest Cure, rehabilitation and respite care (Code-Excl05)**

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

a. 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.

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

VI. **Obesity/ Weight Control (Code-Excl06)**

Expenses related to the surgical treatment of obesity that does not fulfil all 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

VII. **Cosmetic or plastic Surgery (Code-Excl08)**

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.

VIII. **Hazardous or Adventure sports (Code-Excl09)**

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.

IX. **Breach of law (Code-Excl10)**

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

X. **Excluded Providers (Code-Excl11)**

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our 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.

The complete list of excluded providers can be referred to on our website.

XI. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences there of. **(Code-Excl12)**

XII. 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)**

XIII. **Refractive Error (Code-Excl15)**

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

XIV. **Unproven Treatments (Code-Excl16)**

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.

XV. **Sterility and Infertility (Code-Excl17)**

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

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

c. Gestational Surrogacy

d. Reversal of sterilization

XVI. **Maternity Expenses (Code-Excl18)**

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.

Specific Exclusions

I. **Personal Waiting Period**

Conditions specified for an Insured Person under Personal Waiting Period (if any) will be subject to a Waiting Period of up to 48 months from the inception of the First Policy with Us.

II. **Circumcision:**

Circumcision unless necessary for the treatment of a disease or necessitated by an Accident.

III. **Conflict & Disaster:**

Treatment for any Injury or Illness resulting directly or indirectly from nuclear, radiological emissions, war or war like situations (whether war is declared or not), rebellion (act of armed resistance to an established government or leader), acts of terrorism.

IV. **External Congenital Anomaly:**

Screening, counseling or treatment related to external Congenital Anomaly.

V. **Dental/oral treatment:**

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required by an Insured Person while Hospitalized due to an Accident.

VI. Medical & ambulatory devices used at home like BP monitors, Sugar monitors, automation device for peritoneal dialysis, CPAP, BiPAP, Crutches, wheel chair etc.

VII. Any expenses incurred on OPD treatment.

VIII. **Unrecognized Physician or Hospital:**

a. Treatment or Medical Advice provided by a Medical Practitioner not recognized by the Medical Council of India or by Central Council of Indian Medicine or by Central council of Homeopathy.

b. Treatment provided by anyone with the same residence as an Insured Person or who is a member of the Insured Person's immediate family or relatives.

c. Treatment provided by Hospital or health facility that is not recognized by the relevant authorities in India.

IX. Treatment related to intentional self inflicted Injury or attempted suicide by any means.

X. Costs which are not Reasonable and Customary and treatments which are not Medically Necessary. Refer Definition 2.1.31 for Reasonable and Customary Charges.

XI. Artificial life maintenance for the Insured Person who has been declared brain dead or in vegetative state

General Terms and Clauses

1. **Free Look Period**

The Free Look Period shall be applicable on individual health insurance policies and not on renewals.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy.. If he/she is not satisfied with any of the terms and conditions , he/she has the option to cancel his/her policy.

In the event the policyholder disagrees to any of the policy terms or conditions, or otherwise and has not made any claim, he/she shall have the option to retun the policy to the insurer for cancellation, stating the reasons for the same.

Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

2. **Cancellation**

The policy holder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The insurer shall:

a. Refund proportionate premium for unexpired policy period, if the term of the policy upto one year and there is no claim(s) made during the policy period.

b. Refund preium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years are not commenced.

3. **Renewal of Policy**

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured.

An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.

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

ii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (annual installment) to maintain continuity of benefits without break in policy.

iii. Coverage is available during the grace period.

iv. No loading shall apply on renewals based on individual claims experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience.

v. Insurer shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc at renewal stage where there is no change in sum insured offered. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured

4. **Possibility of Revision of Terms of the Policy Including the Premium Rates**

The Company, with prior approval of IRDAI, 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.

5. **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. The insurer shall obtain nomination at the time of new business and at the time of renewal for existing policies.

6. **Fraud**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy: a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true; b) the active concealment of a fact by the insured person having knowledge or belief of the fact; c) any other act fitted to deceive; and d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. **Withdrawal of 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 either renew (up to 90 days from renewal date) same product or to migrate to a 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.

8. **Redressal of Grievance:**

   In case of any grievance the insured person may contact the company through:

   Website: www.nivabupa.com

   Toll free: 1860-500-8888

   E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)

   Fax : 011-4174-3397

   Courier: Customer Services Department

   Niva Bupa Health Insurance Company Limited

   D-5, 2nd Floor, Logix Infotech Park

   opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

   Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

   Head – Customer Services

   Niva Bupa Health Insurance Company Limited

   D-5, 2nd Floor, Logix Infotech Park

   opp. Metro Station, Sector 59, Noida, Uttar Pradesh, 201301

   Contact No: 1860-500-8888

   Fax No.: 011-4174-3397

   Email ID Email our Grievance officer through our Grievance Redressal platform https:// transactions.nivabupa.com/pages/grievance-redressal.aspx

   For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx

   If the Insured person is not satisfied with the above, they can escalate to GRO@nivabupa.com

   If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (at the addresses given in Policy Terms and Conditions).

   Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in/

9. **Claim settlement (Provision for Penal interest)**

   I. The Company shall settle or reject a claim, as the case may be, within 15 days from the claim submission date.

   II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of claim intimation till the date of payment of claim at a rate 2% above the bank rate.

   (Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

10. **Moratorium Period**

    After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on the grounds of non-disclosure, misrepresentation, except on grounds of established fraud. The period of sixty continuous months is called as moratorium period. The moratorium will be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would 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.

    Note: the accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium Period.

11. **Multiple Policies**

    I. **Indemnity Based Policies:**

       a. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his / her claim in terms of any of his / her policies. In all such cases the insurer chosen by the Policyholder shall be considered as the Primary Insurer and will be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

       b. If the amount to be claimed exceeds the available coverage of the said policy, then the primary insurer shall seek the details of other available policies of the policyholder and shall coordinate with other insurers to ensure settlement pf the balance amount as per the policy conditions, without causing any hassles to the policy holder.

    II. **Benefit Based Policies:**

       a. On occurrence of the insured event, the policy holder can claim from all Insurers under all policies..

12. **Migration**

    In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained 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.

    The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months

13. **Portability**

    A Policyholder has the choice to port his/ her policies from one Insurer to another irrespective of individual or group policy subject to the Board approved underwriting policy of the insurers.

    The policyholder is entitled to transfer the credits gained 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.

14. **Disclosure of Information**

    The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder.

    (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

15. **Condition Precedent to Admission of Liability**

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

16. **Complete Discharge**

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

17. **Premium Payment in Instalments (Wherever applicable)**

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or 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 30 days in all policy types, and a period of 15 days in case of monthly installments.

ii. For policies where premium is paid in instalments only, the coverage will be given during grace period.

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 instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get canceled.

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

18. **Automatic Cancellation:**

The Policy shall automatically terminate in the event of death of the all Insured Person(s). A refund in accordance with Section 2 (Cancellation) shall be payable provided that no claim has been admitted or lodged or not benefit has been availed by the insured person under the policy.

19. **Additional premium (Risk Loading)**

i. We may ask for additional premium after due risk evaluation (it's what referred to as Underwriting) based on all information provided by you. We will issue policy to you only after you pay us the additional premium and provide us consent.

ii. We will never ask for more than 100% for any particular health condition and never more than 150% for any individual.

iii. Once applied, Risk loading continues even for all renewals.

20. **Other Renewal Conditions:**

a. **Renewal Premium:**

Renewal premium will alter based on Age. For Family Floater policies, the age of eldest insured person will be considered for calculating the premium.

b. **Addition of Insured Persons on Renewal:**

If a new member is added in the Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable afresh for that member.

c. **Changes to Sum Insured on Renewal:**

You may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting. All Waiting Periods as defined in the Policy shall apply afresh for this enhanced limit from the effective date of such enhancement.

d. **Split of policy for child:**

Child under a family floater policy will get a separate policy at renewal after attaining age 26 years.

21. **Claims**

a. Cashless claim facility is available at our network hospitals ONLY. As list of network hospitals is dynamic, for the latest list, refer to our website www. nivabupa.com.

b. Documents required with claim form:

Hospital / Medical records:

- Original Discharge summary with first and subsequent consultation papers.
- Original Final Hospital bill with detailed break-up and payment receipt (including pharmacy bills).
- Laboratory investigation reports with supporting prescriptions.
- MLC/First Information Report (FIR) (in accident cases).

Policyholder documents (Nominee in case of death of Policyholder):

- KYC documents
- Cancelled cheque

IMPORTANT:

- All documents **MUST** be submitted at the earliest possible time .
- For any delay in submission, You **MUST** provide the reasons in writing. We will condone such delay on merits (i.e. reasons beyond your control).
- You **MUST** submit all claim related documents for expenses within the Deductible amount (if applicable).
- We reserve the right to check and investigate the hospital / medical records from any doctor, Hospital, clinic, individual or institution.

c. The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment are placed as Annexure II.

d. If you opt for a Hospital room which is higher than the eligible room category, then We will pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:

(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

e. For any hospitalization, we will pay for items included in the bill by the Hospital during the duration of hospitalization. Items not included in the bill will not be paid.

Please Note:

i. Once the final authorization request is received for discharge, the same will be processed within three hours from the final documents received. In case of delay from our end, any additional amount charged by the hospital will be borne by us. This amount will be paid over and above the policy limits.

ii. We offer Cashless Everywhere, even in hospitals which are not part of our network. For More details and process please visit our website: https://transactions.nivabupa.com/cashlessclaims/pages/intimation-claim.aspx

22. **Policy Disputes**

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

23. **Territorial Jurisdiction**

All claims shall be payable in India in Indian Rupees only.

24. **Alteration to the Policy**

This Policy constitutes the complete contract of insurance. Any change in the Policy will only be evidenced by a written endorsement signed and stamped by Us. No one except Us can within the permission of the IRDAI change or vary this Policy.

25. **Zonal pricing**

For the purpose of calculating premium, the country has been divided into the following 3 zones:

i. Zone 1: Delhi, Gurgaon, Faridabad, Gautam Buddha Nagar, Ghaziabad, Noida, Surat, Kolkata, Mumbai, Thane

ii. Zone 2: Pune, Nasik, Ludhiana, Jaipur, Baghpat, Bulandshahr, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Rohtak and Sonipat

iii. Zone 3: Rest of India.

Your premium depends upon your residential city. Please inform us immediately in case of change in your city.

26. **Assignment**

The Policy can be assigned subject to applicable laws.

27. **Sum Insured**

In case of Individual or Family Floater policy, Sum Insured means the total of the Base Sum Insured and No claim Bonus (if applicable). Our maximum, total and cumulative liability for all claims during the Policy Year will be Sum Insured and amount provided under Refill benefit.

The sequence of utilization of Sum Insured will be as below:

i. Base Sum Insured followed by;

ii. Accumulated No Claim Bonus (if applicable) followed by;

iii. Refill benefit (if applicable)

If the Policy Period is 2 years or 3 years, then the Sum Insured shall be applied separately for each Policy Year in the Policy Period. All claims paid (except for Health Check-up and Hospital Cash) will reduce the Sum Insured for the Policy Year in which the insured event has occurred. Any claim admitted under Pre & Post Hospitalization shall reduce the Sum Insured for the Policy Year in which Hospital admission claim has incurred.

If you wish to know more about Niva Bupa's Health Companion and/or would like a personal quote, speak to our specially trained sales team or your local advisor. They'll take time to fully understand your requirements and help you to select the right plan for you.

Customer Helpline No: 1860-500-8888

Annexure I - Product Benefits Table

Variant 2022

Plan Type (all limits in Rs unless defined as percentage)	Individual / Family Floater											
Base Sum Insured	3 lac	4 lac	5 lac	7.5 lac	10 lac	12.5 lac	15 lac	20 lac	30 lac	50 lac	75 lac	100 lac
Base benefits												
Inpatient Care	Covered up to Sum Insured											
Day Care Treatment	Covered up to Sum Insured											
AYUSH Treatment	Covered up to Sum Insured											
Modern treatments	Covered up to Sum Insured											
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured											
Post-Hospitalization Medical Expenses (180 days)	Covered up to Sum Insured											
Organ Donor	Covered up to Sum Insured											
Ambulance	Road ambulance: up to Rs.2,000 per hospitalization Air ambulance: up to Rs.2,50,000 per hospitalization											
No Claim Bonus	In case of claim free year, increase of 20% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured (In case of claim, no reduction in No Claim Bonus)											
Refill	Up to Base Sum Insured (Applicable for both same & different illness)											
Health Check-up	Annual (From Day 1); For defined list of tests; up to Rs. 500 for every Rs. 1L Base Sum Insured (Individual policy: maximum Rs. 5,000 per Insured; Family Floater policy: maximum Rs. 10,000 per policy)											
Vaccination for Animal Bite	Up to Rs. 5,000											
Home Care / Domiciliary Treatment	Covered up to Sum Insured											
Optional benefit												
Hospital Cash	1,000/day				2,000/day			4,000/day				
Personal Accident	Up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore											
Annual Aggregate Deductible (INR)	10,000 / 20,000 / 30,000 / 50,000 / 1 lac / 2 lac / 3 lac / 4 lac / 5 lac / 10 lac											

Variant 2023

Plan Type (all limits in Rs unless defined as percentage)	Individual / Family Floater											
Base Sum Insured	3 lac	4 lac	5 lac	7.5 lac	10 lac	12.5 lac	15 lac	20 lac	30 lac	50 lac	75 lac	100 lac
Base benefits												
Inpatient Care	Covered up to Sum Insured for Shared Room. 20% co-pay in case of higher room category											
Day Care Treatment	Covered up to Sum Insured											

AYUSH Treatment	Covered up to Sum Insured		
Modern treatments	Covered up to Sum Insured		
Pre-Hospitalization Medical Expenses (60 days)	Covered up to Sum Insured		
Post-Hospitalization Medical Expenses (180 days)	Covered up to Sum Insured		
Organ Donor	Covered up to Sum Insured		
Ambulance	Road ambulance: up to Rs.2,000 per hospitalization Air ambulance: up to Rs.2,50,000 per hospitalization		
No Claim Bonus	In case of claim free year, increase of 20% of expiring Base Sum Insured in a Policy Year; maximum up to 100% of Base Sum Insured (In case of claim, no reduction in No Claim Bonus)		
Refill	Up to Base Sum Insured (Applicable for both same & different illness)		
Health Check-up	Annual (From Day 1); For defined list of tests; up to Rs. 500 for every Rs. 1L Base Sum Insured (Individual policy: maximum Rs. 5,000 per Insured; Family Floater policy: maximum Rs. 10,000 per policy)		
Vaccination for Animal Bite	Up to Rs. 5,000		
Home Care / Domiciliary Treatment	Covered up to Sum Insured		
Optional benefit			
Hospital Cash	1,000/day	2,000/day	4,000/day
Personal Accident	Up to 5 times of Base Sum Insured. Maximum up to INR 1 Crore		
Annual Aggregate Deductible (INR)	10,000 / 20,000 / 30,000 / 50,000 / 1 lac / 2 lac / 3 lac / 4 lac / 5 lac / 10 lac		

Note: Variant 2023 will be offered with lesser commission

Annexure II - The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment

List I – Expenses not covered

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	BABY FOOD	24	ATTENDANT CHARGES	47	LUMBO SACRAL BELT
2	BABY UTILITIES CHARGES	25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	48	NIMBUS BED OR WATER OR AIR BED CHARGES
3	BEAUTY SERVICES	26	BIRTH CERTIFICATE	49	AMBULANCE COLLAR
4	BELTS/ BRACES	27	CERTIFICATE CHARGES	50	AMBULANCE EQUIPMENT
5	BUDS	28	COURIER CHARGES	51	ABDOMINAL BINDER
6	COLD PACK/HOT PACK	29	CONVEYANCE CHARGES	52	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES
7	CARRY BAGS	30	MEDICAL CERTIFICATE	53	SUGAR FREE Tablets
8	EMAIL / INTERNET CHARGES	31	MEDICAL RECORDS	54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	32	PHOTOCOPIES CHARGES	55	ECG ELECTRODES
10	LEGGINGS	33	MORTUARY CHARGES	56	GLOVES
11	LAUNDRY CHARGES	34	WALKING AIDS CHARGES	57	NEBULISATION KIT
12	MINERAL WATER	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
13	SANITARY PAD	36	SPACER	59	KIDNEY TRAY
14	TELEPHONE CHARGES	37	SPIROMETRE	60	MASK
15	GUEST SERVICES	38	NEBULIZER KIT	61	OUNCE GLASS
16	CREPE BANDAGE	39	STEAM INHALER	62	OXYGEN MASK
17	DIAPER OF ANY TYPE	40	ARMSLING	63	PELVIC TRACTION BELT
18	EYELET COLLAR	41	THERMOMETER	64	PAN CAN
19	SLINGS	42	CERVICAL COLLAR	65	TROLLY COVER
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	43	SPLINT	66	UROMETER, URINE JUG
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	44	DIABETIC FOOT WEAR	67	AMBULANCE
22	TELEVISION CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)	68	VASOFIX SAFETY
23	SURCHARGES	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER		

List II – Items that are to be subsumed into Room Charges

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	14	BED PAN	27	ADMISSION KIT
2	HAND WASH	15	FACE MASK	28	DIABETIC CHART CHARGES
3	SHOE COVER	16	FLEXI MASK	29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
4	CAPS	17	HAND HOLDER	30	DISCHARGE PROCEDURE CHARGES
5	CRADLE CHARGES	18	SPUTUM CUP	31	DAILY CHART CHARGES
6	COMB	19	DISINFECTANT LOTIONS	32	ENTRANCE PASS / VISITORS PASS CHARGES
7	EAU-DE-COLOGNE / ROOM FRESHNERS	20	LUXURY TAX	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
8	FOOT COVER	21	HVAC	34	FILE OPENING CHARGES
9	GOWN	22	HOUSE KEEPING CHARGES	35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
10	SLIPPERS	23	AIR CONDITIONER CHARGES	36	PATIENT IDENTIFICATION BAND / NAME TAG
11	TISSUE PAPER	24	IM IV INJECTION CHARGES	37	PULSEOXYMETER CHARGES
12	TOOTH PASTE	25	CLEAN SHEET		
13	TOOTH BRUSH	26	BLANKET/WARMER BLANKET		

List III – Items that are to be subsumed into Procedure Charges

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	HAIR REMOVAL CREAM	9	WARD AND THEATRE BOOKING CHARGES	17	BOYLES APPARATUS CHARGES
2	DISPOSABLES RAZORS CHARGES (for site preparations)	10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	18	COTTON
3	EYE PAD	11	MICROSCOPE COVER	19	COTTON BANDAGE
4	EYE SHEILD	12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER	20	SURGICAL TAPE
5	CAMERA COVER	13	SURGICAL DRILL	21	APRON
6	DVD, CD CHARGES	14	EYE KIT	22	TORNIQUET
7	GAUSE SOFT	15	EYE DRAPE	23	ORTHOBUNDLE, GYNAEC BUNDLE
8	GAUZE	16	X-RAY FILM		

List IV – Items that are to be subsumed into costs of treatment

Sl. No.	Item	Sl. No.	Item	Sl. No.	Item
1	ADMISSION/REGISTRATION CHARGES	7	INFUSION PUMP– COST	13	MOUTH PAINT
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC	14	VACCINATION CHARGES
3	URINE CONTAINER	9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	15	ALCOHOL SWABES
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	10	HIV KIT	16	SCRUB SOLUTION/STERILLIUM
5	BIPAP MACHINE	11	ANTISEPTIC MOUTHWASH	17	GLUCOMETER & STRIPS
6	CPAP/ CAPD EQUIPMENTS	12	LOZENGES	18	URINE BAG

Benefit Illustration (5 Lac Sum Insured, Policy Term 1 year)										
Age of the members insured	**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 the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or Consolidated premium for all members of family (Rs.)**	**Floater discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
Illustration 1										
18	8,685.22	500,000	8,685.22	868.52	7,816.70	500,000	8,685.22	16,935.79	23,701.75	500,000
21	8,685.22	500,000	8,685.22	868.52	7,816.70	500,000	8,685.22			
39	10,894.06	500,000	10,894.06	1,089.41	9,804.65	500,000	10,894.06			
45	12,373.03	500,000	12,373.03	1,237.30	11,135.73	500,000	12,373.03			
Total premium for all members of the family is **Rs.40,637.54**, when each member is covered separately. Sum Insured available for each individual is **Rs.500,000.**			Total premium for all members of the family is **Rs.36,573.78,** when they are covered under a single policy. Sum Insured available for each family member is **Rs.5,00,000.**				Total premium when the policy is opted on floater basis is **Rs.23,701.75** Sum Insured of **Rs.500,000** is available for the entire family.			

Illustration 2										
55	20,536.21	500,000	20,536.21	2,053.62	18,482.59	500,000	20,536.21	4,964.60	51,332.36	500,000
63	35,760.76	500,000	35,760.76	3,576.08	32,184.68	500,000	35,760.76			
Total premium for all members of the family is **Rs.56,296.963,** when each member is covered separately. Sum Insured available for each individual is **Rs.500,000.**			Total premium for all members of the family is **Rs.50,667.27,** when they are covered under a single policy. Sum Insured available for each family member is **Rs.5,00,000.**				Total premium when the policy is opted on floater basis is **Rs.51,332.36** Sum Insured of **Rs.500,000** is available for the entire family.			
Illustration 3										
65	35,760.76	500,000	35,760.76	3,576.08	32,184.68	500,000	35,760.76	15,459.44	66,276.64	500,000
70	45,975.32	500,000	45,975.32	4,597.53	41,377.79	500,000	45,975.32			
Total premium for all members of the family is **Rs.81,736.08,** when each member is covered separately. Sum Insured available for each individual is **Rs.500,000.**			Total premium for all members of the family is **Rs.73,562.47,** when they are covered under a single policy. Sum Insured available for each family member is **Rs.5,00,000.**				Total premium when the policy is opted on floater basis is **Rs.66,276.64** Sum Insured of **Rs.500,000** is available for the entire family.			

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

Zone 1 and variant 2022 premium is considered