Prospectus - Smart Health Insurance Policy

I. Introduction:

This health insurance Policy provides cover for hospitalisation expenses incurred for treatment of disease, illness, injury. The Policy among other things covers Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker and artificial limbs etc. The Policy also provides cover against hospitalisation treatment of specified critical illnesses and further provides for payment of daily allowance for the days the Insured has been hospitalised.
The Policy offers varying plan and benefit options. The Policy can also be issued to cover the individual Insured or Insured's family of maximum four persons comprising of the Insured, spouse and two dependent children upto the age of 23 years.

II. Variants of Cover:

The following variants of cover are available:

- Smart Health Basic
- Smart Health Premium
- Smart Health Optimum

III. Eligibility

- This Policy covers persons in the Age group 91 days to 65 years.
- The minimum entry age is 91 days and maximum entry Age is restricted upto 65 years.
- Children below the age of 5 years can be covered only in the event of either or both the parents being covered
- There is no maximum cover ceasing age in this policy for renewal This Policy can be issued to an individual and/or family as a Family Floater.
- The family includes self, spouse, upto 2 Dependent children upto the age of 23 years.
- Residents in India shall include all Citizens of India and permanent residents of India as well as expatriates or foreigners who are holding an employment pass, dependant pass or work permit and residing in India.
- Expatriates or foreigners must provide a copy of either a valid employment pass or work permit, and a bona-fide residential address in India.

IV. Sum Insured:

	SI	SI	SI	SI	SI
Smart Health Basic	50000	100000	200000	300000	500000
Smart Health Premium	100000	200000	300000	400000	500000
Smart Health Optimum	100000	200000	300000	400000	500000

V. Scope of coverage

The Policy provides for -

1. Hospitalisation Benefit

Payment or reimbursement of hospitalisation expenses that are reasonably and necessarily incurred by the Insured/Insured Person for treatment of disease, illness, injury in a Hospital as an in-patient which includes, among other things, cover for Hospital (Room & Boarding and Operation

theatre) charges, fees of Surgeon, Anaesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.

2. Pre and post hospitalisation expenses
Payment or reimbursement of pre hospitalisation expenses incurred for specified days prior to hospitalisation and post hospitalisation expenses incurred for specified days following discharge from Hospital / Nursing Home.

3. Pre-existing diseases
Payment or reimbursement of expenses incurred in a Hospital/ Nursing Home for treatment relating to pre-existing diseases, illness, injury after a specified waiting period from the inception of the Policy.

4. Day Care Treatment
Payment or reimbursement of hospitalisation expenses incurred in case of day care treatment (where 24 hours of hospitalisation is not required due to technologically advanced treatment protocol) such as dialysis, chemotherapy, radiotherapy, eye surgery, lithotripsy (kidney stone removal), D & C, tonsillectomy taken in a Hospital / Nursing Home.

5. Domiciliary hospitalisation
Reimbursement of domiciliary hospitalisation expenses involving medical treatment for a period exceeding three days for disease, illness, injury which in the normal course would require care and treatment at a Hospital/Nursing Home but is actually taken whilst confined at home in India under any of the following circumstances namely: -

i) the condition of the patient is such that he / she cannot be removed to Hospital / Nursing Home, or
ii) the patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

6. Critical Illness
This benefit provides for coverage of expenses incurred for treatment of any of the specified critical illnesses. The coverage can be either in the form of payment of lump sum benefit amount or payment /reimbursement of expenses incurred for treatment of such specified Critical Illness in a Hospital / Nursing Home as per the plan and Sum Insured selected by the Proposer.
If the type of cover opted is benefit basis, the policy will provide for payment of the lump sum benefit equal to the Sum Insured in case the Insured/Insured Person is being diagnosed as contracting any of specified Critical Illnesses and surviving for more than 30 days post such diagnosis.

If the type of cover opted is reimbursement basis the Policy will provide for payment/reimbursement of, hospitalisation expenses incurred by the Insured/Insured Person upto the limit of Sum Insured if the Insured/Insured Person is being diagnosed as contracting any specified Critical Illnesses and has undertaken treatment in a Hospital for the same.

This benefit is available after a waiting period of 60 days from the date of inception of the Policy in the first year of cover.

The Sum Insured available under this benefit is separate and additional to the Sum Insured available under the Hospitalisation benefit Section of the Policy.

6.a Dread Disease recuperation
Payment of an allowance towards Recuperation expenses incurred by the Insured/Insured Person post discharge from the Hospital, in case the Insured/Insured Person contracts any of the Critical

Illnesses and undertakes treatment for the same in a Hospital as an in-patient for which a valid claim under the Policy is admissible. This benefit is payable for 60 days subject to medical requirement as certified by the attending Medical Practitioner.

6.b Transplantation of Organs

Payment or reimbursement of hospitalisation expenses incurred towards donor for a major organ transplant in case the Insured/Insured Person contracts any of the critical illnesses requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible. This benefit is subject to overall limit of the Sum Insured.

VI. Additional Benefits:

Benefits under these Sections are payable as Additional Benefits upto the limits of Sum Insured specified. A valid claim should have been admitted under the Hospitalisation benefit Section of the Policy, for admission of liability under these Sections. These benefits are also payable when there is a hospitalisation claim for Critical Illness treatment under the Critical Illness Section, subject to limit of Sum Insured.

1. Hospital Cash Allowance:

Payment of daily allowance for the days the Insured/Insured Person is hospitalised beyond a specified number of days for treatment of any disease / illness / injury for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

2. Home Nursing:

Payment of an allowance towards expenses incurred for availing medical care services of a nurse at the residence of the Insured/Insured Person following discharge from Hospital after treatment for a disease / illness / injury and/or critical illness, if the same is recommended as necessary by the attending Medical Practitioner and is related directly to the treatment of disease, illness or injury and/or for critical illness, for which the Insured/Insured Person has been hospitalized. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

3. Ambulance Charges:

Reimbursement of expenses incurred for the transportation of the Insured/Insured Person by ambulance to and from the Hospital for treatment of disease, illness or injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

4. In-patient Physiotherapy Charges:

This benefit provides for reimbursement of charges incurred towards physiotherapy in the Hospital as an in-patient that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the disease, illness or injury for which the Insured/Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under this Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

5. Recovery Grant:

In case the Insured/Insured Person is hospitalized for a period of 8 consecutive days or more for treatment of any disease / illness / injury for which a valid claim is admissible under the Policy, this

benefit provides for payment of a fixed allowance/grant as mentioned in Exhibit of Benefits annexed hereto. This benefit is applicable irrespective of the number of occurrences during the Policy period.

6. Accompanying Person's Expenses:
This benefit provides for payment an allowance towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured/Insured Person for the disease, illness or injury for which a valid claim is admissible under the Policy. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

7. Parent Accommodation as Companion for Child:
This benefit provides for payment of a fixed daily allowance towards meeting the expenses for the stay of one of the parents at the Hospital/Nursing Home when a child below the age of 12 years is hospitalized. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

8. Out-patient Dental Emergency Treatment (arising out of Accident only):
This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Dentist following an accident where the Insured/Insured Person suffers injuries or damage to his natural teeth and/or gums. This benefit further provides cover for medical expenses incurred for follow up treatment for the same accidental dental injury up to a maximum of 15 days by the same Dentist. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

9. Out-patient Emergency treatment for accidents:
This benefit provides for reimbursement of medical expenses incurred towards emergency treatment by a Medical Practitioner following an accidental injury to the Insured/Insured Person and such Emergency Treatment administered within 24 hours following the accident.
It also provides cover for medical expenses incurred for follow-up treatment by the same Medical Practitioner in respect of the same accidental injury up to 30 days from the date of accident, including expenses incurred for medication prescribed on a written basis by the attending Medical Practitioner for that same treatment or consultation. This benefit is applicable irrespective of the number of occurrences during the Policy period and is subject to the limits specified in Exhibit of Benefits annexed hereto.

10. Children Education Fund:
This benefit provides for payment of a fixed amount per dependent child, upto a maximum of two dependant children who pursue studies and are below the age of 23 years, in the event of death of the Insured/ Insured Person whilst under treatment in a Hospital as an in-patient for a disease / illness / injury and/or critical illness for which a valid claim is payable under the Policy. The benefit is limited to the amount specified in the Exhibit of Benefits annexed hereto.

11. Mortal Remains:
This benefit provides for reimbursement of expenses incurred for transportation of the mortal remains of the deceased Insured/Insured Person from Hospital to his/her place of residence in the event of death at the Hospital as an in-patient whilst under treatment of a disease / illness / injury and/or critical illness for which a valid claim is payable under the Policy, subject to the limits specified in the Exhibit of Benefits annexed hereto.

For detailed and updated list of non payable items, kindly visit our website www.bharti-axagi.co.in

VII. ADDITIONAL FEATURES

1. Renewal Discount:

Discount equivalent to 5% of renewal premium every year on a progressive scale will be given back to the Insured as No claim Bonus at the time of renewal, where the Policy which is renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed upto 25%. In case of renewal of a Policy where there is a loss, the Insured will lose the entire Renewal Discount accumulated. This additional benefit is available on the policies taken and renewed with our Company continuously without any break and without any claim.

2. Cost of Health Check up:

This benefit provides for reimbursement of cost of medical check-up once at the end of a block of every four continuous underwriting years provided there were no claims reported /made under the Policy during the block. This benefit is limited to 1% of the average Sum Insured per person during the block of four underwriting years.

This additional benefit is available on the policies taken and renewed with our Company for four continuous years without any claim.

However, this benefit is also available in respect of similar health insurance policies of any other general insurance company/s in India which are taken and renewed for a period of four continuous years without any claim

VIII. Policy Period

Policy will be issued for annual period of 12 months.

IX. Policy Servicing

The Policy will be serviced by Third Party Administrator who will provide among other things cash less facility for hospitalisation treatment.

The scope of cover and the Sum Insured levels under the various Plans available are mentioned in Exhibit of Benefits annexed hereto.

X. Free-look period:

You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy.

If You have any objections to any of the terms and conditions, You have the option of canceling the Policy stating the reasons for cancellation and You shall be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium.

You can cancel your Policy only if You have not made any claims under the Policy. All Your rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

Free look provision is not applicable and available at the time of renewal of the Policy.

XI. Pre Policy Check:

The Company shall reimburse 50% of the cost of medical examination underwent by the Insured person(s) at designated Hospital/ Diagnostic centre, if the proposal is accepted

For all the variants Insured members have to undergo Pre Policy check if their age is above 45 and Sum Insured opted is above 3 lac.

List of test to be undergone:-

- MER
- Blood Test, FP & PP (Blood Sugar)
- Urine Test (ROUTINE & SUGAR) and
- ECG
- Lipid Profile
- X Ray Chest

The Company can call for additional medical test(s) on the basis of declaration in proposal form or based on findings of first set of medical reports the entire cost of which have to be borne by the Insured.

XII. Portability

Insured(s) have an option to migrate from their existing health insurance policy at the time of renewal, provided the previous policy has been maintained without any break.

If the Insured is presently covered or has been continuously covered without any lapses then the waiting periods specified in Exclusion wordings of the Policy shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance policy.

i. From another company to Bharti AXA Policy

(i). If the proposed Insured Person was insured continuously and without a break under another Indian retail health insurance Policy with any other Indian General Insurance company or stand-alone Health Insurance Company, it is understood and agreed that:

(1) If Insured person wish to exercise the Portability Benefit, The Company should have received the application for portability and the completed Portability Form with complete documentation at least 45 days before the expiry of the existing insurance Policy.
(2) This benefit is available only at the time of renewal of the existing health insurance Policy.
(3) Portability benefit is available only upto the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring Policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/ waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.
(5) The Portability Benefit shall be applied by the Company within 15 days of receiving the completed Application and Portability Form from the proposer subject to the following:
   (a) Proposer shall provide the Company all additional documentation and/or information requested;
   (b) The proposer shall pay the Company the applicable premium in full;
   (c) The Company may, subject to medical underwriting, restrict the terms upon which the Company may offer cover, the decision as to which shall be in the Company sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.
   (d) There is no obligation on the Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if the proposer have given all documentation to the Company; This is subject to Company's Board approved Underwriting policy filed with Authority.

(e) The Company shall be received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance Policy through the IRDA's web portal.

ii. No additional loading or charges shall be applied by the Company exclusively for porting the policy.

ii. From the Company's existing health insurance policies to this Policy

(i) If the proposed Insured Person was insured continuously and without a break under another health insurance Policy with the Company, it is understood and agreed that:

(1) If the Insured wish to exercise the Portability Benefit, the Company should have received the Insured's application and completed Portability Form before the expiry of the existing insurance Policy;

(2) This benefit is available only at the time of renewal of existing health insurance Policy ;

(3) Portability benefit is available only upto the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority ;

(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority ;

(5) The Portability Benefit shall be applied by the Company within 15 days of receiving insured's completed Application and Portability Form subject to the following :

(a) Insured / Insured Person shall give the Company all additional documentation and/or information requests;

(b) Insured / Insured Person pay the Company the applicable premium in full;

(c) The Company may, subject to medical underwriting, restrict the terms upon which the company may offer cover, the decision as to which shall be in Company's sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.

(d) There is no obligation on Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if Insured/ Insured person have given all documentation ; This is subject to Company's Board approved Underwriting policy filed with Authority.

(ii) No additional loading or charges shall be applied by Company exclusively for porting the Policy.

The Company reserves the right to modify or amend the terms and the applicability of the Portability Benefit in accordance with the provisions of the regulations and guidance issued by the Insurance Regulatory and Development Authority as amended from time to time.

XIII. Exclusions under the Policy:

The Policy will not cover expenses relating to -

- Treatment of asthma, chronic nephritis and nephritis syndrome, gastro-enteritis, diabetes mellitus and insipidus, epilepsy, hypertension, influenza, cough and cold, all psychiatric or psychosomatic disorders, pyrexia of unknown origin for less than 10 days, tonsillitis and URTI, arthritis, rheumatism, as far as domiciliary hospitalisation is concerned.
- Pre-existing diseases / illness / injury / conditions. However, the same would be covered from the 5th year of the Policy after four continuous renewals with the Company without a break.

- Personal exclusions if any mentioned in respect of any one or more specific insured persons covered
- Any benefit under Critical illness within first 60 days of inception of the Policy for the first year. This exclusion doesn't apply for subsequent renewals with the Company without a break.
- Medical expenses incurred for treatment undertaken for disease or illness and/or for critical illness within 30 days of the inception date of this Policy. This exclusion doesn't apply for subsequent renewals with the Company without a break.
- Treatment of Cataract, Benign Prostatic Hypertrophy, Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy, Dilation and curettage, Hernia, hydrocele, congenital internal disease, fistula in anus, sinusitis, Skin and all internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant /adenoids and hemorrhoids, Dialysis required for chronic renal failure, Gastric and Duodenal ulcers and Joint Replacement surgeries unless necessitated by accident during the first two years of the operation of the Policy. However, this exclusion doesn't apply for subsequent renewals with the Company without a break.
- Circumcision unless necessary for treatment of a disease, illness or injury treatment of which is not excluded hereunder or due to an accident.
- Dental treatment or surgery of any kind unless requiring hospitalisation.
- Birth control procedures, hormone replacement therapy, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
- Routine medical, eye and ear examinations, cost of spectacles, laser surgery, contact lenses or hearing aids, vaccinations and inoculation of any kind, issue of medical certificates and examinations as to suitability for employment or travel.
- Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to accident or as a part of any disease/ illness / injury
- Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
- Vitamins and tonics unless forming part of treatment for disease, illness or injury.
- Treatment of obesity, general debility, convalescence, run down condition or rest cure, congenital external / internal disease/ illness or defects or anomalies, sterility, venereal disease or intentional self-injury and use of intoxicating drugs/alcohol.
- Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
- Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner
- Prostheses, corrective devices and medical appliances, which are not required intra-operatively or for the disease/ illness/ injury for which the Insured / Insured Person was hospitalised
- Sex change or treatment, which results from, or is in any way related to, sex change.
- Treatment of mental disease / illness, stress, psychiatric or psychological disorders.
- Treatment by a family member and self-medication or any treatment that is not scientifically recognized.
- Treatment from persons not registered as Medical Practitioners under respective medical councils
- Any criminal act.
- War, terrorism and nuclear group of perils.
- Disease / illness / injury whilst performing duties as a serving member of a military or a police force.

- Experimental and unproven treatment.
- Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment.
- Costs of donor screening or treatment, unless specifically covered and specified in the Schedule to this Policy.
- Naturopathy treatment.
- Any treatment received outside India.
- Insured/Insured Person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports.
- Insured/Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air charter company

Please refer the policy wordings for complete exclusion list.

XIV. Conditions to be fulfilled by the Insured / Insured person. (*This list is not exhaustive. For detailed conditions see the Policy)*

1. Premium payable under this Policy shall be payable in advance.
2. Completely and duly filled and signed proposal form Supporting Medical papers, previous policy copies, IRDAI portability form as applicable
3. Pre- Policy Check-up as per the grid
4. The Insured/Insured Person is required to ensure there is no misrepresentation, misdescription or nondisclosure of any material fact.
5. The Insured /Insured Person shall ensure due observance and fulfillment of the terms, conditions and endorsements on the Policy.
6. Every notice and communication to the Company shall be in writing addressed to the Policy issuing office of the Company.
7. Upon the happening of any event giving rise or likely to give rise to a claim under the Policy, the Insured /Insured Person shall -
   a. give immediate notice to the Third Party Administrator (TPA) named in the Schedule to the Policy, by calling the toll free number as specified therein or by sending written communication to the address of the TPA shown in the Schedule with all available information.
   b. deliver to the TPA at their own expenses within 30 days of the Insured's/Insured Person's discharge from the hospital (for post-hospitalisation expenses, completion of post-hospitalisation period or completion of treatment, whichever is earlier), any and all information and documents concerning the claim or the Company's liability for it.
   c. submit, if so required, to examination by a Medical Practitioner authorized by the Company.

XV. Terms of Renewal:

1. Maximum Age:

The Company offers life-long renewal unless the Insured Person or any one acting on behalf of an Insured Person has acted in an improper, dishonest or fraudulent manner or has made misrepresentation in relation to this policy or the Policy poses a moral hazard.

2. Renewal Premium:

The premium for renewal will be applicable as per the premium chart based on age and company will not load the premium for any adverse claims experience of particular insured.

The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDA) and inform the same to the Insured at least 3 months prior to the date of revision and/ or modification or renewal

3. Sum Insured Enhancement:

- The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company.

- The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the Company post underwriting.

- The enhancement can be made upto next available sum insured slab in the same plan without medicals, subject to no claim in the previous policies and Good Health Declaration, (upto 55 Years).

- In respect of insured beyond 55 years, medical reports as may be called for will be required.

- All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy in respect of such increased Sum Insured.

4. Grace period:

All applications for renewal of the policy must be received by us before the end of the policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy. However, there is no coverage for injury sustained or disease contacted during this period

5. In the likelihood of this policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the policy. Insured will have the option to migrate to other plan under similar health insurance policy at the time of renewal, provided the policy is maintained without a break.

XVI: Premium Rates

- As per the Premium Chart enclosed
- The premium under individual coverage will be charged on the completed age of the individual insured member
- The premium under family floater coverage will be charged on the completed age of the eldest insured member
- Premium rates can be revised subject to approval from the IRDA

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XVII. Termination/ Cancellation:

The Company may cancel this Policy, by giving 15 days notice in writing by Registered Post Acknowledgment Due to the Insured at his / their last known address. The company shall exercise its right to cancel only in case of non-cooperation of the Insured / Insured Person in implementing the terms and conditions of this Policy, mis representation, fraud, non disclosure of material facts in which case the the policy shall stand cancelled ab-initio and there will be no refund of premium.
The Insured may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period

scales. Provided however that refund on cancellation of Policy by the Insured shall be made only if no claim has occurred up to the date of cancellation of this Policy.

Period on Risk	Rate of Premium to be retained
Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	100%

XVIII: Claim Notification Multi Model Intimation:

It is the endeavour of BhartiAxa to give multiple options to the insured/covered person/patient's care taker to intimate the claim to the Third party administrator (TPA)/Company. The intimation can be given in following ways

- Toll Free call centre of the TPA (24x7)
- Toll Free call centre of the Insurance Company(24x7) - - **1800-103-2292**
- Login to the website of the Insurance Company and intimate the claim - http://www.bharti-axagi.co.in/contact-us
- Send an email to the TPA/Company - customer.service@bharti-axagi.co.in
- Post/courier to TPA/Company - Bharti AXA General Insurance Company Limited, 1st Floor, Ferns Icon, Survey No.28, Doddanekundi, Bangalore – 560037
- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 1st Floor, Ferns Icon, Survey No.28, Doddanekundi, Bangalore – 560037, Dial :+ 91 80 49123900

In all the above the intimations are directed to a central team for prompt, standardized action.

Information Details

When the insured/covered person/patient's care taker intimate the claim as mentioned above the following information should be kept handy & given for prompt services.

- Policy number
- Name of the Insured/Covered person
- Contact details
- Nature of the disease, illness or injury
- Name and address, phone number of the attending medical practitioner/hospital

Claim Form

Upon the notification of the claim the TPA/Company will dispatch the claim form to the Insured/Covered person. Claim forms will also be available with the network hospitals and Company offices and on its website

XIX Claim Procedure

Cashless hospitalisation:

- Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.
- List of network Hospitals is provided to the Insured/Covered person along with the Policy .Insured/Covered person can view the updated Hospitals list from the website of the TPA/Company too.
- Insured/covered person on admission (emergency) or willing to admit (planned admission) in the network Hospitals, a preauthorization request form has to be filled in by the treating

doctor/ Hospital and the same has to be faxed to the TPA by the insured/Hospital. The TPA after verifying the same will decide on the issuance of authorization after necessary discussion(approval) with insurance company. The action of pre-authorization will be done within 6 hours for emergency admission and 48 hours for planned admission.

- The preauthorization request form will be available in the guide issued along with the Policy, and also will be available in the Hospitals or can be downloaded from the website of the TPA/Company or can request for the same to the TPA/Company via email or fax or can be collected in person from the branches of the TPA/Company.
- Denial of the cashless does not mean the claim has been rejected. Such claims will be examined on merits and will be paid on reimbursement basis later if admissible.
- The Insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.
- The Insured/covered person need not pay any amount to the Hospital if he/she has received the authorization letter except;
  - If the bill amount is in excess of the Sum insured
  - Non-medical expenses
  - Unrelated treatments
  - Excess/deductible, if any which has to be borne by insured
- The Hospital will receive the payment from Company within 21 days from the date of receipt of complete claim documents.

Reimbursement claims

- All reimbursement claims should be intimated to TPA/Insurance company within 7 days from date of discharge.

- Insured/covered person admitted in a non-network Hospital can send the claim documents to the TPA/ Company for the reimbursement within 30 days from the date of discharge. However Pre and post hospitalization bills can be sent within 15 days from the end of post hospitalization period as specified in the Policy.

XX Claim Service Guarantee

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, tthe claim will be settled 30 days from the date of submission of the said documents. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid.

XXI Tax Benefit:

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

XXII Withdrawal:

In the likelihood of this policy being withdrawn in future, we will intimate you about the same 90 days prior to expiry of the policy. You will have the option to migrate to similar health insurance policy available with us at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines issued by IRDA.

XXIII Loading and / or exclusion

We may apply a risk loading on the premium payable and /or exclude an illness / disease (based upon the declarations made in the proposal form, investigation reports and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. 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).

We will inform you about the applicable risk loading and / or exclusion. You need to revert to us in writing with consent and additional premium (if any) and exclusion, within 15 days of such information. In case, you neither accept such loading and / or exclusion nor revert to us within 15 days, we shall cancel your application and refund the premium paid within next 7 days. Please note that we will issue policy only after getting your consent.

XXIV CUSTOMER SERVICE – SENIOR CITIZENS

In respect of Senior Citizens, both the Company and TPA have established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company or TPA for faster attention or speedy disposal of grievance, if any.

- Website : www.bharti-axagi.co.in
- Email : customerservice@bharti-axagi.co.in
- Phone : 080-49123900
- Courier : Any of the Company's Branch office or corporate office

Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday

XXV Exhibits of Benefits

SmartHealth_Exhibit of Benefits1.xls

GENERAL NOTE

- The Proposer can contact the agent / intermediary / any of our offices for a full version of the Policy document.
- This Policy is subject to IRDA - Protection of Policyholder's Interests Regulations, 2002.

14. PROHIBITION OF REBATES (UNDER SECTION 41 OF INSURANCE ACT, 1938)

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 prospectus or tables of the Insurers which shall be in conformity with regulations.

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

Disclaimer

This document 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 approach your insurance advisor if you require any further information or clarification.

Insurance is the subject matter of the solicitation. For more details you may refer to the Policy wordings which may be collected on request