

INDUSIND MOTOR ACCIDENTAL MEDICAL EXPENSES - PROSPECTUS

1. ELIGIBILITY CRITERIA

The Policy can be availed by owners of Motor Vehicles which are for personal use. The Policy shall cover the Owner and their Family members. Family members shall include:

- Legally wedded spouse
- Children (i.e. biological or legally adopted)
- Parents

2. SCOPE OF COVER

2.1. Base covers

The following base covers are available to the Insured, subject to the availability of the Sum Insured in the Policy.

In the event that the Insured meets with a Accident during the Policy Period, and the Insured sustains any Injury resulting solely and directly from the Accident, then the Company shall indemnify the Insured, up to limits specified in the Policy Schedule for the below mentioned Medical Expenses:

2.1.1. Hospitalization Covers

2.1.1.1. Accidental Medical Hospitalization

Medical Expenses incurred by the Insured Person during the Policy Period for Hospitalization solely and directly arising due to the Motor Accident.

The Medical Expenses as mentioned below shall mean the Reasonable and Customary Charges which include the following:

- i. Room Rent
- ii. Nursing expense
- iii. Intensive care Unit (ICU) charges
- iv. Medical Practitioner(s) fees
- v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
- vi. Medicines, drugs and consumables expenses
- vii. Diagnostic procedures expenses
- viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure, unless specifically excluded.

Provided that:

- i. Such Medical Expenses shall be the Reasonable and Customary Charges incurred for In-Patient Hospitalization or Daycare for such Injury to be covered under this Policy.
- ii. The Injury should have necessarily occurred as a direct result of a Motor Accident which is covered under the Policy and Hospitalization should have occurred within 24 hours of the Accident.
- iii. The Claims under this cover shall be available on both Cashless and Reimbursement basis.
- iv. Domiciliary Hospitalization and/or Out-Patient treatment shall not be covered under this cover.
- v. Any unutilized limit under this benefit shall not be carried forward to next Policy Period.
- vi. The cover shall be limited to the number of passengers

specified in the Policy Schedule.

2.1.1.2. Emergency Road Ambulance

Expenses incurred by the Insured Person on availing road Ambulance services offered by a Hospital or by an Ambulance service provider, provided

- i. The Company has accepted the Hospitalization claim under Benefit 2.1.1.1 Accidental Medical Hospitalization
- ii. The coverage includes the cost of the transportation of the Insured Person to the nearest Hospital in case of an emergency Life Threatening Medical Condition, or from one Hospital to another Hospital which is prepared to admit the Insured Person and provide the necessary medical services.
- iii. Such Life-Threatening Medical Condition is certified by the Medical Practitioner
- iv. The transportation from one Hospital to another Hospital has been prescribed by a Medical Practitioner and is medically necessary.

2.1.1.3. Post Hospitalization

Medical Expenses incurred in the 60 days immediately after the Insured Person was discharged post Hospitalization, provided that:

- i. Such costs are incurred in respect of the same condition for which the Insured has taken Hospitalization, and
- ii. The Company has accepted the claim for these Hospitalization expenses under Benefit 2.1.1.1 Accidental Medical Hospitalization

2.1.2. Accidental Medical OPD

Reasonable and Customary charges incurred by the Insured Person towards the following Out-patient expenses for Injury arising out of the Accident, provided that the expenses are directly associated with the Injury suffered due to the Accident:

- **OPD Consultations:** Expenses toward Consultation from a Medical Practitioner on Outpatient basis.
- **Pharmacy:** Expenses incurred towards prescription drugs prescribed by the consulting Medical Practitioner.
- **Diagnostic Tests:** Expenses incurred toward Diagnostic tests prescribed by the consulting Medical Practitioner and conducted on an Outpatient basis.
- **Minor Surgical treatments:** Minor surgical procedures (other than Day Care Procedures) such as plaster cast, synthetic cast, suturing, dressings for Accidents and animal bite related Outpatient procedures, for treatment of the Accidental Injury that are carried out by a Medical Practitioner, which are supported with requisite diagnostic results (wherever applicable).

Terms & Conditions:

- i. The expenses under this cover are to be necessarily incurred within 15 days of the occurrence of the Accident.
- ii. Condition Precedent: The claim for Diagnostic Tests and Pharmacy shall become payable only in relation to an OPD Consultation which is payable under this cover.
- iii. Expenses related to Pharmacy and Diagnostic services



must be substantiated with original bills issued by the Pharmacy or Chemist, based on a valid prescription from a Medical Practitioner.

- iv. The Pharmacy Bills must clearly show the price and bear the receipt stamp of the Pharmacy / Chemist.
- v. Dental Implants, CAD/CAM restorations and bone graft are not covered
- vi. Any unutilized OPD limit shall not be carried forward to next Policy period.
- vii. OPD Expenses for any Cosmetic/ routine preventive health check-ups / dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances shall not be covered.

2.1.3. Doctor Referral

The Company shall also assist the Policyholder in telephonically arranging contact details of the nearest available Medical Practitioner. However, the Company shall not be responsible for unavailability of Medical Practitioner within reasonable distance of the Accident site or the timeline within which the Medical Practitioner is able to reach at the Accident site or for the quality of service rendered by the Medical Practitioner. The Medical Practitioner's fees shall be borne by the Insured.

2.2. Optional Covers

The covers listed below are optional covers and are available to the Insured Persons, on payment of additional premium, subject to below mentioned terms, conditions, and exclusions.

2.2.1. Hospital Cash Cover

If the Company has accepted and paid a claim under 2.1.1.1 Accidental Medical Hospitalization, then the Company shall pay the Insured Person an amount equal to the Daily Cash amount specified in the Policy Schedule per day of Hospitalization, provided:

- i. The Daily Cash amount shall be payable for each 24 hours of continuous and completed Hospitalization as In-Patient.
- ii. The amount under this benefit shall be payable maximum up to 10 days in a Policy Year.
- iii. Time Deductible: If the Hospitalization is for less than a continuous and consecutive period of 24 hours, no amount shall be payable under this benefit. If the Hospitalization extends beyond a continuous and consecutive period of 24 hours, the Daily Cash amount shall be payable for each 24 hours exceeding this period.
- iv. Time Deductible shall be applicable on each and every In-Patient Treatment claim reported under the Policy.

3. SPECIFIC TERMS & CONDITIONS (APPLICABLE TO ALL COVERS)

- i. For the Claim to be payable under this Policy, Insured is required to submit to the Company appropriate evidence of the Accident for which the Claim is made.
- ii. The Insured Person is required to check the applicable list of Network Hospital in the Company's website or call center before availing the Cashless services.

4. EXCLUSIONS

4.1. Any claim arising out of or resulting from or traceable to:

- i. Intentional self-injury unless in self-defense or to save life, suicide or attempted suicide physical defect or infirmity.
- ii. Insured committing any breach of law with criminal intent.
- iii. Viral or Bacterial Infections (Except pyogenic infection which occurs through an Accidental cut or wound), Hernia.

- iv. While riding in the Motor Vehicle while the licensed capacity of the vehicle is exceeded.
- v. Whilst participating as the Driver, co-Driver or passenger of a motor vehicle during motor racing or trial runs.
- vi. Arising out of participation in any naval, military or air force operations whether in the form of military exercises or war games or actual engagement with the enemy, whether foreign or domestic.

4.2. Artificial Life support equipment: Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

4.3. Consequential losses: Consequential losses of any kind, be they by way of loss of profit, loss of opportunity, loss of gain, business interruption, market loss or otherwise, or any claims arising out of loss of a pure financial nature such as loss of goodwill or any legal liability of any kind whatsoever.

4.4. Complications in Pregnancy: Pregnancy, resulting childbirth, miscarriage, abortion, or complications arising out of any of these.

4.5. Charges other than Reasonable and Customary Charges: Any Medical Expenses which are not Reasonable and Customary Charges.

4.6. Claim not related to Accident: In Any claim related to a sickness, disease or medical disorder not directly related to the Accident.

4.7. Claim not supported by valid bill: If the claim is not supported by a copy of valid bill/receipt and related prescription of attending the Medical Practitioner/ Hospital/ Nursing Home.

4.8. Cosmetic Treatment: Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident 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.

4.9. Dietary Supplements & Substances: Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

4.10. Documentation Charges: Any charges incurred to procure any medical certificate, treatment/illness related documents pertaining to any period of Hospitalization/illness.

4.11. Domiciliary: Any expenses incurred on Domiciliary Hospitalization and Domiciliary treatment.

4.12. Excluded Providers: Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim. (For updated and detailed list of Excluded Providers refer website- www.indusindinsurance.com)

4.13. External durable medical equipment: Any expenses incurred on, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/ thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition.



4.14. Hearing Aids and spectacles: Any charges incurred on hearing aids, cost of spectacles, contact lenses, routine eye and ear examinations.

4.15. Investigation & Evaluation

- i. Expenses related to any admission primarily for diagnostics and evaluation purposes.
- ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

4.16. Limitation as to use: Any accidental loss damage and/or liability caused sustained or incurred whilst the Declared Motor Vehicle herein is Being used otherwise than in accordance with the Limitations as to Use

4.17. Medical Practitioner who is a member of the Insured's family: Treatments rendered by a Medical Practitioner who is a member of the Insured's family or stays with him/her.

4.18. Non-Allopathic Treatment: Expenses incurred for treatment of Accidental injuries by systems of medicines other than Allopathy

4.19. Non-Hospital Treatment: Treatment at a healthcare facility which is not a Hospital, except for Claim under 2.1.2 Accidental Medical OPD.

4.20. Non-Payable Items: All expenses listed in Annexure-A (List I) of the Policy Wording.

4.21. Nuclear and Radioactive substances: Any liability of whatsoever nature directly or indirectly caused by or contributed to by or arising from:

- i. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.
- ii. Nuclear weapons material
- iii. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
- iv. Nuclear, chemical and biological terrorism.

4.22. Other than Medically Necessary Treatment: Any treatment or part of a treatment that is not Medically Necessary Treatment

4.23. Occupational hazard: Expenses incurred in connection with Injury resulting due to participation in one's occupation.

4.24. Person serving in military: Persons serving in any branch of the Military, Navy or Air-force or any branch of Armed Forces or any paramilitary forces except during peace time.

4.25. Pre-existing condition: Any injury directly or indirectly arising out of or contributed to any pre-existing condition.

4.26. Reconstructive Surgery: Expenses incurred in connection with Reconstructive Surgery, unless such surgery is carried out immediately following the Accident, as part of the emergency response treatment immediately following the Accident.

For the purpose of this Policy, Reconstructive Surgery means Medically Necessary repair, replacement or reconstruction of Bone or soft tissue or nerves, carried out to restore the normal function of a body part.

4.27. Rest Cure, rehabilitation and respite care: Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- 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.

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

4.28. RMO charges and Service charges: Expenses related to any kind of RMO charges, service charge where nursing charges are also charged, night charges levied by the Hospital under whatever head.

4.29. Treatment taken outside Geographical coverage: Treatment taken outside the geographical limits opted.

4.30. Treatment outside Discipline: Treatment taken from anyone not falling within the scope of definition of Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication

4.31. Treatment other than by prescription: Any drugs or treatments which are not supported by a prescription.

4.32. Unproven Treatment: 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.

4.33. War: War (whether declared or not), civil war, invasion, act of foreign enemies, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraint or detainment, confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.

4.34. Wellness and Rejuvenation: Treatments received in health 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.

Subject otherwise to all other terms, conditions, limitation, and exclusions of the Policy.

5. GENERAL TERMS & CONDITIONS

5.1. Claim Procedure

5.1.1. Notification of Claim

- i. Intimation about an event or occurrence that may give rise to a claim under this policy must be given within 24 hours of its happening.
- ii. Claims for insurance benefits must be submitted to the Company not later than one (1) month after the completion of the treatment or after transportation of the mortal remains/ burial in the event of Death.
- iii. If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalization in an Emergency, the Company shall be informed within 24 hours of the admission of the Insured Person in Hospital..

Note: The Company will examine and relax the time limit mentioned herein above depending upon the merits of the case.

5.1.2. Claim Documents

Following are the basic documents required for All Claims under IndusInd Motor Accidental Medical Expenses:

- i. Details of Accident
- ii. Duly completed and signed Claim Form, in original
- iii. Photo Identity Proof of the Insured Person like Aadhar / PAN
- iv. KYC Documents
- v. Driving License of the Insured and the Driver
- vi. Copy of Medical/Medico Legal Certificate (wherever it is required as per the circumstance of the Accident) duly attested by the concerned Hospital



vii. Cancelled cheque/NEFT details

Following are the documents required for claim under each cover:

Cover Name	List of Claim Documents
Base Covers	
Hospitalization Covers	<ul style="list-style-type: none"> Medical Practitioner's prescription advising drugs / diagnostic tests / consultation Original bills, receipts and discharge card from the Hospital / Medical Practitioner Original bills from pharmacy / chemists Original pathological / diagnostic test reports and payment receipts Indoor case papers Discharge Summary from the Hospital Medical & Investigation reports Ambulance receipt and bill Any other medical, investigation reports, inpatient or consultation treatment papers as applicable Any other document as required by the Company to assess the Claim
<ul style="list-style-type: none"> Accidental Medical Hospitalization Emergency Road Ambulance Post Hospitalization 	
Accidental Medical OPD:	<ul style="list-style-type: none"> Medical & Investigation reports Prescriptions, and consultation papers of the treatment Any other document as required by the Company to assess the Claim
<ul style="list-style-type: none"> OPD Consultations Diagnostic tests Pharmacy Minor Surgical Procedures 	
Doctor Referral:	<ul style="list-style-type: none"> Details of Accident Details of Insured Person
Optional Covers	
Hospital Cash Cover	<ul style="list-style-type: none"> Same Documents as mentioned above for 2.1.1.1 Accidental Medical Hospitalization

5.1.3. Proportionate Deductions (Applicable to Section 2.1.1.1 Accidental Medical Hospitalization)

Subject to the other Terms and Conditions of this Policy, the Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

- The Insured Person chooses a higher room category than the category that is eligible as per the terms and conditions of the Policy. In this case, higher room category means a room category in which the room rent expenses charged by the Hospital is more expensive than the eligible room category as per the terms and conditions of the Policy.
- The Insured Person chooses a room category in which the room rent charges are more than the applicable Sum Insured sub-limit (in percentage or Rupee terms) on the room rent as per the Policy terms and conditions.

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization

Medical Expenses as mentioned in 2.1.1.1 Accidental Medical Hospitalization of the Policy wordings, barring the below mentioned expense break ups:

- Cost of Pharmacy and Consumables
- Cost of Implants and Medical Devices
- Cost of Diagnostics

The proportional reduction will be done in a manner consistent with the below table:

Sr. No.	Header	Explanation
I	Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
II	Eligible Room Rent Limit	Room Rent allowed as per policy is Single Private A.C Room (upto Deluxe Room)
A	Actual Medical Bills Incurred	As per submitted documents
	(-) Any expense not covered under Policy Benefits	
B	= Covered Medical Expenses	
	(-) Cost of Pharmacy and consumables, implants and medical devices and diagnostics	
D	= Covered Medical Expenses which shall be subject to Proportionate Deduction	
	(*) (Eligible Room Rent Limit)/(Actual Room Rent)	
E	= Claim after Proportionate Deduction	If Actual Room Rent is within eligibility, then no deduction to be applied [E=D]
	(+) Cost of Pharmacy and consumables, implants and medical devices and diagnostics	
F	= Assessed Claim amount	
	(-) Deduction for Copay	
G	= Ground up claim amount	
	(-) Deductions for Policy Deductibles and Limits	
H	= Payable claim amount	

Proportionate Deduction is subject to the following:

- Apart from the Associate Medical Expenses, no other expenses will be proportionately reduced.



indusindinsurance.com



022 4890 3009 (Paid)



74004 22200 (WhatsApp)

IRDAI Registration No. 103 IndusInd General Insurance Company Limited (Formerly known as Reliance General Insurance). An ISO 9001:2015 Certified Company For complete details on the benefits, coverage, terms & conditions and exclusions, do read the sales brochure, prospectus and policy wordings carefully before concluding sale. Registered & Corporate Office: 6th Floor, Oberoi Commerz, International Business Park, Oberoi Garden City, Off. Western Express Highway, Goregaon (E), Mumbai-400063. Corporate Identity Number: U66603MH2000PLC128300. IndusInd Motor Accidental Medical Expenses. UIN No.: IRDAN103RPM0001V01202526. IGI/MCOM/CO/IMAME/PROSPECTUS/Ver.1.0/300126.



IndusInd
Insurance App



Download Now



- ii. If the given Hospital do not follow differential billing or if there are items in the claim for which the Hospital do not follow differential billing, the Company shall not be proportionately reducing the Claims. This shall be applied in case of admissions in Government Hospitals and the Network Hospitals of the Company.
- iii. ICU charges shall not be proportionately reduced in all cases.

5.1.4. 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 date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 30 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 30 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(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)

5.1.5. Payment Terms

- i. The payments under this Policy shall be made in INR. The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of payment to the Hospital shall be used for conversion of amounts settled in other currency into INR for calculation of claim payments under this Policy. If the RBI rates are not published on the date of the Insured Person's discharge from the Hospital, the exchange rate next published by the RBI shall be considered for currency conversion.
- ii. Claims shall not be admissible under this Policy unless the Company's Empaneled Service Provider/TPA/Company has been provided with the complete documentation / information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.
- iii. The Company will only be liable to pay for such Benefits for which the Policyholder/ Insured Person has specifically claimed in the Claim Form.
- iv. The Sum Insured shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Year.

5.1.6. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, Insured person may contact the Company through:

Website: www.indusindinsurance.com

022-4890 3009 (Paid)

Dedicated Senior Citizen helpline: 022-33834185 (paid line)

E-mail: services@indusindinsurance.com

Fax: +91 22 3303 4662

Courier:

IndusInd General Insurance Co. Limited

No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Kishe Sapphire, Madhapur, Hyderabad - 500 081

5.2. Condition Precedent to Admission of Liability

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

5.3. 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).

5.4. 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 maybe, 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.

5.5. Multiple Policies

- i. In case of multiple policies taken by the Policyholder or Insured during a period from one or more insurers to indemnify treatment costs, the Insured 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 Insured shall 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;
- ii. Insured having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other Policy / Policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy;
- iii. If the amount to be claimed exceeds the sum insured under a single Policy, the Insured shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- iv. Where the Policyholder has policies from more than one insurer to cover the same risk on indemnity basis, the Policyholder shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

5.6. Fraud

If any claim made by the Insured, 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 or anyone acting on his/her behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no court action or suit is commenced within twelve months after such rejection, 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 or by his agent or the Hospital/doctor/any other party acting on behalf of the Insured, with intent to deceive the insurer or to induce the insurer to issue an Insurance Policy:

- The suggestion, as a fact of that which is not true and which the Insured does not believe to be true;
- The active concealment of a fact by the Insured having knowledge or belief of the fact;
- Any other act fitted to deceive; and
- Any such act or omission as the law specially declares to be fraudulent.

The Company shall not repudiate the Policy on the ground of fraud, if the insured person / beneficiary can prove that the mis-statement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the Company. Onus of disproving is upon the Policyholder, if alive, or beneficiaries

5.7. Notice and Communication

- Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- The Company shall communicate to the Policyholder at the address or through any other electronic mode mentioned in the schedule.
- Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail
- Agents are not authorized to receive notices and declarations on the Company's behalf.

5.8. Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

5.9. Cancellation and Refund

5.9.1. In case of no claim in the Policy

i. Cancellation by Company:

The company may cancel the policy by sending Seven days' notice by recorded delivery to the Policyholder at the Policyholder's last known address in the event of cancellation of this policy on the grounds of fraud, the policy shall stand cancelled ab-initio and the return premium calculated as per following point shall be retained by the Company.

ii. Cancellation by Policyholder:

The policy may be cancelled at any time during the term, by informing the insurer without assigning any reason provided no claim has arisen during the period of insurance. In the event of cancellation by the Policyholder the refund amount shall be on pro-rata basis and shall be calculated as per the terms laid out below:

Calculation of Pro-Rata refund:

$$\text{Return Premium} = \text{Policy Year Premium} * \left(1 - \left(\frac{\text{Number of Policy days expired}}{\text{Total Days in Policy Year}} \right) \right)$$

For e.g. If Policy Premium for a 365 policy is Rs. 900, and if cancellation is effected on expiry of 243 days from policy inception, then The Return Premium = 900 * (1- (243 / 365)) = 300.82

5.9.2. In case of claim in the policy

Where any claim has been admitted or has been lodged by the Insured under the Policy, there shall be no refund of premium for the Policy period.

5.10. Nomination

The Insured 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/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.

5.11. Material Change

The Policyholder shall immediately notify the Company in writing of any material change in the risk at his own expense and the Company may adjust the scope of cover and/or premium, if necessary, accordingly.

5.12. Records to be maintained

The Policyholder shall keep an accurate record containing all relevant medical records until final adjustment (if any) and resolution of all Claims under this Policy and shall allow the Company or its representative(s) to inspect such records. The Policyholder shall furnish such information as the Company may require under this Policy.

5.13. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder which is in possession of the Company and not specifically informed by the Policyholder shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium

5.14. Policy disputes:

Any and all disputes or differences under or in relation to validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and subject to Indian law.

5.15. Geographical Area

The Geographical Area of coverage under this Policy shall be the geographical boundaries of the Republic of India.

5.16. Jurisdiction

The Policy is subject to the exclusive jurisdiction of the Courts of India.

5.17. Limitations to Use

The Policy doesn't cover Accident in connection with use of Motor Vehicle by Insured for any purpose as mentioned here;



- i. Hire or Reward
- ii. Carriage of goods (other than samples or personal luggage)
- iii. Organized racing
- iv. Pace making
- v. Speed testing
- vi. Reliability trials
- vii. Any purpose in connection with Motor Trade

5.18. Procedure for Cashless and Reimbursement of claims

A. Cashless

Cashless facility is available only at a Network Hospital. The Insured can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured:

- i. Pre-authorization: Prior to Hospitalization, the Policyholder/ Insured must call the call center of the Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.
- ii. The Company will process the Policyholder's/ Insured's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Policyholder/ Insured and the Company will confirm such Cashless authorization / rejection in writing or by other means.
- iii. If the procedure above is followed and the Policyholder's/ Insured's request for Cashless facility is authorized, the Policyholder/ Insured will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit). Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.
- iv. The Company reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Policyholder/ Insured shall, in any event, be required to settle all other expenses, copayment and/ or deductibles (if applicable), directly with the Hospital.
- v. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.
- vi. There can be instances where the Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder/ Insured may be required to pay for the treatment and submit the Claim for reimbursement to the Company which will be considered subject to the Policy Terms & Conditions.
- vii. The Policyholder/ Insured shall be required to submit the documents with the Network Hospital.

Note: Under Cashless facility, the Company may authorize upon the Policyholder's / Insured's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the Company. In such cases, the Company will directly settle all eligible amounts as per the Policy Terms & Conditions with the Network Hospital to the extent the Claim is covered under the Policy.

The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured is required to check the applicable list of Network Hospital on the Company's website.

B. Reimbursement:

- i. In case of any Claim under the Benefits, where Cashless Facility is not availed, the list of documents shall be provided by the Policyholder/Insured, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured's expense to avail the Claim.
- ii. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to any adult Insured in the Policy whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.19. Responsibility of Policyholder/ Insured Person

- i. Forthwith intimate / file / submit a Claim in accordance with Clause 6.1 of this Policy.
- ii. If so requested by the TPA/Company, the Insured Person will have to submit himself for a medical examination by the Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.
- iii. The Policyholder/ Insured Person is required to check the applicable list of Network Hospitalization the TPA/ Company's website or call center before availing the Cashless services.
- iv. On occurrence of an event which will lead to a Claim under this Policy, the Policyholder/ Insured Person shall:
 - Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
 - Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
 - If the Policyholder / Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

5.20. Limitation Period

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 5.1 above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable.



6. GRIEVANCE

In case of any grievance the Policyholder may contact the Company through

- i. Website: www.indusindinsurance.com
- ii. Call: 022 4890 3009 (paid)
Dedicated Senior Citizen helpline: 022-33834185 (paid line)
- iii. E-mail: grievances@indusindinsurance.com
- iv. Fax: +91 22 3303 4662
- v. Courier: Any branch office, the correspondence address, during normal business hours.
Write to us at: IndusInd General Insurance, (Correspondence Only) Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

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:

Grievance Redressal Officer

The Grievance Cell,

IndusInd General Insurance Co. Limited

No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad – 500 081.

Grievance Redressal officer email ID:

headgrievances@indusindinsurance.com

For updated details of grievance officer, kindly refer the link <https://www.indusindinsurance.com/Insurance/About-Us/Grievance-Redressal.aspx>

7. COVERAGE SUMMARY

Note: The coverage is subject to limits and deductibles specified in the Policy Schedule. Please refer to the entire Policy Wording for detailed Terms and Conditions of Coverage.

Cover Name	Indemnity/ Benefit	Individual/ Floater
Base Covers:		
1. Hospitalization covers		
1.1. Accidental Medical Hospitalization	Indemnity	Floater
1.2. Emergency Road Ambulance	Indemnity	Floater
1.3. Post-hospitalization	Indemnity	Floater
2. Accidental Medical OPD	Indemnity	Floater
<ul style="list-style-type: none"> • OPD Consultations • Pharmacy • Diagnostic tests • Minor Surgical Procedures 		
3. Doctor referral	(Assistance Service)	
Optional Cover:		
4. Hospital Cash Cover	Benefit	Individual

