

INDUSIND HEALTH SURROGATE AND OOCYTE DONOR RIDER - PROSPECTUS

SECTION 1: ELIGIBILITY CRITERIA

- a. Who can buy this Rider: The Policy can be availed by existing customers (Intending Couple/Intending Woman) of IndusInd General opting for childbirth through Surrogacy or Oocyte donation.
The Intending Couple or Intending Woman shall fulfil all the conditions laid out in The Surrogacy (Regulation) Act, 2021 or The Assisted Reproductive Technology (Regulation) Act, 2021 as applicable.
- b. Who will be covered by the Rider cover: the Surrogate Mother or the Oocyte Donor.
- c. When can this Rider be bought: The Intending Couple or Intending Woman can purchase this rider with the Base Policy offered by IndusInd General during renewal or in the mid of the policy year of the Base Policy, after screening of the Surrogate Mother or Oocyte Donor is completed and relevant certificate is obtained.

SECTION 2: POLICY PERIOD

This Policy will be issued for a period as below:

- For Surrogate Mother: 3 years from the start date of Rider
- For Oocyte Donor: 1 year from the start date of Rider

SECTION 3: SUM INSURED OPTIONS

Sum Insured options are as below,

Type of Policy	Individual Policy
Sum Insured (In INR)	5,00,000 and 10,00,000

Note: Sum Insured opted under this Rider cannot be greater than sum insured opted under the base policy

SECTION 4: COVERAGE

The covers listed below are in-built Policy benefits and shall be available to Insured Persons in accordance with the procedures set out in this Policy.

4.1. Hospitalization Expenses

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital /Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
- ii. Intensive Care Unit (ICU) | Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.
- iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor | surgeon or to the hospital
- iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits
- ii. Dental treatment, necessitated due to disease or injury
- iii. Plastic surgery necessitated due to disease or injury
- iv. All the day care treatments
- v. Expenses incurred on road Ambulance subject to a maximum of Rs. 2000/- per hospitalisation

Note:

1. Expenses of Hospitalization for a mini mum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/ payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs. 40,000/-, whichever is lower, per each eye in one policy year.

4.4. Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

4.5. Post Hospitalization

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

4.6. Modern Treatment

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the Policy Schedule, during the Policy Period:

- A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
- B. Balloon Sinuplasty
- C. Deep Brain stimulation
- D. Oral chemotherapy
- E. Immunotherapy- Monoclonal Antibody to be given as

injection

- F. Intra vitreal injections
- G. Robotic surgeries
- H. Stereotactic radio surgeries
- I. Bronchical Thermoplasty
- J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment) K.
- K. IONM - (Intra Operative Neuro Monitoring)
- L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.7. The expenses that are not covered in this policy are placed under List-I of Annexure-A attached to the Policy document. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

SECTION 5: CUMULATIVE BONUS

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

- i. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

SECTION 6: WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

6.1. Pre-Existing Diseases(Code: Excl 01)

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

This exclusion shall not apply in case of medical complications arising within 6 weeks of childbirth through Surrogacy.

6.2. First Thirty Days Waiting Period (Code: Excl 03)

- i. 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.
- ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

6.3. Specific Waiting Period (Code: Excl 02)

- a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
- b) 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.

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

i. 24 months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age-related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

SECTION 7: EXCLUSIONS (APPLICABLE TO ALL BENEFITS UNDER THE POLICY)

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

7.1. Standard Exclusions

7.1.1. Investigation & Evaluation (Code: Excl 04)

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

7.1.2. Rest Cure, rehabilitation and respite care (Code: Excl 05)

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

- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7.1.3. Obesity/ Weight Control (Code: Excl 06):

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

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

2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
 - a) greater than or equal to 40 or
 - b) 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:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

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

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

7.1.5. Cosmetic or Plastic Surgery (Code: Excl 08):

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

7.1.6. Hazardous or Adventure sports (Code: Excl 09):

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

7.1.7. Breach of law (Code: Excl 10):

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

7.1.8. Excluded Providers (Code: Excl 11):

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations 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)

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

7.1.10. Treatments received in health spas, 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)

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

7.1.12. Refractive Error (Code: Excl 15):

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

7.1.13. Unproven Treatments-Code (Code: Excl 16):

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

7.1.14. Sterility and Infertility (Code: Excl 17):

Expenses related to sterility and infertility. This includes:

- i. Any type of contraception, sterilization
- ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- iii. Gestational Surrogacy
- iv. Reversal of sterilization

7.1.15. Maternity Expenses (Code - Excl 18)

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

7.2. Specific Exclusions

7.2.1. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

7.2.2. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
- b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
- c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

7.2.3. Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

7.2.4. Treatment taken outside geographical limits of India.

7.2.5. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

7.2.6. Any Surrogacy or Oocyte donation procedure carried out outside geographical limits of India.

7.2.7. Screening and processing charges for Surrogacy and Oocyte donation shall not be payable.

7.2.8. Costs associated with Surrogacy and Oocyte donation procedure itself and the associated maternity expenses shall not be payable.

SECTION 8: 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 grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

SECTION 9: PRE POLICY MEDICAL CHECK UP (PPMC)

Medical Underwriting: The underwriter may carry out tele underwriting depending on the details and declarations provided in the Proposal form.

The Company may also ask for Pre-Policy Medical Check-up on case-to-case basis depending on the Tele underwriting outcome.

In case the Insured Person undergoes a medical check-up then 100% cost for such test shall be borne by the Company, where the Proposal is accepted, and Policy is issued.

The cases where the Proposal is rejected, or the Proposer denies the accepted proposal then 100% cost for such tests shall be borne by the Customer.

SECTION 10: CLAIMS PROCEDURE

10.1. Procedure for Cashless claims:

- i. Treatment may be taken in a network provider and is subject to pre-authorization by the Company or its authorized TPA.
- ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
- iii. The Company/ TPA upon getting cashless request form and related medical information from the Insured Person/ network provider will issue pre-authorization letter to the hospital after verification.

The Pre-auth request shall be processed after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is being sought and the TPA/Company will confirm such Cashless authorization / rejection in writing or by other means. There may be initial partial approval of the cashless amount requested which can be enhanced subsequently subject to review of the utilization.

If the procedure above is followed and the request for Cashless is authorized, the Insured Person shall 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 TPA/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 Insured Person shall, in any event, be required to settle all other non-medical and inadmissible expenses, co-payment and / or deductibles (if applicable), directly with the Hospital.
- v. There can be instances where the TPA/Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the TPA/Company which will be considered subject to the Policy Terms & Conditions.
- vi. The documents mentioned under 10.4 Documents to be submitted are required to be submitted to the Company.

Note: Under Cashless facility, the TPA/Company may authorize upon the request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the TPA/Company. In such cases, the TPA/ 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 TPA/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 Insured Person is required to check the applicable list of Network Hospital on the TPA/Company's website.

10.2. Procedure for Reimbursement of Claims

For Reimbursement of claims the insured person may submit the documents to TPA (If applicable) company within the prescribed time limit as specified hereunder,

Sr. No.	Type of claim	Prescribed Time Limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within fifteen days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

10.3. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

- i. Within 24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

The following details are to be provided to the TPA/Company at the time of intimation of Claim:

- a. Policy Number
- b. Name of the Policyholder,
- c. Name of the Insured Person in whose relation the Claim is being lodged.
- d. Nature of Illness / Injury
- e. Name and address of the attending Medical Practitioner and Hospital
- f. Date of Admission to Hospital or proposed date of admission to Hospital for Planned Hospitalization
- g. Any other information as requested by the Company.

10.4. Documents to be submitted

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

- i. Duly Completed claim form, in original
- ii. Photo Identity proof of the patient
- iii. Photo Identity proof of the Intending Couple or Intending Woman
- iv. Medical Practitioner's referral letter advising Hospitalization
- v. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
- vi. Original bills with itemized break-up
- vii. Payment receipts
- viii. Discharge summary including complete medical history of the patient along with other details.
- ix. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
- x. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
- xi. Sticker/Invoice of the Implants, wherever applicable.
- xii. Indoor case papers
- xiii. Ambulance receipt and bill
- xiv. MLR (Medico Legal Report co-pay if carried out and FIR (First information report) if registered, where ever applicable.
- xv. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
- xvi. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
- xvii. Legal heir/succession certificate, wherever applicable

- xviii. Proof of Surrogacy/Oocyte donation including the date of procedure
- xix. Details of Surrogacy/ART clinic
- xx. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

10.5. Payment of claim

All claims under the policy shall be payable in Indian currency only.

SECTION 11: CANCELLATION

- a. The Policyholder cannot cancel this Rider once opted under the Base Policy .
- b. The Company may cancel the Policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

SECTION 12: AUTOMATIC CHANGE IN COVERAGE UNDER THE POLICY CANCELLATION

The coverage for the insured Person(s) shall automatically terminate in the case of his/ her (Insured Person) demise.

SECTION 13: AUTOMATIC TERMINATION

If the Base Policy terminates then the rider attached to the Base Policy shall also terminate.

SECTION 14: PORTABILITY

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/ Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

- i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
- ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer - www.irdai.gov.in (Circular IRDA/HLT/REG/CIR/003/012020, dated 01012020)

Section 15: Renewal of Policy

The policy is not ordinarily renewable.

SECTION 16: 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 migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI

guidelines, provided the policy has been maintained without a break

SECTION 17: 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 affected.

SECTION 18: FREE LOOK PERIOD

The Free Look Period shall be applicable at the inception of the Rider Policy. And not at the time of porting the policy.

The insured shall be allowed a period of thirty days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. A refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
- ii. Where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

SECTION 19: REDRESSAL OF GRIEVANCES

In case of any grievance the Insured Person may contact the Company through

Website: www.indusindinsurance.com

Toll free: 022 4890 3009 (paid)

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

E-mail: services@indusindinsurance.com

Fax: +91 22 3303 4662 Courier: Any branch office, the correspondence address, during normal business hours.

Write to us at: IndusInd General Insurance, (Correspondence Only) Correspondence Unit, Winway Building 2nd & 3rd Floor, 11/12 Block No-4, Old no-67, South Takoganj, Indore (M.P)-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://indusindinsurance.com/Insurance/About-Us/Grievance-Redressal.aspx>

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.

The contact details of the Insurance Ombudsman offices have been provided as Annexure-B

Grievance may also be lodged at IRDAI Integrated Grievance Management System <https://igms.irda.gov.in/>

Insurance is the subject matter of solicitation

Policyholder can reach us through any of the following methods for any service related issue and assistance:

Claims Servicing	
Name:	Health Care
Correspondence Address:	IndusInd General Insurance. No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block Krishe Sapphire, Madhapur, Hyderabad - 500081.
Contact No.:	022 4890 3009 (paid)
E-mail:	healthcare@indusindinsurance.com
Fax No.:	022 4890 3009

1. ANNEXURE 1- RATE CHARTS

The below is the rate chart for this product:

Premium Rate Chart for Single Life (Premium and SI in INR):

Age Band	5,00,000	10,00,000
23-25	3,807	4,424
26-30	4,732	5,496
31-35	5,884	6,836
36-37	7,347	7,775

2. ANNEXURE 2- PREMIUM ILLUSTRATION

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

Premium Illustration for a non floater policy (SI and Premiums in INR)						
Member details [A]	Age [B]	Relationship [C]	SI [D]	Premium from the Rate Chart [E]	Medical Loading [F]	Final Premium [G = D*(1+F)]
Member 1	30	Self	500000	4,732	0%	4,732

Note:

- The Premiums above are annual premiums exclusive of taxes and levies
- Age Band shall be basis Age of the Insured (Surrogate Mother or the Oocyte Donor)
- For 3 years policy, age at each Policy Year shall be considered

Discounts/Loading

There are some loading and discounts built into the product these are:

Adjustment Factor	Rationale for providing this discount	Maximum Adjustment
Discount for 3 year policy		10%
Medical Underwriting Loading	Depending upon the medical result loading up to 150% per life. 100% per illness condition.	Maximum 150% per life

