भारतीय बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND
DEVELOPMENT AUTHORITY OF INDIA

Ref: IRDA/HLT/GDL/MISC/036/02/2021

25th February,2021

Guidelines on Standard Personal Accident Insurance Product

INDEX

To
All General and Health Insurers,

Re: Guidelines on Standard Personal Accident Insurance Product

A. Preamble:

1. The insurance market is having a wide variety of personal accident insurance products. Each product has unique features and the insuring public may find it a challenge to choose an appropriate product. Therefore, with the objective of having a standard product with common coverage and policy wordings across the industry, the Authority has decided to mandate all general and health insurers to offer the standard personal accident insurance product.

2. Towards this, the following Guidelines on Standard Personal Accident Insurance Product are issued under the provisions of Section 34 (1) (a) of Insurance Act, 1938.

3. The standard product shall have the basic mandatory covers as specified in these Guidelines which shall be uniform across the market.

4. The optional covers as specified shall only be offered along with the standard product.

5. The insurer may determine the price keeping in view the covers proposed to be offered subject to complying with the norms specified in the IRDAI (Health Insurance) Regulations, 2016 (HIR, 2016) and Guidelines notified there under.

6. The policy tenure of the standard product shall be for a period of one year.

7. The standard Product shall comply with all the provisions of IRDAI (Health Insurance) Regulations, 2016, all other applicable Regulations, Consolidated Guidelines on Product filing in Health Insurance Business (Ref: IRDAI/HLT/REG/CIR/194/07/2020 dated 22nd July, 2020), Master Circular on Standardization of Health Insurance Products (Ref: IRDAI/HLT/REG/CIR/193/07/2020 dated 22nd July, 2020) and other applicable Guidelines as amended from time to time.

8. Every General and Standalone Health Insurer, who has been issued a Certificate of Registration to transact General and/or Health Insurance Business, shall mandatorily offer standard Individual Personal Accident product.
9. This product is allowed to be offered as a group product also.

B. Construct of Standard Personal Accident (PA) Product: The Standard Personal Accident Product shall offer the following covers.

10. **Base Covers**:

a) **Death:** Benefit equal to 100% of Sum Insured shall be payable on death of the insured person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident.

b) **Permanent Total Disablement:** Benefit equal to 100% of Sum Insured shall be payable if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:
   a) Total and irrecoverable loss of sight of both eyes or
   b) Physical separation or loss of use of both hands or feet or
   c) Physical separation or loss of use of one hand and one foot or
   d) loss of sight of one eye and Physical separation or loss of use of hand or foot
   e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

c) **Permanent Partial Disablement:**
Sum Insured specified below shall be payable if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

	Loss Covered	**Percentage of Sum Insured**
1.	Loss of Use/ Physical Separation: One entire hand One entire foot Loss of Sight of one eye Loss of toes – all Great both phalanges Great – one phalanx Other than great if more than one toe lost	 50% 50% 50% 20% 5% 2% 1%
2.	Loss of Use of both ears	50%
3.	Loss of Use of one ear	20%
4.	Loss of four fingers and thumb of one hand	40%

5.	Loss of four fingers	35%
6.	Loss of thumb - both phalanges - one phalanx	 25% 10%
7.	Loss of Index finger - three phalanges two phalanges one phalanx	 10% 8% 4%
8.	Loss of middle finger – three phalanges two phalanges one phalanx	 6% 4% 2%
9.	Loss of ring finger - three phalanges two phalanges one phalanx	 5% 4% 2%
10.	Loss of little finger – three phalanges two phalanges one phalanx	 4% 3% 2%
11.	Loss of metacarpus - first or second (additional) third, fourth or fifth (additional)	 3% 2%
12.	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to sum insured chosen by the policyholder.

Note:

a) The base sum insured chosen and cumulative bonus, if any is applicable cumulatively for all the three covers specified under 10(a),10(b) and 10(c) above i.e, there is a single sum insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.

b) If the accident occurs during the policy period, benefits covered under 10(a),10(b) and 10(c) above are payable, even if death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of policy period, but within 12 months from the date of accident.

11. **Optional Covers:**

a) Temporary Total Disablement:

If the Insured Person sustains an Injury in an Accident during the Policy Period and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable

of performing at the time of the Accident (Temporary Total Disablement), compensation shall be payable, at the rate of 0.2% of the base sum insured per week, till the time the insured person is able to return to work, provided that:

(i) Such period of temporary total disablement exceeds 4 weeks, however, benefit shall be payable for the entire duration of disablement.

(ii) The compensation payable under this benefit mentioned under Section 11(a), shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the Sum Insured.

(iii) The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident.

(iv) The compensation payable, shall be paid by the insurer at quarterly intervals, after ascertaining the amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period.

(v) During the course of payment under this benefit, the insurance company shall have right to call for a certification from an independent medical practitioner with regard to the continuity of temporary total disability specified under this section.

b) **Hospitalisation Expenses due to Accident**: Hospitalisation expenses arising due to accident shall be indemnified up to the limit of 10% of base sum insured.

The hospitalisation expenses shall cover the following:

i. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
ii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.

(*Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day*.)

iv. Intensive Care Unit **(ICU)** / Intensive Cardiac Care Unit **(ICCU)** expenses
v. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure carried out to treat the accidental injury covered under the policy
vi. Expenses incurred on hospitalization due to accident, under AYUSH (as defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

The following expenses necessitated due to injury shall also be covered under the optional cover specified under Section 11(b):

i. Dental treatment.
ii. Plastic surgery.
iii. All the day care treatments.
iv. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

c) Education Grant:

Following an admissible claim of the insured person under the policy towards Death or Permanent Total Disability of the insured person, a one-time Educational Grant of 10% of the Base Sum insured, per child, shall be payable, to all dependent children of the Insured provided that:

a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.
b) Age of the child or children as the case shall not be more than 25 completed years.

Note:

i. The benefits payable under each of the covers 11(a),11(b) and 11(c) are independent and over and above the base sum insured.
ii. Claim admissibility under the optional covers "Temporary total disablement" and "hospitalization due to accident" is independent of claim admissibility under the base covers.

12. **Cumulative Bonus (CB)**: Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued. The cumulative bonus is applicable only in respect of base covers referred at Section 10.

13. No deductibles are permitted in this product.

C. Other Norms applicable for Standard Personal Accident (PA) Product:

Sl.No	Particulars	Norms Applicable
1.	Plan Variants	No plan variants are allowed.
2.	Distributions Channels	Standard PA product may be distributed across all distribution channels including Point of sale persons and Common Public Service Centres, but must necessarily be offered through online channel by all insurers.

		Distribution of standard PA product shall be governed by the regulations of concerned distribution channels.
3.	Individual Basis	Standard PA product shall be offered on Individual basis. When offered as a family cover, the chosen sum insured shall apply to each family member separately.
4.	Definition of family	Family consists of the proposer and any one or more of the family members as mentioned below: (i) legally wedded spouse. (ii) Parents and Parents-in-law. (iii) dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
5.	Category of Cover	The base covers of Standard PA product and the optional covers “temporary total disablement benefit” and “Education grant” shall be offered on benefit basis. The optional cover “Hospitalisation Expenses due to Accident” shall be offered on indemnity basis.
6.	Grace Period for premium payment	Standard product shall comply with Regulation 2(i)(e) of HIR 2016 at the time of renewal of the policy. For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
7.	Minimum and Maximum Sum Insured	Minimum sum insured shall be Rs.2.5 lakhs and maximum sum insured shall be Rs.1 Crore. Sum insured offered shall be in multiples of Rs 50,000/-. Beyond the range specified above, insurers can offer on their own and can use the same name for the product if all terms and conditions remain the same.
8.	Policy tenure	The individual standard PA product shall be offered with the policy tenure of one year.
9.	Modes of premium payment	All the modes (Yly, Hly, Qly, Mly) shall be allowed for the standard PA product.

		ECS (Auto Debit facility) is also allowed in respect of the above mentioned modes.
10.	Entry age	Minimum entry age shall be 18 years and maximum age at entry shall be at least 70 for the insured members including principal insured. Insurers are permitted to fix the maximum age at entry beyond 70 years, subject to underwriting policy. Dependent Child / children shall be covered from the age of 3 months to 25 years subject to the definition of 'Family' and underwriting policy.
11.	Benefit Structure	The benefit pay out should be explicitly disclosed in the format of application (Form – IRDAI-UNF-PASP) along with other relevant documents.
12.	Underwriting	Underwriting of the proposals received under this product shall be based on the board approved underwriting policy.
13.	Pricing	Insurer shall disclose applicable premium rates in the prospectus and other relevant documents. The prices may be displayed on the websites of the insurers.

D: Construct of Terms and Conditions for Standard Product:

14. The Policy Terms and Conditions of the Standard Product shall be in the format specified in Annexure – 1. Insurer may suitably modify the definitions and other clauses of the policy contract prospectively based on the Regulations or Guidelines that may be issued by the Authority time to time.

15. Insurers are allowed to use the name of standard product for the group policy by adding the word "group". However, the benefit structure of the standard policy remains the same except premium rate and specification of terms and conditions suitable to group policy.

E: Other Norms:

16. The nomenclature of the product shall be Saral Suraksha Bima, succeeded by name of insurance company (Saral Suraksha Bima, <name of insurer>). No other name is allowed in any of the documents.

17. The Proposal Form used for the product shall be subject to the norms specified under the Consolidated Guidelines on Product Filing in Health Insurance.

18. Insurers shall mandatorily issue Customer Information Sheet as per the format specified in Annexure-2.

19. The Standard product shall be launched without prior approval of the Authority subject to complying with the following conditions.
    - **a.** The product shall be approved by the Product Management Committee.
    - **b.** Insurers shall obtain UIN for the standard product by filing the relevant particulars in Form – IRDAI-UNF-PASP (as specified in Annexure – 3 of these Guidelines) along with a certificate from Chief Compliance Officer that the product filed is in compliance with the norms specified under these guidelines.
    - **c.** On review of the application, the Authority may call for such further information as may be required and may issue suitable directions which shall be retrospectively effected in respect of all contracts issued under this product.

20. General and Health Insurers shall offer this product from 01st April, 2021 onwards.

21. This has the approval of the competent authority.

Sd/-
General Manager (Health)

Annexure-1

Saral Suraksha Bima, [Company Name]

1. PREAMBLE

This Policy is a contract of insurance issued by *[name of the Company]* (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

Any amount payable under the policy shall be subject to the terms of coverage, exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured and Cumulative Bonus (if any) specified in the Schedule.

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and third gender and references to any statutory enactment includes subsequent changes to the same.

3.1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy

3.3. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

3.4. **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.5. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

3.6. Day Care Treatment:

Day care treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

ii. which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.7. Disclosure to information norm: 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.

3.8. Emergency Care: Emergency care means management for an injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

3.9. Family: Family consists of the proposer and any one or more of the family members as mentioned below:

(iv) legally wedded spouse.

(v) Parents and Parents-in-law.

(vi) dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

3.10. Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.11. **Hospitalisation** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

3.12. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

3.13. **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

3.14. **Insured Person** means person(s) named in the schedule of the Policy.

3.15. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

3.16. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

3.17. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.18. **Medical Expenses** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

3.19. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

3.20. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.21. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

3.22. **Non- Network Provider** means any hospital that is not part of the network.

3.23. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

3.24. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

3.25. **Policy period** means period of one policy year for which the Policy is issued.

3.26. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy

3.27. **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

3.28. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

3.29. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person.

3.30. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

3.31. **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

4. COVERAGE:

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

a) **Death**: The company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, on death of the insured person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of insured person following an accident, if after the payment of accidental death claim, it is found that the insured person has survived the accident, then the policyholder has to refund the payment back to the company in consideration of the obligatory guarantee as provided during the claim.

b) **Permanent Total Disablement:** The company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a) Total and irrecoverable loss of sight of both eyes or
b) Physical separation or loss of use of both hands or feet or
c) Physical separation or loss of use of one hand and one foot or
d) loss of sight of one eye and Physical separation or loss of use of hand or foot
e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

c) Permanent Partial Disablement:

The company shall pay the following percentage of Sum Insured, specified in the policy schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

	Loss Covered	Percentage of Sum Insured
1.	Loss of Use/ Physical Separation: One entire hand One entire foot Loss of Sight of one eye Loss of toes – all Great both phalanges Great – one phalanx Other than great if more than one toe lost	 50% 50% 50% 20% 5% 2% 1%
2.	Loss of Use of both ears	50%
3.	Loss of Use of one ear	20%

4.	Loss of four fingers and thumb of one hand	40%
5.	Loss of four fingers	35%
6.	Loss of thumb - both phalanges - one phalanx	 25% 10%
7.	Loss of Index finger - three phalanges two phalanges one phalanx	 10% 8% 4%
8.	Loss of middle finger – three phalanges two phalanges one phalanx	 6% 4% 2%
9.	Loss of ring finger - three phalanges two phalanges one phalanx	 5% 4% 2%
10.	Loss of little finger – three phalanges two phalanges one phalanx	 4% 3% 2%
11.	Loss of metacarpus - first or second (additional) third, fourth or fifth (additional)	 3% 2%
12.	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to sum insured chosen by the policyholder.

Note:

a) The base sum insured chosen and cumulative bonus, if any, is applicable cumulatively for all the three covers specified under 4.1(a),4.1(b) and 4.1(c) above i.e, there is a single sum insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.

b) If the accident occurs during the policy period, benefits covered under 4.1(a),4.1(b) and 4.1(c) above are payable, even if death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of policy period, but within 12 months from the date of accident.

4.2.**Optional Covers:** The covers listed below are optional benefits and shall be available to Insured Persons in accordance with the terms set out in the Policy, if the listed cover is opted.

a) Temporary Total Disablement:

If the Insured Person sustains an Injury in an Accident during the Policy Period and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable of performing at the time of the Accident (Temporary Total Disablement), the company shall pay the benefit as specified in the policy schedule, till the time the insured person is able to return to work, provided that:

(i) The period of temporary total disablement shall exceed four consecutive weeks from the date of accident, however, the benefit shall be reckoned from the date of accident and shall be payable for the entire duration of disablement.

(ii) the compensation payable under this benefit mentioned under Section 4.2(a) shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the Sum Insured.

(iii) The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident.

(iv) The compensation shall be paid by the company at quarterly intervals, after ascertaining the amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period

(v) During the course of payment under this benefit, the company shall have right to call for a certification from an independent medical practitioner with regard to the continuity of temporary total disability specified under this section.

(vi) The insured shall notify the company immediately on resuming to his occupation/employment. Where it is found that the insured resumed to his occupation/employment without notifying to the company and received the compensation under this cover, the company shall have right to claim the recovery of such benefit paid.

Note: For the purpose of this benefit, "week" is a period of seven consecutive calendar days.

b) **Hospitalisation Expenses due to Accident:** The Company shall indemnify medical expenses incurred for hospitalisation arising due to accident during the policy period, up to the limit of 10% of the base sum insured, specified in the policy schedule.

The hospitalisation expenses shall cover the following:

i. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home,
ii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.

iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.

(Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day.)

iv. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses

v. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure carried out to treat the accidental injury covered under the policy

vi. Expenses incurred on hospitalization due to accident, under AYUSH (as defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

The following other expenses necessitated due to injury shall also be covered under the optional cover specified under Section 4.2(b):

i. Dental treatment.
ii. Plastic surgery.
iii. All the day care treatments.
iv. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

Note: The expenses that are not covered under the section 4.2(b) are placed under List-I of Annexure-B. 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-B respectively.

c) Education Grant:

Following an admissible claim of the insured person under the policy towards Death or Permanent Total Disability of the insured person, the company shall pay a one-time educational grant of 10% of the Base Sum insured (specified in the policy schedule), per child to all dependent children of the Insured provided that:

a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.

c) Age of the child or children as the case shall not be more than 25 completed years.

Note:

i. The benefits payable under each of the optional covers 4.2(a), 4.2(b) and 4.2(c) are independent and over and above the base sum insured.

ii. Claim admissibility under the optional covers "Temporary total disablement" and "hospitalization due to accident" is independent of claim admissibility under the base covers.

5. Cumulative bonus:

Sum insured (excluding cumulative bonus) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

Notes:

i. The cumulative bonus is applicable only in respect of base covers referred at Section 4.1(a),4.1(b) and 4.1(c). Addition or reduction of cumulative bonus will be done only if claim made under base covers

ii. The CB shall be added and available individually to the insured persons under the policy, if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.

iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. 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

6. EXCLUSIONS (applicable to all sections of the policy)

The Company shall not be liable to make any payments under this policy in respect of:

(i) Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalisation of the insured person, directly or indirectly due to 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.

(ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person

a. from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;

b. whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication.

c. whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world.
[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]

d. arising or resulting from the Insured Person committing any breach of law with criminal intent.

(iii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

(iv) Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:

A. 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.

B. Nuclear weapons material

C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

D. Nuclear, chemical and biological terrorism

(v) Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

6.1 Exclusions specific to section 4.2(b) "Hospitalisation Expenses due to Accident"

The Company shall not be liable to make any payments under this policy in respect of any expenses incurred by the insured person in connection with or in respect of:

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

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

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

ii. 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)

iii. Expenses incurred for treatment of accidental injuries which does not warrant hospitalization.

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

v. Treatment taken outside the geographical limits of India.

vi. All expenses listed in Annexure-B (List I) of the Policy.

7. CLAIM PROCEDURE

7.1.Notification of claim:

i. Intimation about an event or occurrence that may give rise to a claim under this policy must be given within 30 days 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 Hospitalisation 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.

7.2.Documents to be submitted:

7.2.1 Basic documents required for All claims

i. Duly completed claim form
ii. Photo Identity Proof of the insured person
iii. Copy of FIR/ Panchnama /Police Inquest Report (wherever these reports are required as per the circumstance of the Accident) duly attested by the concerned Police Station
iv. Copy of Medico Legal Certificate (wherever it is required as per the circumstance of the Accident) duly attested by the concerned Hospital
v. Any other relevant document required by the Company for assessment of the claim

7.2.2 Documents required in case of Death covered under Section 4.1(a)

i. Death certificate;
ii. Post Mortem Report (if conducted);
iii. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.

7.2.3 Documents required in case of Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD), covered under Sections 4.1(b) and 4.1(c)

i. Original treating Medical Practitioner's certificate describing the disablement
ii. Original Discharge summary from the Hospital
iii. Disability certificate issued by treating Medical Practitioner
iv. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable.

7.2.4 Documents required in case of Temporary Total Disablement (TTD), covered under Section 4.2(a)

i. Original treating Medical Practitioner's certificate confirming the disability
ii. Original Discharge summary from the Hospital
iii. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

iv. Leave/Absence Certificate from Employer (If Employed)
v. Medical Practitioner's certificate confirming the Injury and advising rest/ unfit to work for specified number of days
vi. Fitness Certificate issued by the treating doctor.

7.2.5 Documents required for coverage under Section 4.2(b)- Hospitalisation Expenses due to Accident:

i. Discharge Summary from The Hospital
ii. Medical & Investigation reports
iii. Prescriptions, and consultation papers of the treatment
iv. Any other medical, investigation reports, as applicable

7.2.6 Documents required for coverage under Section 4.2(b)- Education Grant:

i. Proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate.
ii. Photo Identity Proof of Child
iii. Age proof of Child
iv. Bonafide Certificate issued by the educational institution confirming that he/she is a full time student of the institution

[Note: Insurer may specify the documents required in original and waive off any of above required as per their claim procedure]

7.3. Claim Settlement

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(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)

7.4. Services Offered by TPA(To be stated where TPA is involved)

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

7.5. Payment of Claim

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

8. General Terms and Conditions

8.1. 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)

8.2. Condition Precedent to Admission of Liability

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

8.3. Material Change

The Insured Person shall immediately notify the Company in writing of any change in his business or occupation or physical defect or infirmity with which he has become affected since the payment of last preceding premium.

8.4. Automatic Termination of Insurance

This policy shall automatically terminate upon the Insured Person's death or payment of 100% Sum Insured. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

8.5. Complete Discharge

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

8.6. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

8.7. Territorial Limit

The coverage is worldwide except for the optional cover "Hospitalization expenses due to accident".

The coverage of optional cover "Hospitalization expenses due to accident", is limited to medical treatment taken in India only.

8.8. Multiple policies (Applicable to covers which offer fixed benefits)

In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar policies.

8.9. Multiple policies (Applicable for Section 4.2(b)- Hospitalisation Expenses due to Accident)

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person 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 person 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 person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only have indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

8.10. Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy: —

(a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

(b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

(c) any other act fitted to deceive; and

(d) any such act or omission as the law specially declares to be fraudulent

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

8.11. Cancellation

i. The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

(Note to Insurers: Insurers to specify the percentage of refund subject to pricing design)

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8.12. Nomination:

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

8.13. Renewal of the Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
iv. No loading shall apply on renewals based on individual claims experience.
v. The cover for the Insured shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under Coverage Death or Permanent Total Disability and no Renewal of contract will be permissible.
vi. The insured may also avail an optional cover or opt out of the optional cover at the time of renewal.

8.14. Possibility of revision of the premium rates:

The company, with prior approval of IRDAI, may revise or modify the premium rates.

8.15. Policy Disputes:

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

8.16. Arbitration:

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

8.17. Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iv. No interest will be charged If the instalment premium is not paid on due date.

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

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

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

9. Claim Related Information

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

i. Website :
ii. Toll Free :
iii. E-mail:
iv. Fax :
v. Courier :

10. <u>Grievances</u>

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

i. Website:
ii. Toll free:
iii. E-mail:
iv. Fax :
v. Courier:

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 …….

For updated details of grievance officer, kindly refer the link…….

(Note to insurers: Address of the Grievance Officer and link having updated details of grievance officer on website to be specified by the insurer. Insurer to also specify separate contact details for senior citizens)

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

Insurance Ombudsman –The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-A. [Insurers are advised to note the revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html and ensure that updated details are prospectively incorporated in the policy documents for the information of the policyholders].

11. TABLE OF BENEFITS

Name	Standard Personal Accident Insurance policy,[Company Name]
Product Type	Individual
Category of Cover	All the covers are benefit based except the optional cover "Hospitalisation Expenses due to Accident" which is indemnity based.
Sum insured	On Individual basis – SI shall apply to each individual family member
Policy Period	1 year
Base covers	i. Death ii. Permanent total disablement iii. Permanent partial disablement
Optional covers	i. Temporary total disablement ii. Hospitalisation Expenses due to Accident iii. Education grant
Cumulative bonus	Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured.

Annexure-A.

The contact details of the **Insurance Ombudsman** offices are as below-

Areas of Jurisdiction	**Office of the Insurance Ombudsman**
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road,JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in

Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam-682015. Tel.: 0484 - 2358759/2359338 Fax: 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in

Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in

[Note to Insurers: Insurers are advised to mention the correct address, e mail Id, phone number etc. of insurance ombudsmen while issuing policy contracts]

Annexure-B

List I - Items for which coverage is not available in the policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)

46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY

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

Sr No	Item
1	Baby Charges (Unless Specified/Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-De-Cologne / Room Freshners
8	Foot Cover
9	Gown
10	Slippers

11	Tissue Paper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	Hvac
22	House Keeping Charges
23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges / Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag

37	Pulseoxymeter Charges

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

Sr No.	Item
1	Hair Removal Cream
2	Disposables Razors Charges (For Site Preparations)
3	Eye Pad
4	Eye Sheild
5	Camera Cover
6	Dvd, Cd Charges
7	Gause Soft
8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonicscalpel,Shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-Ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron

22	Torniquet
23	Orthobundle, Gynaec Bundle

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

Sr No.	Item
1	Admission/Registration Charges
2	Hospitalisation For Evaluation/ Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/ Capd Equipments
7	Infusion Pump– Cost
8	Hydrogen Peroxide\Spirit\ Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges- Diet Charges
10	Hiv Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabes
16	Scrub Solution/ Sterillium
17	Glucometer& Strips
18	Urine Bag

Annexure-2

Customer Information Sheet (Description is illustrative and not exhaustive)

Sl No.	TITLE	DESCRIPTION	Refer to policy clause number
1.	***Product Name***	Saral Suraksha Bima , [Company Name]	
2.	***What am I covered for***	**1.Base Covers:**	
		a) Accidental Death	4.1(a)
		b) Permanent total Disablement due to accident	4.1(b)
		c) Permanent Partial Disablement due to accident	4.1(c)
		2.**Optional Covers**:	
		a) Temporary Total Disablement	4.2(a)
		b) Hospitalisation Expenses due to Accident	4.2(b)
		c) Education Grant	4.2(c)
3.	***What are the Major exclusions in the policy***	Following is a partial list of the policy exclusions. Please refer to the policy document for the complete list of exclusions: Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalization of the insured person e. directly or indirectly due to 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.	6(i)
		f. from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide.	6(ii)
		g. Arising from 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.	6(iv)
		h. arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.	6(v)
4.	***Waiting period***	Not applicable	
5.	***Payment basis***	a) The payment of claims under all the base covers of Standard PA product and the optional covers “temporary total disablement benefit” and “Education grant” is on benefit basis. b) The payment of claims under the optional cover “Hospitalisation Expenses due to Accident” is on indemnity basis (Cashless/Reimbursement).	

6.	***Loss sharing***	Not applicable	
7.	***Renewal Conditions***	a) The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person. b) This policy shall automatically terminate upon the Insured Person's death or payment of 100% Sum Insured. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. Automatic Termination of Insurance.	8.14 8.4
8.	***Cancellation***	i. The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period. i. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.	8.11 (i) 8.11 (ii)
9.	***Claims***	Notification: Intimation about an event or occurrence that may give rise to a claim under this policy must be given within 30 days of its happening.	7.1
		The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.	7.3
10.	***Policy Servicing***	Insurer to provide the details of company officials.	
	Grievances/Complaints	a. Details of Grievance redressal officer (Insurer to provide the link) b. IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/ c. Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-A of Policy document.	
11.	***Insured's Rights***	Insurer to specify the norms on settlement of claims. TAT for Pre-Auth(applicable for the section "Hospitalisation expenses due to accident) shall also be specified.	
12.	***Insured's Obligations***	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.	8.1
Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.			

Annexure-3

Form IRDAI-UNF-PASP

[All the items should be filled in properly and carefully. No item must be left blank.]

S No	Item	Particulars (to be filled in by insurer)
Section I: General Information		
1.1	Name of Health / General Insurer	
1.2	Registration No.alloted by IRDAI	
1.3	Name of Appointed Actuary [Please note that his/her appointment should be in force as on the date of this application]	
1.4	Brand Name [Give the name of the product which will be printed in Sales Literature and known in the market. This name should not be altered/modified in any form after launching in the market. This name shall appear in all returns etc. which would be submitted to IRDAI	Saral Suraksha Bima, <Name of the insurer>
1.5	Date of approval by PMC	
Section II: Underwriting		
2.	Underwriting –Selection of Risks [This section should discuss how the different segments of the population will be dealt with for the purpose of underwriting (to the extent they are relevant and a brief detail of procedure adopted for assessment of various risk classes may be given.)	
2.1	Specify Non-medical Limit [Where no pre-medical examination is asked for]	
2.2	Specify when and what classes of lives would be subject to medical examination	
2.3	Whether any loading based on the health status are applicable	Yes / No
2.4	Whether any loading based on the occupation are applicable	Yes / No
2.5	Specify, any other underwriting criteria	
2.6	Whether Underwriting of the product aligned to the Board	Yes / No

	Approved Underwriting policy of the Company							
2.7	Whether full costs of pre policy medical check up are borne by the Insurer	Yes / No						
2.8	If no, specify the percentage proposed to be borne by the Insurer.							
Section III - Distribution Channels								
3	Distribution channels:							
	3.1	Specify the various distribution channels to be used for distributing the product- [reply shall be specific and can not refer to the replies like "as approved by IRDAI]						
	3.1	Commission scales to distribution channels—specify the rates which are to be paid-[reply shall be specific]						
3.2	Expected proportions of business to be procured by each channel shall be indicated for the next 5 years.		Distribution Channel	Year 1	Year 2	Year 3	Year 4	Year 5
			1.Individual Agents					
			2. Corporate Agents					
			3. Insurance Brokers					
			4.Web Aggregators					
			5.Micro Insurance Agents					
			6.CSC					
			7.PoS					
			8.Direct – Only Online					
			9.Direct Marketing - Others					
			(Incorporate separate line for each distribution channel)					

		10. Others-specify						
		11. Total						
Section IV - Reinsurance arrangements								
4.1	Retention limit							
4.2	Name of the reinsurer (s)							
4.3	Terms of reinsurance(type of reinsurance, commissions, etc.).							
4.4	Any recapture provisions shall be described.							
4.5	Reinsurance rates provided							
4.6	Whether a copy of the reinsurance program and a copy of the Treaty is submitted to the Authority.		Yes/No					
	4.6.1	Whether reinsurance program and a copy of the treaty enclosed (required only if these are not filed with the Authority previously)	Yes/No					
	4.6.2	Whether the reisurance proposed for the product is in line with the Board approved reinsurance program filed with the Authority	Yes / No					
	4.6.3	If no, furnish the particulars						
Section V: Pricing								
5	*Premium Loadings & Discounts* *(Please provide objective and transparent criteria to offer discounts/rebate/Loadings And complete financial justifications by AA to every item referred hereunder.* *In case of General and Health Insurers to be also furnished separately in the Technical Note)*							
	5.1	Sum insured rebates/discounts offered, if any						
	5.2	Rebates/charges for different modes offered:						
	5.3	Premium rebates/discounts						

	5.4	Staff rebates	
	5.5	Any other discounts offered	
	5.6	Maximum cap on all Discounts for all variables taken together	
	5.7	Any loadings proposed	
	5.8	Maximum Cap on all Loading for all variables taken together	
	5.9	Subrogation (Not applicable to Health Insurance)	
5.10	**Pricing Assumptions and Methodology:** The pricing assumptions and the methodology may vary depending on the nature of product. Give details of the following		
5.11	Give the actuarial formulae, if any, used; if not, state how premiums are arrived at briefly explaining the methodology and details:		
5.12	Source of data (internal/industry/ reinsurance)		
5.13	Rate of morbidity [The tables whereever relevant shall be the prescribed one.]		
5.14	Rates of policy terminations. [The rates used must be in accordance with insurer's experience. If such experience is not available, this can be from the industry/reinsurer's experience .]		
5.15	Rate of interest, if any. [The rate or rates must be consistent with the investment policy of the insurer.]		
5.16	Commission scales [Give rates of commission. These are explicit items.]		
5.17	Expenses - Split into First Year, Renewal and Claim related:- [Expense assumptions must be company specific. If such experience is not available, the Appointed Actuary might consider industry experience or make reasonable assumptions.]		
	5.17.1	First Year expenses by: sum assured related, premium related, per policy related	

	First Year Expenses	sum assured related	premium related	per policy related			
	5.17.2	Renewal expenses where relevant (including overhead expenses) by : sum assured related, premium related, per policy related					
	Renewal Expenses	sum assured related	premium related	per policy related			
	5.17.3	Claim expenses					
	5.17.4	Future inflationary increases, if any					
5.18	Allowance for transfers to shareholder, if any: [Please see section 49 of the Insurance Act, 1938]						
5.19	Taxation. [Please see the relevant sections of the Income Tax Act, 1961 applicable for payment of taxes by the Insurer]						
5.20	Any other parameter relevant to pricing of product –specify						
5.21	Reserving assumptions (please specify all the relevant details)						
5.22	Base rate (risk premium)-furnish the rate table, if any						
5.23	Gross premium- furnish the rate table, if any						
5.24	Annualised Premium						
	5.24.1 Minimum						
	5.24.2 Maximum						
5.25	Expected loss ratio (for the product) -						
5.26	Age-wise loss ratio-	S.No	Age	Loss ratio			
5.27	Sum insured-wise- loss ratio	S.No	SA	Loss ratio			
5.28	Age and sum insured wise loss ratio -	Table given below (SI band and age bands shall be increased.The format given below is indicative.)					
	S.NO	SI/Age bands	100000	150000	200000	250000	300000

	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					
	12	>=66					

5.29	Expected combined ratio	
5.30	Age-wise combined ratio-	
5.31	Sum insured-wise- combined ratio	
5.32	Age and sum insured wise combined ratio - to be furnished for each option or plan separately	Table given below (SI band and age bands shall be increased.The format given below is indicative.)

	S.NO	SI/Age bands	100000	150000	200000	250000	300000
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					

	12	>=66						

5.33	Expected cross-subsidy between age/sum insured	
5.34	Experience of similar products, if any for the preceding Five Financial Years	

S.No	Exposure	Premium – Rs.	Number of claims	Incurred claims -Rs.	Claim frequency	Average cost per claim	Burning cost-Rs.	Loss ratio	Combined ratio
FY									
FY-1									
FY-2									
FY-3									
FY-4									

1. Exposure: earned life year (no of life earned during a particular financial year);

2. Premium: premium earned during the financial year;

3.Number of claims: claims occurred during the financial year;

4. Incurred claims: Incurred amount as of today for claims mentioned in “3”;

5. Claim frequency: No. of claims/ Exposure;

6. Average cost per claim: Incurred claims / No. of claims;

7. Burning cost: Claims frequency* Average cost per claim;

8. Loss ratio: Incurred claims/ Premium;

9. Combined ratio: Loss ratio + Expense ratio;

5.35	**Revision in pricing for existing products (Submit separately as an Annexure, percentage difference between existing and modified premium rates for each rating factor)**	
5.35.1	Whether there is an increase or decrease in the premiums	*Increase/Decrease/Increase in certain age groups only/Decrease in certain age groups only/NA*
5.35.2	Justification for change/ modification in premium	
5.35.3	Experience of the product across plans / sum insured / age bands	
5.35.4	How the pricing methodology differs between sum insured options	

5.36	**Results of Financial Projections/Sensitivity Analysis:** [The profit margins should be shown for various model points for base,optimistic and pessimistic scenarios in a tabular format below. The definition of profit margin should be taken as the present value of net profits to the p.v of premiums. Please specify assumptions made in each scenario. For terms less than or equal to one year loss ratio may be used and for terms more than one year, profit margin may be used.]			
5.37	Risk discount rate used in the profit margin			
5.38	Average Sum Insured Assumed			
5.39	Assumptions made under pessimistic scenario			
5.40	Assumptions made under optimistic scenario			
5.41	Age [PM: Profit Margin/Loss Ratio] [Age Band may be revisted based on the product design paratmeters]	*PM (base scenario)*	*PM (pessimistic scenario)*	*PM (optimistic scenario)*
	>=0<=2			
	>=3<=15			
	>=16<=25			
	>=26<=30			
	>=31<=35			
	>=36<=40			
	>=41<=45			
	>=46<=50			
	>=51<=55			
	>=56<=60			
	>=61<=65			
	>=66			
Section VI: Enclosures to the Application: The following specimen documents should be enclosed:				
6.1	Sales Literature /Prospectus. This is the literature which is to be used by the various distribution channels for selling the product in the market. This shall enumerate all the salient features of the product along with the exclusions applicable for the basic benefits and shall be in complaince with the relevant circulars issued by the Authority at all times).			
6.2	Policy Document& Policy Schedule			
6.3	Technical Note on Pricing			

6.4	Proposal form, wherever necessary
6.5	Premium Table
6.6	Certificates by Appointed Actuary and Chief Compliance Officer
6.7	CIS

Soft ware used for product design and monitoring --- (for information of the Authority)

The Insurer shall enclose a certificate from the Chief Compliance Officer, Appointed Actuary, countersigned by the principal officer of the insurer, as per specimen given below:(The language of this should not be altered)

Certification by Chief Compliance Officer:

I------- (Name of Chief Compliance Officer) the undersigned, on behalf of the Insurer named below, hereby affirm and declare as follows:

1. That the details of the (Name of product) filled in above are true and correct and reflect what the policy and other documents indicate.
2. That the product complies with the various provisions of the IRDAI Health Insurance Regulations, 2016, Guidelines on Standardization of Health Insurance, Product Filing, Guidelines on Standardization of Exclusions in Health Insurance Contracts, Guidelines on Standard Personal Accident Insurance Product, issued thereon and the applicable provisions of extant IRDAI Regulations and all circulars issued by IRDAI from time to time.
3. That this application and all other documents are complete and have been verified for correctness and consistency not only in respect of each item of each document but also vis-a-vis one another.
4. I certify that the policy wordings and Customer Information sheet filed along with this application is in compliance with IRDAI (Health Insurance) Regulations, 2016, Product Filing Guidelines, Guidelines on Standardization of Health Insurance, Guidelines on Standardization of Exclusions in Health Insurance Contracts, Guidelines on Standard Personal Accident Insurance product ,issued thereon.
5. I further certify that the Prospectus submitted is in compliance with the applicable provisions of Rules, IRDAI Regulations and Guidelines on Product Filing and Insurance Advertisements.

Date: (Chief Compliance Officer)
Name of Insurer

Certification by Appointed Actuary:

" I, (**name of the appointed actuary**), the appointed actuary, hereby solemnly declare that the information furnished in this Application Form is true. I also certify that, in my opinion, the premium rates, advantages, terms and conditions of the above product are workable and sound, the assumptions are reasonable and premium rates are fair."

I have carefully studied the requirements of the Product Filing Procedure in relation to the design and rating of insurance products.

The rates, terms and conditions of the above mentioned product are determined on technically sound basis and are sustainable on the basis of the information and claims experience available in the records of the insurer.

An adequate system has been put in place for collection of data on premiums and claims based on every rating factor that will enable review of the rates and terms of the cover from time to time. It is planned to review the rates, terms and conditions of cover (--- mention periodicity of review) based on emerging experience.

It is further certified that the underwriting of the product now filed shall be within the Board approved underwriting philosophy of the Company.

The requirements of the Product Filing Procedure have been fully complied with in respect of this product or revision or modification of the product.

I further declare that except the Sections mentioned in S.No., no other feature/benefit/clause is modified in the product (applicable only for revision or modification of the product)

Place Signature of the Appointed Actuary

Date:

Certification by Principal Officer or CEO

I (name of the Principal Officer or CEO), (mention designation) hereby confirm that:

1. The rates, terms and conditions of the above-mentioned product filed with this certificate have been determined in compliance with the IRDA Act, 1999, Insurance Act, 1938, and the Regulations and guidelines issued there under, including the File and Use / Product Filing guidelines.

2. The prospectus, sales literature, policy and endorsement documents, and the rates, terms and conditions of the product have been prepared on a technically sound basis and on terms that are fair between the insurer and the client and are set out in language that is clear and unambiguous.

3. These documents are also fully in compliance with the underwriting and rating policy approved by the Board of Directors of the insurer.

4. The statements made in the filing Form -IRDAI-UNF-PASP are true and correct.

5. The requirements of the Product Filing Guidelines have been fully complied with in respect of this product.

Date: Signature of Principal Officer or Designated Officer

Place: Name and designation along with Company's seal