

Stay financially protected against rising medical costs with 4X health cover and assured life cover.

Click **2** Protect Optima Secure from **HDFC Life** and **HDFC ERGO**



Life & Health cover of ₹50,000 & ₹5 Lakh respectively @ ₹890 per month*



2X coverage from day 1
with Secure Benefit



100% increase in coverage
with Plus Benefit



100% restore coverage
with Restore Benefit

Click **2 Protect Optima Secure**

A Non-Linked Non Participating Combi Insurance Plan



Sar utha ke jayo!

* Premium rates for age- 30 years, Male, Non Smoker, Annual mode, regular pay, exclusive of taxes & inclusive of 5% discount. Protection - Life Protect Fixed Term Option - ₹229, Sum Assured - ₹50,000, Policy Term - 5 years. Health - Individual Option - ₹10,450, Sum Assured - ₹5 Lakh, Policy Term- Life Long Renewal, Applicable for NCR & Mumbai Metropolitan region only. Total annual premium = ₹10,679, monthly premium (10,679/12= ₹890(rounded up))

The present time warrants us to be financially prepared to overcome life's uncertainties. Our foremost responsibility is to protect our loved ones by being insured with all-round protection for life and health.

HDFC Life and HDFC ERGO have joined hands to give you **Click 2 Protect Optima Secure** - A comprehensive plan that offers life and health cover for you and your family. This product will help you stay truly protected and lead a life of pride!

WHAT ARE THE KEY FEATURES AVAILABLE?

Protection



- Provides comprehensive financial protection to your family
- Option to choose a cover which fits your needs from 3 plan options
- Auto balances Death and Critical Illness benefits with increasing age[^]
- Get income payouts from age 60 onwards under Income Plus Option
- Option to avail cover for Whole of Life*
- Get back all premiums paid on survival till maturity with Return of Premium option**
- Waiver of Premium on diagnosis of Critical Illness (through WOP CI option) #
- Additional Sum Assured on Accidental Death (through ADB option)##
- Special premium rates for female lives and non-tobacco users



Health:

my: Optima Secure is a unique indemnity health insurance product which covers expenses incurred on hospitalization due to Illness or Accident. Some of the innovative benefits offered are:

- Secure Benefit offers additional coverage amount equivalent to 100%/200% of the Base Sum Insured.
- Plus Benefit offers additional coverage equivalent to 100% of the Base Sum Insured in 2 years irrespective of a claim.
- Automatic Restore Benefits restores 100% of Base Sum Insured automatically on partial or complete utilization of Base Sum Insured (i.e. Base Sum Insured, Secure Benefit and Plus Benefit / Cumulative Bonus)
- Protect Benefit pays towards the Non-Medical expenses like gloves, food charges and other consumables during hospitalization.
- Global cover provides coverage for hospitalization expenses incurred outside India.

[^]Available under Life & CI Rebalance Option only

*Available under Life Protect and Income Plus Options only

**Available as an inbuilt feature under Income Plus Option and on payment of extra premium under Life Protect Option (Fixed Term variant) and Life & CI Rebalance Option.

WoP on diagnosis of CI is available as an inbuilt feature under Life & CI Rebalance Option and on payment of extra premium under Life Protect Option (Fixed Term variant).

ADB option is available on payment of extra premium under Life Protect Option.

WHAT ARE THE ELIGIBILITY CONDITIONS?

Protection:

Plan Option	Life & CI Rebalance	Life Protect		Income Plus	
		Fixed Term	Whole Life	Fixed Term	Whole Life
Min. Age at Entry	18 years	18 years	45 years	30 years	45 years
Max. Age at Entry	65 years	65 years for non-PoS 60 years for PoS	65 years	50 years	10 Pay: 50 years Single Pay, 5 Pay: 55 years
Min. Age at Maturity	28 years	18 years for non-PoS 23 years for PoS	Whole of Life	70 years	Whole of Life
Max. Age at Maturity	75 years	85 years for non-PoS 65 years for PoS	Whole of Life	85 years	Whole of Life
Min. Policy Term	10 years	Single Pay: 1 month for non-PoS 5 years for PoS Regular Pay: 5 years Limited Pay: 6 years	Whole of Life	70 years - Age at Entry	Whole of Life
Max. Policy Term	30 years	85 years - Age at Entry for non-PoS 65 years - Age at Entry for PoS	Whole of Life	40 years	Whole of Life
Premium Payment Term	Single Pay, Regular Pay, Limited Pay (5 to any PPT less than PT)		Limited Pay (5, 10, 15 pay)	Single Pay, Limited Pay (5, 10 pay)	
Min. Basic Sum Assured	₹ 20,00,000	₹ 50,000			
Max. Basic Sum Assured	No limit, subject to Board Approved Underwriting Policy (BAUP)				

*PoS applicable only for Fixed Term option of Life Protect variant; For PoS, the Basic Sum Assured shall be in multiples of ₹50,000. Only Return of Premiums (ROP) & Accidental Death Benefit (ADB) options available; No other optional benefit or rider applicable for PoS.

Minimum Premiums under various Premium Payment Terms & Premium Frequencies are as mentioned below:

Premium Payment Term	Premium Frequency	Minimum Premium Per Instalment
Single Pay (SP)	Single	₹ 59
Limited Pay (LP) / Regular Pay (RP)	Annual	₹ 205
	Half-yearly	₹ 105
	Quarterly	₹ 53
	Monthly	₹ 18

Premium will vary depending on the plan option chosen.

For non-annual modes, premiums paid are calculated as: Annualized premium multiplied by a conversion factor as given below:

Frequency	Conversion Factor
Half-yearly	0.5100
Quarterly	0.2600
Monthly	0.0875



Health

- This Policy covers Insured Persons in the age group of 91 days and above.
 - The minimum entry age for an adult is 18 years and there is no limit on maximum entry age.
 - The minimum entry age for a dependent child (i.e. natural or legally adopted) is 91 days and maximum entry age is 25 years.
 - Dependent Child between 91 days and 5 years can be insured provided either of the parent is getting insured under this Policy.
 - Dependent Child between 5 to 25 years can be insured on individual basis wherein proposer may not be an insured.
 - When the child attains the age of 25 years, he or she shall be ineligible for coverage in the subsequent renewals and will be migrated to a new Policy, with continuity benefits.
 - There is no maximum cover ceasing age on renewals.
 - The family includes following relationships: spouse, dependent children, parents and parents-in-law.
 - In a family floater Policy, a maximum of 4 adults and a maximum of 6 dependent children can be included in a single Policy. The 4 adults can be a combination of self, spouse, parents and parents-in-law.
 - In an individual Policy, a maximum of 6 adults and a maximum of 6 dependent children can be included in a single Policy.
- List of relationships which can be included is mentioned below:

i. Spouse	viii. Daughter-in-law	xv. Sister
ii. Son	ix. Son-in-Law	xvi. Sister-in-law
iii. Daughter	x. Grandfather	xvii. Brother-in-law
iv. Father	xi. Grandmother	xviii. Nephew
v. Mother	xii. Grandson	xix. Niece
vi. Father-in-law	xiii. Granddaughter	
vii. Mother-in-law	xiv. Brother	

Minimum Premium is as mentioned below:

Cover	Region	Premium Payment Term	Sum Insured	Age	Minimum Premium Per Instalment
Individual	Rest of India	Annual	₹ 5,00,000	91 days - 1Year	₹ 5,480
Individual	National Capital Region & Mumbai metropolitan region	Annual	₹ 5,00,000	91 days - 1Year	₹ 5,654

Note: -The above premiums are for Optima Suraksha plan option (offline). The above premiums shown are exclusive of any riders and are exclusive of taxes and levies.

What are the plan options/Benefits available?

Click 2 Protect Optima Secure has both protection and health benefits.

Protection:

You can choose from following 3 plan options -

- 1. Life & CI Rebalance** - A smart cover which aims to achieve a balance between Death and Critical Illness benefit as you go along in your life. Critical Illness cover increases at each policy anniversary with corresponding reduction in Life Cover. In addition, all future premiums are waived off on detection of any of the covered Critical Illnesses and the life cover continues.
- 2. Life Protect** - Under this plan option, a lump sum is provided on death of the life assured.
- 3. Income Plus** - Under this plan option, the Life Assured is covered for the entire policy term and also receives a lump sum payout on maturity along with regular income starting from age 60.

You may choose one of the above plan options at inception of the policy. Plan option once selected cannot be changed during the Policy Term. Benefits under each option are detailed below.

Benefits payable under various plan options:

1. Life & CI Rebalance

Under this plan option, Basic Sum Assured chosen by you will be split between Life Cover SA and Critical Illness SA (CI SA).

At the beginning of the cover, Life Cover SA is set at 80% of Basic Sum Assured and CI SA is set at 20% of Basic Sum Assured. For an in-force policy, at every policy anniversary, starting from the first policy anniversary, CI SA will increase every year and Life Cover SA will decrease by the same amount. This amount will be calculated as follows:

$$30\% \times \frac{\text{Basic Sum Assured}}{\text{Policy Term}}$$

Basic Sum Assured (Life Cover SA + CI SA) will remain the same throughout the policy term.

Example: for Basic Sum Assured of 50 lakhs and policy term of 10 years, benefit structure will vary over the term as follows:

Policy Year	Life Cover SA	CI SA
1	40.0 lakh	10.0 lakh
2	38.5 lakh	11.5 lakh
3	37.0 lakh	13.0 lakh
4	35.5 lakh	14.5 lakh
5	34.0 lakh	16.0 lakh
6	32.5 lakh	17.5 lakh
7	31.0 lakh	19.0 lakh
8	29.5 lakh	20.5 lakh
9	28.0 lakh	22.0 lakh
10	26.5 lakh	23.5 lakh

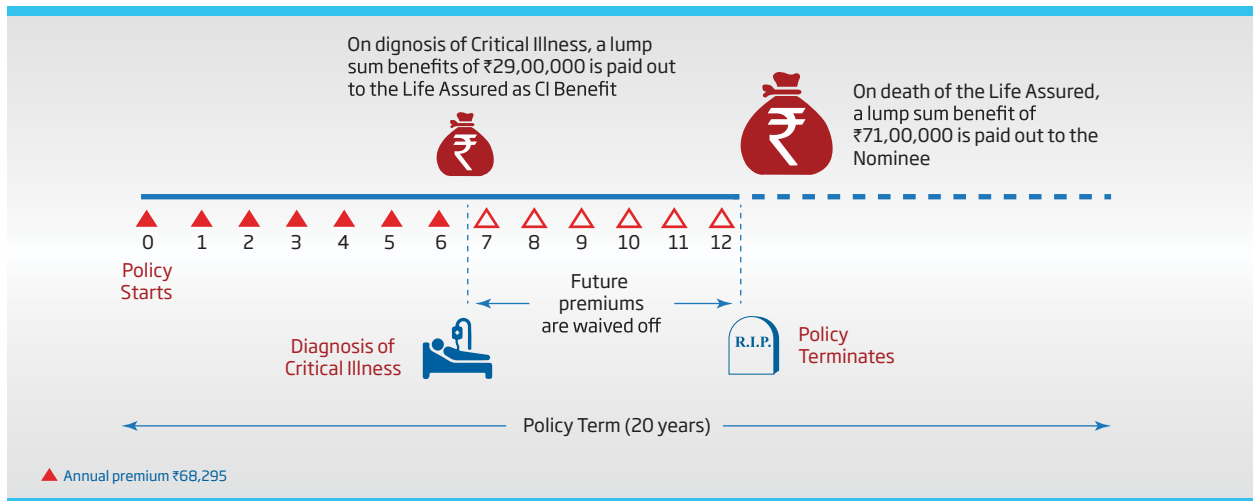
Once a Critical Illness claim is made, the Life Cover SA will be fixed at the then applicable level and the same SA will continue until the end of policy term.

Example: Mr. Xavier, a 45 years old gentleman, buys the Life & CI Rebalance option of HDFC Life Click 2 Protect Life for a policy term of 20 years, regular pay, and avails a basic sum assured of ₹ 1,00,00,000. He pays a premium of ₹68,295 annually.

He is diagnosed with a Critical Illness in the 7th policy year. His future premiums are waived off and he receives ₹29,00,000 as lump sum Critical Illness benefit. His Life Cover SA is now fixed at ₹ 71,00,000.

Mr. Xavier passes away in the 13th policy year. His nominee will receive a lump sum death benefit of ₹ 71,00,000.

Total Premiums Paid: ₹4,78,065



Death Benefit:

"Death Benefit" is payable as a lump sum to your Nominee if you, the Life Assured die during the policy term. It is the highest of:

- Sum Assured on Death
- 105% of Total Premiums Paid
- Life Cover SA

Sum Assured on Death for Single Pay (SP) is the higher of:

- 125% of Single Premium
- Sum Assured on Maturity

Sum Assured on Death for other than Single Pay (Limited Pay and Regular Pay) is the higher of:

- 10 times of the Annualized Premium
- Sum Assured on Maturity

Where,

Annualized Premium is the premium amount payable in a year chosen by the policyholder, excluding taxes, rider premiums, underwriting extra premiums and loadings for modal premiums, if any.

Total Premiums Paid are the total of all the premiums received, excluding any extra premium, any rider premium and taxes. In case ROP option has been selected, Total Premiums Paid includes premium paid for base plan option and the additional premium paid for ROP option.

Sum Assured on Death is the absolute amount of benefit which is guaranteed to become payable on death of the life assured in

accordance with the terms and conditions of the policy or an absolute amount of benefit which is available to meet the health cover.

Basic Sum Assured is the amount of sum assured chosen by the policyholder.

Sum Assured on Maturity is the amount which is guaranteed to become payable on maturity of the policy, in accordance with the terms and conditions of the policy.

Benefit on diagnosis of Critical Illness:

On diagnosis of any of the covered critical illnesses, the applicable Critical Illness (CI) SA at the time of diagnosis of the disease, will be payable to you.

In addition, all future premiums payable under the plan will be waived off and the life cover continues.

Please refer the section on "Critical Illnesses covered" for list of Critical Illnesses covered and definitions and exclusions relating to the same.

Maturity Benefit:

On survival until Maturity, Sum Assured on Maturity will be payable.

Sum Assured on Maturity will be equal to the Total Premiums Paid if ROP benefit is selected, Nil otherwise.

Upon the payment of death or maturity benefit as above, the policy terminates and no further benefits are payable.

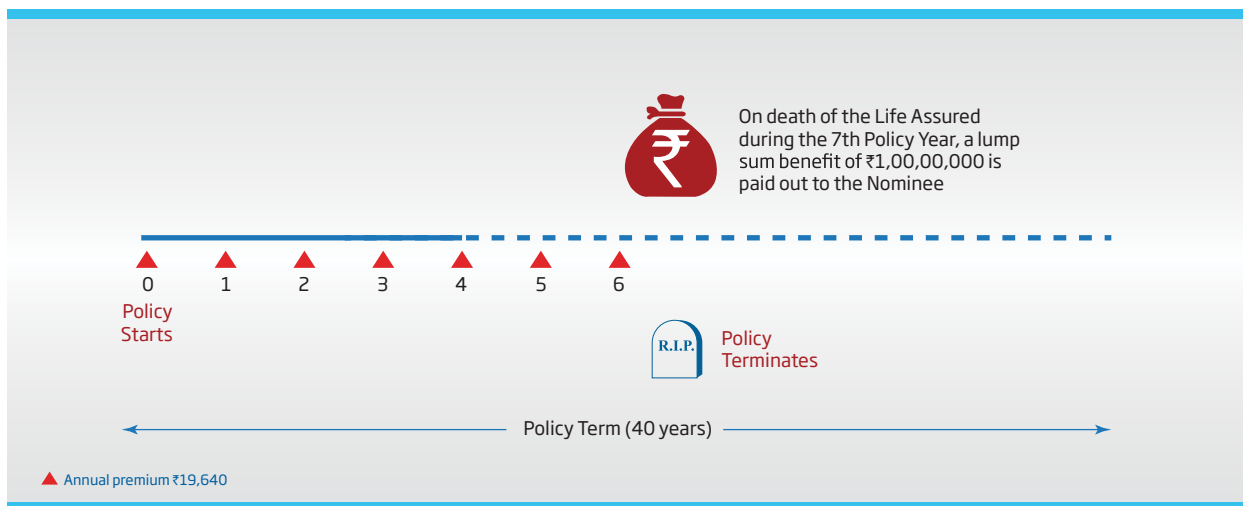
2. Life Protect -

Under this plan option, you are covered for death during the policy term. In case of your unfortunate demise during the policy term, your nominee gets a lump sum benefit.

Example: Mr. Bansal, a 35 years old gentleman, buys the Life Protect Option of HDFC Life Click 2 Protect Life for a policy term of 40 years, regular pay, and avails a level cover of ₹ 1,00,00,000 by paying a premium of ₹ 19,640 annually.

Mr. Bansal passes away in the 7th policy year. His nominee will receive a lump sum benefit of ₹ 1,00,00,000.

Total Premiums Paid: ₹1,37,480



Death Benefit:

"Death Benefit" is payable as a lump sum to your Nominee if you, the Life Assured die during the policy term. It is the higher of:

- Sum Assured on Death
- 105% of Total Premiums Paid

Sum Assured on Death for Single Pay (SP) is the highest of:

- 125% of Single Premium
- Sum Assured on Maturity
- Basic Sum Assured

Sum Assured on Death for other than Single Pay (Limited Pay and Regular Pay) is the highest of:

- 10 times of the Annualized Premium
- Sum Assured on Maturity
- Basic Sum Assured

Maturity Benefit:

On survival until Maturity, Sum Assured on Maturity will be payable.

Sum Assured on Maturity will be equal to the Total Premiums Paid if ROP benefit is selected, Nil otherwise.

Upon the payment of death or maturity benefit as above, the policy terminates and no further benefits are payable.

3. Income Plus

This option provides you with a life cover for the chosen policy term and regular monthly income from age 60 onwards along with a lump sum payout on maturity. Monthly income of 0.1% of the Basic Sum Assured shall be paid in arrears, starting from the policy anniversary following your 60th birthday and continues until your death or policy maturity, whichever occurs earlier. The Survival Benefits already paid out shall be deducted from the Death Benefit payable to the Nominee.

You may choose maturity ages as per the below table, subject to eligibility criteria mentioned above under Eligibility -

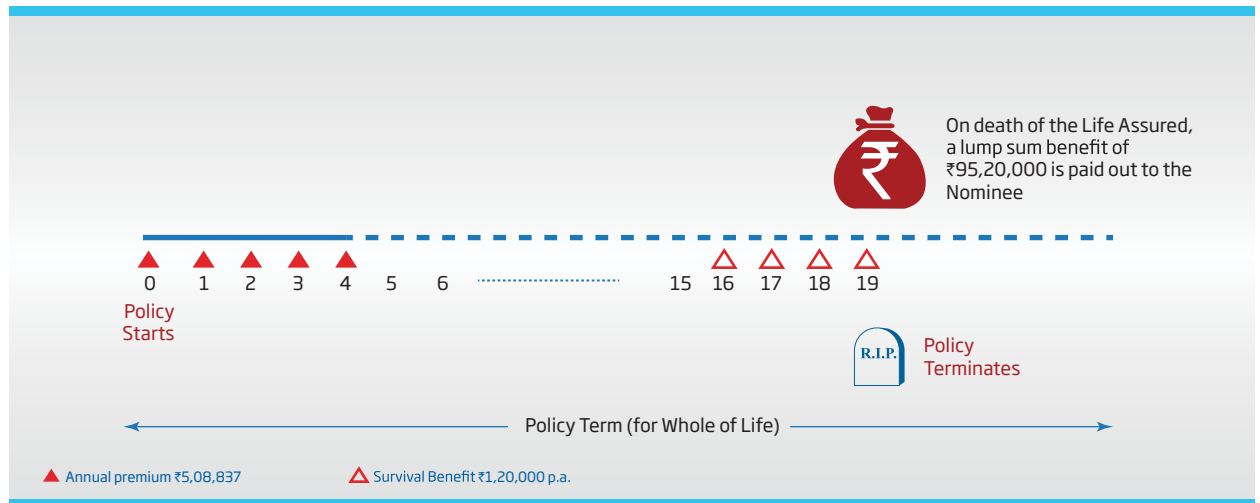
Option	Fixed Term	Whole Life
Maturity Age	70, 75, 80 or 85 years	Whole of Life

Example: Mr. Singh, a 45 years old gentleman, buys the Income Plus option of HDFC Life Click 2 Protect Life with premium payment term of 5 years and coverage for Whole of Life and avails a Basic Sum Assured of ₹1,00,00,000. He pays a premium of ₹5,08,837 annually.

He starts receiving regular monthly income of ₹ 10,000 from the start of 16th policy year (after attaining age 60 years).

He passes away in the first month of 20th policy year. His nominee will receive a lump sum death benefit of ₹95,20,000.

Total Premiums Paid: ₹25,44,185



Death Benefit:

"Death Benefit" is payable as a lump sum to your Nominee if you, the Life Assured die during the policy term. It is the higher of:

- Sum Assured on Death
- 105% of Total Premiums Paid

less total Survival Benefits paid out till the date of death

Sum Assured on Death for Single Pay (SP) is the highest of:

- 125% of Single Premium
- Sum Assured on Maturity
- Basic Sum Assured

Sum Assured on Death for other than Single Pay (Limited Pay and Regular Pay) is the highest of:

- 10 times of the Annualized Premium
- Sum Assured on Maturity
- Basic Sum Assured

Survival Benefit:

On your survival during the policy term provided all due premiums have been paid, an income equal to 0.1% of Basic Sum Assured will be payable to you at the end of every month, following policy anniversary after your attaining age 60 years, until death or end of the policy term, whichever occurs first.

Maturity Benefit:For Fixed Term:

On Survival until Maturity, Sum Assured on Maturity will be payable.

Sum Assured on Maturity will be equal to Max (110% of Total Premiums Paid less total Survival Benefits paid out, 0)

For Whole Life: NIL

Upon the payment of death or maturity benefit as above, the policy terminates and no further benefits are payable.

Health:**3. Base Coverage**

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 and up to the Sub-limits mentioned in the Policy Schedule. Cumulative Bonus shall be available only if the Cover is specified to be applicable in the Policy Schedule.

Claims made in respect of any of these Covers will affect the eligibility for the additional Covers set out in Section 4 and Section 5 below.

3.1. Hospitalization Expenses

The Company shall indemnify Medical Expenses necessarily incurred by the Insured Person for Hospitalization of the Insured Person during the Policy Year due to Illness or Injury, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule for:

- a. Room Rent, boarding, nursing expenses as provided by the Hospital / Nursing Home
- b. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
- c. Surgeon, anaesthetist, Medical Practitioner, consultants, specialist Fees during Hospitalization forming part of Hospital bill.
- d. Investigative treatments and diagnostic procedures directly related to Hospitalization.
- e. Medicines and drugs prescribed in writing by Medical Practitioner.

f. Intravenous fluids, blood transfusion, surgical appliances, allowable consumables and/or enteral feedings. Operation theatre charges.

g. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery.

3.1.1. Other Expenses

h. Expenses incurred on road Ambulance if the Insured Person is required to be transferred to the nearest Hospital for Emergency Care or from one Hospital to another Hospital or from Hospital to Home (within same city) following Hospitalization.

i. Inpatient Care Dental Treatment, necessitated due to disease or Injury

j. Plastic surgery, necessitated due to Injury

k. All Day Care Treatments.

Note:

l. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.

m. The Hospitalization must be for Medically Necessary Treatment, and prescribed in writing by Medical Practitioner.

3.2. Home Health Care

The Company shall indemnify the Medical Expenses incurred by the Insured Person on availing treatment at Home during the Policy Year, if prescribed in writing by the treating Medical Practitioner, provided that:

- a. The treatment in normal course would require In-patient Care at a Hospital, and be admissible under Section 3.1 (Hospitalization Expenses).
- b. The treatment is pre-authorized by the Company as per procedure given under Claims Procedure - Section 6.
- c. Records of the treatment administered, duly signed by the treating Medical Practitioner, are maintained for each day of the Home treatment.

This Cover is not available on reimbursement basis.

3.3. Domiciliary Hospitalization

The Company shall indemnify the Medical Expenses incurred during the Policy Year on Domiciliary Hospitalization of the Insured Person prescribed in writing by treating Medical Practitioner, provided that:

- a. the condition of the Insured Person is such that he/she could not be removed/admitted to a Hospital.
or
- b. the Medically Necessary Treatment is taken at Home on account of non-availability of room in a Hospital.

3.4. AYUSH Treatment

The Company shall indemnify the Medical Expenses incurred by the Insured Person for Inpatient Care under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the Sub-limit specified against this Cover in the Policy Schedule, in any AYUSH Hospital.

3.5. Pre-Hospitalization Expenses

The Company shall indemnify the Pre-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section 3.1 (Hospitalization Expenses), for up to 60 days immediately prior to the date of admissible Hospitalization covered under the Policy.

3.6. Post-Hospitalization Expenses

The Company shall indemnify the Post-Hospitalization Medical Expenses incurred by the Insured Person, related to an admissible Hospitalization under Section 3.1 (Hospitalization Expenses), for up to 180 days from the date of discharge from the Hospital, following an admissible Hospitalization claim under the Policy.

3.7. Organ Donor Expenses

The Company shall indemnify the Medical Expenses covered under Section 3.1(Hospitalization Expenses)which are incurred by the Insured Person during the Policy Yeartowards the organ donor's Hospitalization for harvesting of the donated organ where an Insured Person is the recipient, subject to the following conditions:

- a. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011, Transplantation of Human Organs and Tissues Rules, 2014 and other applicable laws and/or regulations.
- b. Recipient Insured Person's claim under Section 3.1 (Hospitalization Expenses) is admissible under the Policy.
- c. Expenses listed below are excluded from this Cover:
 - i. The organ donor's Pre-Hospitalization Expenses and Post-Hospitalization Expenses.
 - ii. Expenses related to organ transportation or preservation.
 - iii. Any other Medical Expenses or Hospitalization consequent to the organ harvesting.

3.8. Cumulative Bonus (CB) [Applicable only to Optima Suraksha plan]

Cumulative Bonus (CB) will be applied/increased by 10% of the Base Sum Insured 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 cap of 100% of the Base Sum Insured under the current Policy Year. If a claim is made in any particular Policy Year, the CB accrued shall be reduced at the same rate at which it has accrued.

Notes:

- a. In case where the Policy is on individual basis as specified in the Policy Schedule, the CB shall be added and available individually to the Insured Person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
- b. In case where the Policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any Family Member. CB shall reduce in case of claim from any of the Insured Persons.
- c. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- d. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.
- e. In case of floater policies where the Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
- f. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
- g. If the Sum Insured under the Policy has been increased at the time of Renewal, the CB shall be calculated on the Sum Insured of the last completed Policy Year.
- h. If a claim is made in the expiring Policy Year, and is notified to the Company after the acceptance of Renewal premium any awarded CB shall be withdrawn.
- i. If the Policy Period is of two/three years, any CB that has accrued for the first/second Policy Year shall be creditedpost completion of each Policy Year.
- j. New Insured Person added to the Policy during subsequent Renewals will be eligible for CB as per their Renewal terms.
- k. CB shall be available only if the Cover is specified to be applicable in the Policy Schedule.

Sample Illustration (Protection + Health)

Below are few illustrations that will explains the combined benefit of Life & Health under Click 2 Protect Optima Secure

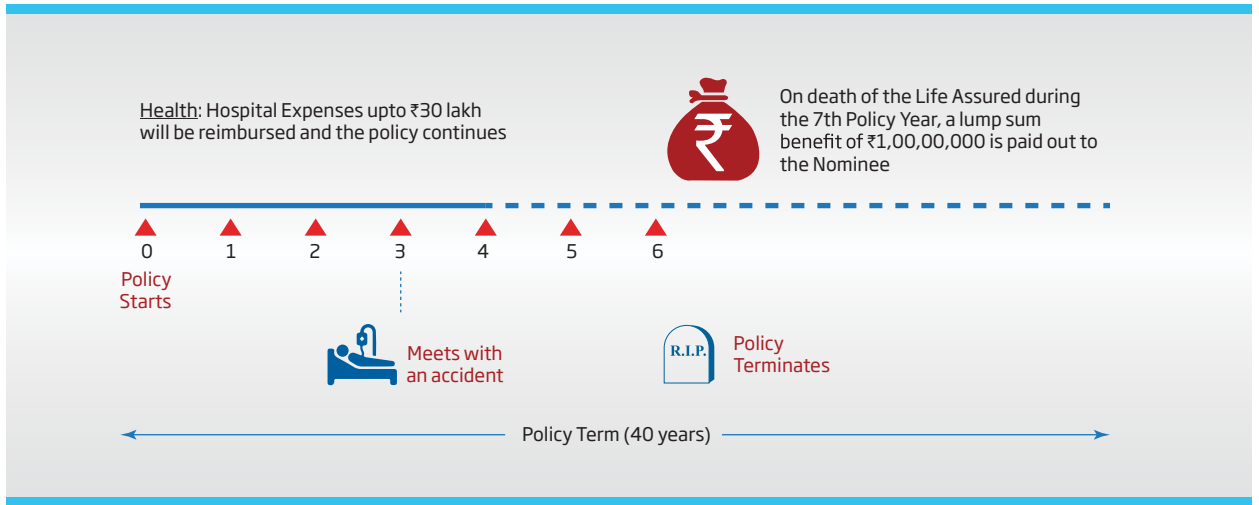
Illustration-1

Mr. Singh is a 25 year old Manager. He buys Click 2 Protect Optima Secure (Protection and health benefit).

Category	Plan Option	Sum Assured	Policy Term
Protection	Life Protect	₹ 1 Crore	40 years
Health	Optima Secure	₹ 5 Lakh	Life Long Renewal

- During the 4th Policy Year, he meets with an accident
- During the 7th Policy Year, he passes away due to illness

The benefit payable to his nominee is as follows:



Protection

- The policy shall terminate on the earlier of death, or expiry of the policy term
- You have to choose the Sum Assured, Policy Term and the Premium Payment Term at the inception of the policy.

Health

- He is covered upto 30 lakhs (Base sum insured + Secure Benefit + Automatic Restore Benefit).

What are the Additional options/ features available?

Protection:

1. Return of Premium (ROP) option

You may choose to opt for this benefit under plan option as per below table:

Option		Allowed to opt for ROP option?
Life & CI Rebalance		Yes
Life Protect	Fixed Term	
	Whole Life	No
Income Plus	Fixed Term	
	Whole Life	

If you choose this plan option, you will have to pay an additional premium over and above the premium payable for the base plan option chosen and you will receive a return of 100% of the Total Premiums Paid as a lump sum, upon survival until maturity.

This add-on option will be available for:

- All policy terms between 10 and 40 years for Single, Regular and 5 Pay.
- All policy terms between 15 and 40 years for 8, 10 and 12 Pay.

2. Waiver of Premium on CI (WOP CI) Option If you choose this add-on option, all future premiums payable under the plan will be waived, if you, the life assured are diagnosed with any of the covered critical illnesses.

This option will be available only where PPT is at least 5 years and Life Protect Option with Fixed Term is selected.

An additional premium (over and above the premium payable for the

base plan) will be payable if this add-on option is chosen.

3. Accidental Death Benefit (ADB) Option

If you choose this add-on option, an additional amount equal to 100% of Basic Sum Assured will be payable to the Nominee on your (Life Assured's) death due to accident during the policy term. This option will be available only where Life Protect Option has been selected.

An additional premium (over and above the premium payable for the

base plan) will be payable if this add-on option is chosen.

4. Alteration of premium payment frequency

You have an option to alter the premium payment frequency during the premium payment term without any charge/ fee.

5. Option to reduce Premium Payment Term from Regular Pay to Limited Pay

You also have an option to convert the outstanding regular premiums into any limited premium period available under the plan options without any charge/ fee.

Health:

4. Optional Covers

The Covers listed below are optional covers. An optional cover is applicable to an Insured Person only if it is specified in the Policy Schedule to be in force for that Insured Person, and such optional cover will be available in accordance with the procedures set out in this Policy and up to the Sub-limits mentioned in the Policy Schedule.

The optional covers shall apply to all Insured Person(s) once selected, without any individual selection.

Note: Please refer to 'Annexure A' for Optional Covers which are in-built in your plan.

4.1. Emergency Air Ambulance

The Company shall indemnify expenses incurred by the Insured Person during the Policy Year towards Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid Ambulance transportation that ground transportation cannot provide from the site of first occurrence of the Illness or Accident to the nearest Hospital. The claim is subject to a maximum of Sum Insured as specified in the Policy Schedule against this Cover, and subject to the following conditions:

- a. The air Ambulance transportation is advised in writing by a Medical Practitioner.
- b. Medically Necessary Treatment is not available at the location where the Insured Person is situated at the time of emergency.
- c. The air Ambulance provider is a registered entity in India. (except Section 4.9 (Global Health Cover (Emergency Treatments Only)) and Section 4.10 (Global Health Cover (Emergency and Planned Treatments Only))
- d. The Insured Person is in India and the treatment is taken in India only. (except Section 4.9 (Global Health Cover (Emergency Treatments Only)) and Section 4.10 (Global Health Cover (Emergency and Planned Treatments Only)).
- e. No return transportation to the Insured Person's Home or elsewhere by the air Ambulance will be covered under this Cover.
- f. A claim for the same Hospitalization is admissible under Section 3.1 (Hospitalization Expenses). OR Section 4.9 (Global Health Cover (Emergency Treatments Only)) OR Section 4.10 (Global Health Cover (Emergency and Planned Treatments Only)).
- g. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.

4.2. Daily Cash for Shared Room

The Company shall pay a daily cash amount as specified in Policy Schedule for each continuous and completed 24 hours of Hospitalization during the Policy Year if the Insured Person is hospitalised in shared accommodation in a Network Provider Hospital and such Hospitalization exceeds 48 consecutive hours.

- a. The Cover is not available for the time spent by the Insured Person in an Intensive Care Unit (ICU).
- b. The claim for the same Hospitalization is not admissible under Section 3.1 (Hospitalization Expenses).
- c. The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.

4.3. Protect Benefit

The Company shall indemnify the Insured Person for the Non-Medical Expenses listed under Annexure B to this Policy incurred in relation to a claim admissible under Section 3 (Base Coverage) during the Policy Year.

Exclusion (k) of Section 7.2 - Specific Exclusions shall not apply to this Cover.

4.4. Plus Benefit

On Renewal of this Policy with the Company without a break, a sum equal to 50% of the Base Sum Insured under the expiring Policy will be added to the Sum Insured available under the Renewed Policy subject to the following conditions:

- a. The applicable Plus Benefit under this Cover can only be accumulated up to 100% of Base Sum Insured, and will be applicable only to the Insured Person covered under the expiring Policy and who continues to remain insured on Renewal. The applicable Plus Benefit shall be applied annually only on completion of each Policy Year, and once added, in the accumulated amount will be carried forward to the subsequent Policy Year, subject to there being no Break in Policy.
- c. This Cover will be applied irrespective of number of claims made under the expiring Policy.
- d. This applicable Plus Benefit under this Cover can be utilized only for claims admissible under Section 3 (Base Coverage) and Section 4.3 (Protect Benefit) of the Policy.

Notes:

- i. In case where the Policy is issued on an individual basis, the Plus Benefit shall be added and available individually to the Insured Person. In case where the Policy is on floater basis, the Plus Benefit shall be added and available to all Family Members on a floater basis.
- ii. Plus Benefit shall be available only if the Policy is renewed and due premium is received within the Grace Period.
- iii. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated Plus Benefit for such Insured Persons under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the Plus Benefit to be carried forward for credit in such Renewed Policy shall be the lowest one that is applicable among all the Insured Persons.
- iv. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the Policy is split due to the child attaining the Age of 25 years, the Plus Benefit of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
- v. If the Sum Insured has been reduced at the time of Renewal, the applicable Plus Benefit shall be reduced in the same proportion to the Sum Insured in current Policy.
- vi. If the Sum Insured under the Policy has been increased at the time of Renewal, the Plus Benefit shall be calculated on the Sum Insured of the last completed Policy Year.
- vii. If the Policy Period is of two or three years, the Plus Benefit shall be credited post completion of each Policy Year, and will be available for any claims made in the subsequent Policy Year.
- viii. New Insured Person added to the Policy during subsequent Renewals will be eligible for the Plus Benefit as per their Renewal terms.

4.5. Secure Benefit

An additional amount as specified in the Policy Schedule will be

available to the Insured Person as Sum Insured for all claims admissible under Section 3 (Base Coverage) and Section 4.3 (Protect Benefit) during the Policy Year, subject to the following conditions:

- a. This Secure Benefit shall be applied only once during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.
- b. The Secure Benefit can be utilized for any number of claims admissible under the Policy during the Policy Year.
- c. The Secure Benefit will be applicable only after exhaustion of Base Sum Insured.
- d. In case of family floater policy, the Secure Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

4.6. Automatic Restore Benefit

In the event of complete or partial utilization of the Base Sum Insured due to any claim admitted during the Policy Year irrespective of the utilization of the Cumulative Bonus, Plus Benefit, and Secure Benefit, the Company shall restore the Sum Insured up to the Base Sum Insured (as applicable under the current Policy Year) for any subsequent claims admissible under Section 3 (Base Coverage) and Section 4.3 (Protect Benefit) (if in force), subject to the following conditions:

- a. This Automatic Restore Benefit shall be applied only once during each Policy Year and any unutilized amount, in whole or in part, will not be carried forward to the subsequent Policy Year.
- b. The Base Sum Insured restoration under the Automatic Restore Benefit would be triggered only upon complete or partial utilization of the Base Sum Insured by the way of first claim admitted under the Policy, and be available for subsequent claims thereafter in the Policy Year, for the Insured Person.
- c. In case of a family floater policy, the Automatic Restore Benefit will be available on floater basis for all Insured Persons covered under the Policy and will operate in accordance with the above conditions.

4.7. Aggregate Deductible

The Insured Person shall bear an amount equal to the Aggregate Deductible specified on Policy Schedule for all admissible claims made by the Insured Person and assessed by the Company in a Policy Year. The liability of the Company to pay the admissible claim under that Policy Year will commence only once the specified Aggregate Deductible has been exhausted. This Cover shall be subject to the following conditions:

- a. This Cover is applicable on annual aggregate basis and can be opted only at inception of the Policy or at subsequent Renewals. Aggregate Deductible can be increased at the time of Renewal.
- b. In case of Individual Policy, the entire amount of Aggregate Deductible must first be exhausted on per Insured Person basis, once in a Policy Year, before the Company pays for claims of that Insured Person in that Policy Year.
- c. In case of family floater Policy, the entire amount of Aggregate Deductible must first be exhausted by any one or more of the Insured Persons once in a Policy Year before the Company pays for claims of any Family Member covered under the Policy in the Policy Year.
- d. Preventive Health Check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force.
- e. Preventive Health Check-up benefit, Secure Benefit, Cumulative Bonus / Plus Benefit, Automatic Restore Benefit, Daily Cash for Shared Room and Unlimited Restore (Add-on) benefits will not be available under the policy if Aggregate Deductible of INR 10 Lakhs or more is in force.

- f. The Aggregate Deductible is not applicable to Sections 4.8 (E-Opinion for Critical Illness), and 5.2 (Preventive Health Check Up). Sections 4.9 (Global Health Cover (Emergency Treatments Only)), Section 4.10 (Global Health Cover (Emergency and Planned Treatments Only)) and Section 4.11 (Overseas Travel Secure). Hence, coverage under Section 4.8 (E-opinion for Critical Illness), Section 5 (Preventive Health Check Up), Section 4.9 (Global Health Cover (Emergency Treatments Only)), Section 4.10 (Global Health Cover (Emergency and Planned Treatments Only)) and Section 4.11 (Overseas Travel Secure) can be availed irrespective of whether the chosen Aggregate Deductible limit is breached or not, during the Policy Year.

4.7.1. Waiver of Aggregate Deductible

- a. Age of eldest Insured Person should be less than 50 years at the time of purchasing this Policy (with aggregate deductible)
- b. Only after completion of 5 continuous Policy Years with Us in this Policy and the age of eldest Insured Person covered in the Policy should be less than 61 years at the time of availing this option.
- c. Continuity benefits of waiting period accrued as per expiring Policy Year (with aggregate deductible) shall be offered even after availing this option.
- d. This option shall apply to all Insured Person(s) once selected, without any individual selection.
- e. Post availing 'Waiver of Aggregate Deductible' option, premium will be charged as per the modification made.
- f. In the event that an Aggregate Deductible is reduced OR is completely waived, at renewal, the Insured Persons shall be eligible for the benefits applicable as per the plan / Aggregate Deductible / Sum Insured applicable in the forthcoming Policy Years post renewal.

4.8. E-Opinion for Critical Illness

The Company shall indemnify the expenses incurred by the Insured Person towards E-Opinion for Critical Illness availed from a Medical Practitioner in respect of any Major Medical Illness (of the nature listed below) through the Network Provider specified in the Policy Schedule, subject to the following conditions:

- a. Benefit under this cover shall be subject to the eligible geography of the Network Provider. The Insured Person may contact the Company or refer to its website for details on eligible Network Provider(s).
- b. The Benefit under this Cover can be availed by an Insured Person only once in a Policy Year, and shall be available for each Insured Person in case the Policy is issued on a floater basis.
- c. The Insured Person is free to choose whether or not to obtain the E-Opinion for Critical Illness, and if obtained, it is the Insured Person's sole and absolute discretion to follow the suggestion for any advice related to his/her health. It is understood and agreed that any information and documentation provided to the Company for the purpose of seeking the E-Opinion for Critical Illness shall be shared with the Network Providers.
- d. Availing this benefit shall not have any impact on the Sum Insured

Disclaimer - E-Opinion for Critical Illness Services are being offered by Network Providers through its portal/mail/App or any other electronic form to the Policyholders/Insured Person. In no event shall the Company be liable for any direct, indirect, punitive, incidental, special, or consequential damages or any other damages whatsoever caused to the Policyholders/Insured Person while receiving the services from Network Providers or arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Network Provider or treating Medical Practitioner.

Major Medical Illness			
1	Cancer of specified severity	26	Apallic Syndrome
2	Open Chest CABG	27	Aplastic Anaemia
3	Kidney failure requiring regular dialysis	28	Bacterial Meningitis
4	Myocardial Infarction (First Heart Attack of specified severity)	29	Cardiomyopathy
5	Open Heart Replacement or Repair of Heart Valves	30	Other serious coronary artery disease
6	Major Organ/Bone Marrow Transplantation	31	Creutzfeldt-Jakob Disease (CJD)
7	Multiple Sclerosis with persisting symptoms	32	Encephalitis
8	Permanent Paralysis of Limbs	33	End Stage Lung Failure
9	Stroke resulting in permanent symptoms	34	Fulminant Hepatitis
10	Benign Brain Tumour	35	Eisenmenger's Syndrome
11	Coma of specified severity	36	Major Head Trauma
12	Parkinson's Disease	37	Chronic Adrenal Insufficiency (Addison's Disease)
13	Alzheimer's Disease	38	Progressive Scleroderma
14	Surgery of Aorta	39	Progressive Supranuclear Palsy
15	End Stage Liver Failure	40	Blindness
16	Deafness	41	Chronic Relapsing Pancreatitis
17	Loss of Speech	42	Elephantiasis
18	Third Degree Burns	43	Brain Surgery
19	Medullary Cystic Disease	44	HIV due to blood transfusion and occupationally acquired HIV
20	Motor Neurone Disease with permanent symptoms	45	Terminal Illness
21	Muscular Dystrophy	46	Myelofibrosis
22	Infective Endocarditis	47	Pheochromocytoma
23	Primary (Idiopathic) Pulmonary Hypertension	48	Crohn's Disease
24	Dissecting Aortic Aneurysm	49	Severe Rheumatoid Arthritis
25	Systemic Lupus Erythematous with Lupus Nephritis	50	Severe Ulcerative Colitis
		51	Angioplasty

4.9. Global Health Cover (Emergency Treatments Only)

On availing this cover, the below mentioned benefits shall be extended for Emergency Medical Expenses which are diagnosed and incurred outside India:

3.1	Hospitalization Expenses
3.4	AYUSH Treatment
3.7	Organ Donor Expenses
4.1	Emergency Air Ambulance
4.3	Protect Benefit
4.4	Plus Benefit
4.8	E Opinion for Critical Illness

A. Global Health Cover (Emergency Treatments Only) is applicable subject to following terms and conditions

- I. Our maximum liability in a Policy Year for claims under this cover shall not exceed the Base Sum Insured and Plus Benefit (if available).
- II. Section 4.7 (Aggregate Deductible) will not be applicable for any claim under this cover. However, a Per Claim Deductible of Rs. 10,000 will apply separately for each and every claim (except Section 4.8 'E Opinion for Critical Illness') under this cover.
- III. Claims shall normally be payable on Reimbursement basis only. Cashless facility may be arranged on case to case basis.
- IV. The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.
- V. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
- VI. We would not be liable to pay any claim wherein the medical treatment taken outside India has not commenced within the first 45 days of a trip. Note: Each trip shall be deemed to start within the Policy Period and from the date Insured Person finally boards the flight (scheduled aircraft operated under a valid license for the transportation of fare paying passengers under a valid ticket) to leave from India.
- VII. There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan.

B. Specific Exclusions applicable to Global Health Cover (Emergency Treatments Only)

- i. Any Planned treatments
- ii. In case we have paid a Hospitalization claim under this benefit, Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expenses related to the claim whether incurred overseas or within India are not payable under this Policy.
- iii. Treatment or part of treatment for any condition which is not Life threatening in nature and can be safely postponed till the Insured Person returns to India.
- iv. Medical treatment taken outside India if that is the sole reason or one of the reasons for the journey.
- v. Any treatment of orthopedic diseases or conditions except for fractures, dislocations and / or Injuries suffered during the Policy Period.
- vi. Oncological (Cancer) diseases
- vii. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction.

4.10. Global Health Cover (Emergency & Planned Treatments)

On availing this cover, the below mentioned benefits shall be extended for both planned and Emergency Medical Expenses incurred outside India:

3.1	Hospitalization Expenses
3.4	AYUSH Treatment
3.5	Pre-Hospitalization cover
3.6	Post-Hospitalization cover
3.7	Organ Donor Expenses
4.1	Emergency Air Ambulance
4.3	Protect Benefit
4.4	Plus Benefit
4.8	E Opinion for Critical Illness

Global Health Cover (Emergency & Planned Treatments) is applicable subject to following terms and conditions

- i. Our maximum liability in a Policy Year for claims under this cover shall not exceed the Base Sum Insured and Plus Benefit (if available).
- ii. Section 4.7 (Aggregate Deductible) will not be applicable for any claim under this cover. However, a Per Claim Deductible of Rs. 10,000 will apply separately for each and every claim (except Section 4.8 'E Opinion for Critical Illness') under this cover.
- iii. Claims shall normally be payable on Reimbursement basis only. Cashless facility may be arranged on case to case basis.
- iv. The treatment should be taken in a registered Hospital, as per law, rules and/ or regulations applicable to the country, where the treatment is taken.
- v. The payment of any Claim under this Benefit will be based on the rate of exchange as on the date of payment to the Hospital published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian Rupees for payment of Claims. If on the Insured Person's Date of Discharge, if RBI rates are not published, the exchange rate next published by RBI shall be considered for conversion.
- vi. The Company may not be liable to make any payment under this Policy, wherein the Government of India has laid down territorial restriction.
- vii. There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan.
- viii. Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expenses incurred and paid overseas shall be indemnified only if the concerned hospitalization was undertaken overseas and claim for such hospitalization was admissible under 'Global Health Cover (Emergency & Planned Treatments)
- ix. In case we have accepted an overseas hospitalization claim under 'Global Health Cover (Emergency & Planned Treatments)' then
 - a. Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expenses concerning such hospitalization shall be paid only if the same have been incurred and paid overseas (as per details in invoice/supporting documents).
 - b. Any Pre-hospitalization Medical Expenses and/or Post-hospitalization Medical Expense emanating from an overseas hospitalization claim but incurred in India shall not be payable under the policy.
- x. In case of Migration and Portability, all waiting periods shall apply afresh only for planned hospitalization claims admissible under 'Global Health Cover (Emergency & Planned Treatments)'. Such waiting periods shall commence from the date 'Global Health Cover (Emergency & Planned Treatments) has come into force.

4.11. Overseas Travel Secure

- i. This optional cover can only be opted along with Optima Secure Global Plan or Optima Secure Global Plus Plan on payment of additional premium.

- ii. Claim under this benefit shall be payable upto Sum Insured and is admissible only if both the below conditions are fulfilled:
 - a. The overseas treating Medical Practitioner has advised a minimum hospitalization of 5 consecutive days and has also advised the requirement of an accompanying person during treatment.
 - b. We have accepted a claim under
 - Section 4.9 Global Health Cover (Emergency Treatments Only) OR
 - Section 4.10 Global Health Cover (Emergency & Planned Treatments)
- iii. There is no separate Sum Insured for this optional cover and any claim triggered under this benefit shall reduce the Sum Insured of the opted plan.

- iv. We will indemnify the following expenses incurred overseas:

1. Travel Expenses

- a. We will indemnify actual expenses incurred on air tickets (most basic economy class airfare in a common carrier) for the Hospitalized Insured Person and any one accompanying person to attend to the Insured Person's medical treatment overseas.
 - i. For Emergency hospitalization cases, we shall indemnify for the following travel expenses
 - For the accompanying person, two way expense incurred on air tickets from his City of Residence OR India to the airport nearest to the site of hospitalization shall be provided.
 - For the Hospitalized Insured Person, we shall only indemnify air expenses incurred to transport him from the airport nearest to the site of Hospitalization to India.
 - ii. For planned hospitalization cases, we shall indemnify for the following travel expenses
 - For the accompanying person, two way expense incurred on air tickets from his City of Residence OR India to the airport nearest to the site of hospitalization shall be provided.
 - For the Hospitalized Insured Person, we shall indemnify two way expense incurred on air tickets from India to the airport nearest to the site of hospitalization shall be provided.
 - iii. In case the accompanying person was already present in that city at the time of such hospitalization, we shall only indemnify air expenses incurred to transport him from the airport nearest to the site of Hospitalization to his City of Residence OR India.
- b. Any kind of other transportation expenses except the expense on airfare is not payable under this optional cover Note - For Insured Person, City of Residence shall be considered as declared in the Proposal Form and mentioned in the Policy Schedule. Whereas, for accompanying person, City of Residence shall be considered as mentioned in the legal document issued by the Government of that particular country.

2. Accommodation Expenses

- a. We will also indemnify the cost of accommodation, at a place near to the site of Hospitalization, for the accompanying person, to attend to the Insured Person's medical treatment overseas.
- b. Cost of accommodation overseas shall be indemnified upto Rs. 15,000 per day, only for the days wherein the Insured person was hospitalized overseas; maximum upto 30 days in a Policy Year.
- c. Any other kind of supplementary expenses such as meals, laundry, transport are not payable under this cover. that any information and documentation provided to the Company

5. Preventive Health Check-up

On each continuous Renewal of the Policy, the Company will indemnify the cost of a Preventive Health Check-up for the Insured Person who was insured during the previous Policy Year, up to the amounts specified in this Cover below.

- This Cover does NOT carry forward if it is not claimed and shall not be provided if the Policy is not renewed further.
- The amount specified in the Policy schedule against this benefit denotes the Company's maximum liability in respect to the benefit and shall not reduce the Sum Insured of the policy.
- For Individual Policies, the below mentioned limits are applicable for each Insured Person per Policy Year.
- This benefit is available every year post completion of the first Policy Year.

Sum Insured under the Policy	5 Lakhs	10 Lakhs	15 Lakhs	20, 25 & 50 Lakhs	100 & 200 Lakhs
Limit of Cover	₹1,500	₹2,000	₹4,000	₹5,000	₹8,000

For Family Floater Policies, the below mentioned limits are applicable cumulatively for all Insured Persons per Policy Year.

Sum Insured under the Policy	5 Lakhs	10 Lakhs	15 Lakhs	20, 25 & 50 Lakhs	100 & 200 Lakhs
Limit of Cover	₹2,500	₹5,000	₹8,000	₹10,000	₹15,000

6. Add on - Cover

my: Optima Secure offers following Add on Covers:

- My: health Critical Illness Add On with Sum Insured options of ₹100,000 to ₹500,00,000 in multiples of ₹100,000
- My: health Hospital Cash Benefit Add On with Sum Insured options of ₹500/ ₹1000/ ₹1500 / ₹2000/ ₹2500 / ₹3000 / ₹5000/ ₹7500/ ₹10,000
- Individual Personal Accident Rider with Sum Insured 5 (five) times the Sum Insured of Base Plan up to a maximum of Rs 1 Crore
- Unlimited Restore (Add on): Provides unlimited restoration in a Policy Year.

(For in depth details on terms and conditions applicable to add-ons, Kindly refer to the Prospectus & Policy wording documents of the respective add-on available under downloads section on our website).

7. Pre Policy Check up

Pre-Policy Check-up at our network may be required based upon the age and basic sum insured.

- We will reimburse 100% of the expenses incurred per Insured Person on the acceptance of the proposal.
- If Proposal is declined post PPC, 100% of Medical test charges will be borne by the customer for ₹500,000 sum insured, 50% for ₹10,00,000 Sum Insured and NIL for other Sum Insureds.
- In case of any adverse medical declaration on the proposal form, we may request for additional medical tests

Other T&C (Applicable for Health Only):

Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

Instalment Premium payment through Auto Debit/ECS Facility

- If premium payment is opted for by instalments through auto debit/ECS facility, a separate authorization form shall be submitted by Insured Person specifying the frequency chosen for premium to be debited.
- Where there is a change either in the terms and conditions of the coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh.
- The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable.
- No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode.

Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

Withdrawal of Policy

- 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.
- 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.

Discount (Health):

- Online Discount: The Insured Person is eligible for 5% discount on premium in case he / she purchase the Policy online from the Company's website or the Company's mobile app. or across technology platforms wherein they undertake digital marketing for the Company or assist with technology systems reducing IT costs for the Company. The subsequent Renewal of the same Policy will continue to enjoy the 5% discount, provided the Policy remains without the involvement of any other insurance agent or insurance intermediary.
- Employee Discount: A discount of 5 % on the Premium is applicable if any Insured Person is a HDFC Group employee (full time employee) / Munich Re Group employee (full time employee) at the time of enrolment, or subsequent renewal; provided that such Policy is purchased through the Company's website or the Company's mobile app and without the involvement of any insurance agent or insurance intermediary.
- Loyalty Discount: If any Insured Person has an active retail insurance Policy with premium above Rs. 2,000 with the Company, a discount of 2.5% on the Policy premium will be applicable at the time of enrolment as well as subsequent renewals.

- Family Discount: The Insured Person will be entitled to receive 10% discount on the premium if two or more family members are covered under the same Policy under the individual Policy option.

The above mentioned discounts are cumulative in nature and the total discount offered under Employee discount, Online discount, Loyalty discount and Family discount shall not exceed 20%.

- Long Term Policy Discount: If the Policy Period is more than one year, the Insured Person will be entitled to receive a discount of 7.5% and 10% will be offered in case a Policy is purchased for 2-year and 3-year tenure respectively, provided he has paid the premium in advance as a single premium.
- NRI Discount - Insured Person residing overseas with declaration that they are based abroad in entirety for the Policy Year will be offered a discount of 40%, subject to the following conditions:
 - This is applicable in case the Insured's status is NRI for the whole year and he wishes to continue earning his PED coverage until upon his return. However, while in India if the Insured wishes to make a claim, he may do so by making the differential payment applicable on the policy.
 - For Insured who have been offered NRI discount in a particular policy year and at policy renewal makes further declaration of his stay abroad for the forthcoming year the applicable NRI discount would be offered on the renewal premium. If the Insured would be based in India then no discount would be applicable upon renewal.
 - For Insured who have been offered NRI discount in a particular policy year and he returns to India anytime during the year, the Insured can notify the Company about the change and make payment for the additional premium (equivalent to the applicable NRI discount). If the additional premium payment hasn't been made during the year, the same would be added to the renewal premium at the policy anniversary. The policy would be renewed subject to the full premium being received by the Company. In case of long term policies, the additional premium will be recovered only for the corresponding year and not from retrospective date.
- Aggregate Deductible Discount: If Aggregate Deductible is opted for all Insured Person, following discount will be applicable on the Policy premium.

Deductible Amount (INR)	Optima Suraksha, Optima Secure & Optima Super Secure			Optima Secure Global Base SI 100/200 lakhs	Optima Secure Global Plus Base SI 100/200 lakhs
	Base SI < 25 lakhs	Base SI = 25 lakhs	Base SI >= 50 lakhs		
25,000	25%	15%	15%	14%	4%
50,000	40%	30%	30%	27%	8%
1,00,000	50%	40%	40%	36%	10%
2,00,000	55%	45%	45%	41%	11%
3,00,000	65%	55%	55%	50%	14%
5,00,000	NA	62%	62%	56%	16%
10,00,000	NA	80.45%	80.45%	73%	20%
20,00,000	NA	NA	88%	80%	22%
25,00,000	NA	NA	90%	82%	23%

Note: Wherever NA is mentioned in the table above, that particular Deductible & Sum Insured combination is not available and cannot be opted under the product

Loadings

- The Company may apply loading on the premium, specific Waiting Period or permanent exclusions, based on the declarations made in the Proposal Form and the health status, habits and lifestyle, past medical records, and the results of the pre-Policy medical examination of the persons proposed to be insured under the Policy.
- The maximum medical underwriting loading shall not exceed 100% for each condition and a total of 150% for each Insured Person.
- Loadings shall be applied from Commencement Date including subsequent Renewal(s), and on increased Sum Insured.

- Proposer shall be informed about the proposed loading with premium, specific Waiting Period or permanent exclusion (if any) through a counter offer letter and Policy will be issued only on specific acceptance within 15 days of the receipt of such counter offer letter. In case the Company does not receive any response to the counter offer letter from the proposer within 15 days, the application shall be cancelled and any premium received shall be refunded within 7 days.

Please Note

- Premium rates and policy terms and conditions are for standard healthy individuals. These may change post underwriting of proposal based on medical tests (where applicable) and information provided on the proposal form. Please visit our nearest branch to referring our underwriting guidelines, if required. Premium rates are subject to change with prior approval from IRDAI.
- In a family floater Policy, a maximum of 4 adults and a maximum of 6 dependent children can be included in a single Policy. The 4 adults can be a combination of self, spouse, parents and parents-in-law. In an individual Policy, a maximum of 6 adults and a maximum of 6 dependent children can be included in a single Policy. List of relationships which can be included is mentioned below:

i. Spouse	viii. Daughter-in-law	xv. Sister
ii. Son	ix. Son-in-Law	xvi. Sister-in-law
iii. Daughter	x. Grandfather	xvii. Brother-in-law
iv. Father	xi. Grandmother	xviii. Nephew
v. Mother	xii. Grandson	xix. Niece
vi. Father-in-law	xiii. Granddaughter	
vii. Mother-in-law	xiv. Brother	

- The premium will be computed basis the city of residence provided by the insured person in the application form. The premium that would be applicable zone wise and the cities defined in each zone are as under:
 - Delhi NCR/Mumbai MMR - Delhi, Gurgaon, Noida, Faridabad, Ghaziabad, Greater Noida, Mumbai, Navi Mumbai, Thane, Kalyan, Dombivali, Bhayandar, Ulhasnagar, Bhiwandi, Vasai, Virar
 - Rest of India- All other cities

What are the Exclusions?

Protection-

Suicide Exclusion

In case of death due to suicide within 12 months from the date of commencement of risk under the policy or from the date of revival of the policy, as applicable, the nominee or beneficiary of the policyholder shall be entitled to at least 80% of the total premiums paid till the date of death or the surrender value available as on the date of death whichever is higher, provided the policy is in force.

Note: Exclusions for Critical Illness and Accidental Death Benefit are mentioned in Annexure-I and Annexure-II below respectively

Health-

The Company shall not make payment for any claim in respect of any Insured Person caused by, arising from or attributable to any of the following unless expressly stated to the contrary in the Policy:

7.1. Standard Exclusions

All the Waiting Periods and exclusions listed below shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

a. Pre-Existing Diseases - Code - Excl01

- 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 insurer.

- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- iv. 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 Insurer.

b. Specified Disease/Procedure waiting period- Code - Excl02

- i. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.
- ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. 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.
- iv. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
- v. 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.

vi. List of specific diseases/procedures is provided below:

Illnesses

	Non infective Arthritis	Pilonidal sinus
Diseases of gall bladder including cholecystitis	calculus diseases of Urogenital system e.g.Kidneystone,Urinary Bladder Stone	Benign tumors, cysts, nodules, polyps including breast lumps
Pancreatitis	Ulcer and erosion of stomach and duodenum	Polycystic ovarian diseases
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)	Sinusitis, Rhinitis
Perineal Abscesses	Perianal Abscesses	Skin tumors
Cataract and other disorders of lens and Retina	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism	Tonsillitis
Osteoarthritis and osteoporosis	Fibroids (fibromyoma)	Benign Hyperplasia of Prostate

Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy	Hernia
Dilatation and curettage (D&C)	Nasal concha resection	Surgery for prolapsed inter vertebral disc
Myomectomy for fibroids	Surgery of Genito urinary system unless necessitated by Malignancy	Surgery for varicose veins and varicose ulcers
Surgery on prostate	Cholecystectomy	Surgery for Perianal Abscesses
Hydrocele/Rectocele	Joint replacement surgeries	Surgery for Nasal septum deviation
Ligament, Tendon and Meniscal tear	Hysterectomy	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries
Endometriosis	Prolapsed Uterus	Rectal Prolapse
Varicocele	Retinal detachment	Glaucoma
Nasal polypectomy		

c. 30-day waiting period - Code - Excl03

- 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.

d. Investigation & Evaluation: Code Excl04

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

e. Rest Cure, rehabilitation and respite care: Code - Excl05:

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

- 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.

f. Obesity/Weight control: Code - Excl06:

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

- i. Surgery to be conducted is upon the advice of the Doctor
- ii. The surgery/Procedure conducted should be supported by clinical protocols
- iii. The member has to be 18 years of age or older and
- iv. 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:
 - 1) Obesity-related cardiomyopathy
 - 2) Coronary heart disease
 - 3) Severe sleep apnoea
 - 4) Uncontrolled type2 diabetes

g. Change-of-Gender treatments:Code - Excl07: Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

h. Cosmetic or plastic Surgery: Code - Excl08: Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

i. Hazardous or Adventure Sports: Code - Excl09: Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

- j. **Breach of Law:Code - Excl10:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
 - k. **Excluded Providers:Code - Excl11:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the Policyholders are not admissible. However, in case of Life Threatening Situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.
 - l. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code - Excl12.**
 - m. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code - Excl13.**
 - n. 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 Careprocedure. **Code - Excl14.**
 - o. **Refractive Error:Code - Excl15:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
 - p. **Unproven Treatments: Code - Excl16:**Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
 - q. **Sterility and Infertility: Code - Excl17:** 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.
 - r. **Maternity: Code - Excl18**
 - 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.
- d. Any Insured Person's participation or involvement in naval, military or air force operation.
 - e. Investigative treatment for sleep-apnoea, general debility or exhaustion ("run-down condition").
 - f. Congenital external diseases, defects or anomalies.
 - g. Stem cell harvesting.
 - h. Investigative treatments for analysis and adjustments of spinal sub luxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
 - i. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).
 - j. Vaccination including inoculation and immunisations (except post animal bite treatment).
 - k. Non-Medical expenses such as food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges and other such items. Full list of Non-Medical Expenses is attached as ANNEXURE B and also available at www.hdfcergo.com.
 - l. Treatment taken on outpatient basis.
 - m. The provision or fitting of hearing aids, spectacles or contact lenses.
 - n. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement methods, optometric therapy.
 - o. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively), prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident.
 - p. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. Drugs or treatments which are not supported by a prescription.
 - q. Any permanent exclusion applied on any medical or physical condition or treatment of an Insured Person as specifically mentioned in the Policy Schedule and as specifically accepted by Policyholder/Insured Person. Such exclusions shall be applied for the condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person as per Company's Underwriting Policy.

What if I don't pay premiums?

Protection:

Grace Period is the time provided after the premium due date during which the policy is considered to be in-force with the risk cover. This plan has a grace period of 30 days for yearly, half yearly and quarterly frequencies from the premium due date. The grace period for monthly frequency is 15 days from the premium due date.

Should a valid claim arise under the policy during the grace period, but before the payment of due premium, we shall still honor the claim. In such cases, the due and unpaid premium for the policy year will be deducted from any benefit payable.

Upon premium discontinuance, if Unexpired Risk Premium Value is not acquired then the policy lapses without any value.

If a policy has acquired Unexpired Risk Premium Value, all benefits such as death, maturity and survival benefits, whether ROP benefit has been selected or not, will be reduced as follows:

7.2. Specific Exclusions:

In addition to the foregoing general exclusions, the Company shall not be liable to make any payment under this Policy caused by or arising out of or attributable to any of the following:

- a. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical or Biological attack or weapons, radiation of any kind.
- b. Aggregate Deductible - Claims/claim amount falling within Aggregate Deductible limit if opted and in force, as specified in the Policy Schedule.
- c. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide.

$$\text{Paid-up benefit} = \text{In-force benefit} \times \frac{\text{Total Premiums Paid}}{\text{Total Premiums Payable}}$$

Health-

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person. If the Insured Person has opted for payment of Premium on an instalment basis i.e. Yearly, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy):

- a. Grace Period as mentioned in the table below would be given to pay the instalment premium due for the Policy

Options	Instalment Premium Option	Grace Period applicable
Option 1	Multi-Year / Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 Days

- b. 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
 - c. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period
 - d. No interest will be charged If the instalment premium is not paid on due date
 - e. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled
 - f. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
 - g. The Company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
- **Basic Sum Insured Enhancement** - Basic sum insured can be enhanced only at the time of renewal subject to the underwriting norms and acceptability criteria of the policy. If the insured enhances the basic sum insured one grid up, no fresh medicals shall be required. In cases where the basic sum insured enhanced is more than one grid up, the case may be subject to medicals. In case of enhancement in the basic sum insured waiting period will apply afresh in relation to the amount by which the basic sum insured has been enhanced. However the quantum of increase shall be at the discretion of the company.
 - Any Insured Person in the Click 2 Protect Optima Secure has the option to discontinue this policy and take an individual policy with the respective Insurer subject to terms and conditions of that policy and guidelines issued by IRDAI

Can I surrender any policy?

Protection:

Unexpired Risk Premium Value (Surrender Value) gets acquired immediately upon payment of premium in case of SP and upon payment of premiums for 2 years in case of LP or RP. Unexpired Risk Premium Value will be calculated as follows:

For Income Plus Option or Return of Premium Option:

Unexpired Risk Premium Value will be the higher of Guaranteed Surrender Value (GSV) and Special Surrender Value (SSV), payable subject to the policy acquiring Unexpired Risk Premium Value.

Where,

$$\text{GSV} = \text{GSV Factor\%} \times \text{Total Prmiums Paid} - \text{Survival Benefits or ROP Instalment Already Paid}$$

The GSV will be floored to 0.

Where Income Plus Option has been selected:

$$\text{SSV} = ((\text{SSCF1 Factor\%} \times \text{Basic Sum Assured}) + (\text{SSVF2 Factor\%} \times \text{Sum Assured on Maturity})) \times \text{Total Premiums Paid} / \text{Total Premiums payable}$$

And where ROP option has been selected:

$$\text{SSV} = \text{SSVF2 Factor\%} \times \text{Total Premiums Paid}$$

For details on GSV and SSV factors, please consult your financial advisor.

For Life Protect Option (Whole Life):

$$50\% \times \text{Total Premiums Paid} \times \frac{\text{Max}(100 - \text{age at surrender}, 0)}{100 - \text{Age at Entry}}$$

Other than Income Plus Option, Life Protect Option (Whole Life) and Return of Premium Option:

Unexpired Risk Premium Value for LP/SP¹ =

$$50\% \times \text{total premiums Paid} \times \frac{\text{Unexpired Policy Term}}{\text{Original Policy Term}}$$

Surrender Value for RP = Nil

¹ If you have exercised the option to change premium payment term, Total Premiums Paid will include only premiums paid from the date of converting to Limited Pay and Original Policy Term will be the outstanding policy term on the date of converting to Limited Pay.

Please note:

- i. For the purpose of calculation of Unexpired Policy Term, only full calendar months shall be considered.
- ii. For the purpose of computation of Unexpired Risk Premium Value, the Premiums shall exclude any applicable taxes and levies paid in respect of this Policy.

Health (Cancellation Other than free look cancellation)

- a. The Policyholder may cancel this Policy by giving 15 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period. Note: For Policies where premium is paid by instalment, In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.
- b. 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.
- c. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s
- d. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

Please Note: Customer can continue with either part of the policy discontinuing the other during the policy term.

Please Note: HDFC Life Insurance Company Limited will process all claims for Protection policy and HDFC ERGO General Insurance Company Limited will process all claims for Health policy.

Which are the Critical Illnesses covered under this plan? (Only applicable for Protection Benefit)

The following is a list of Critical Illnesses covered:

Critical Illnesses covered	
1. Cancer of Specified Severity	2. Myocardial infarction - First heart attack of specific severity
3. Open Heart Replacement or Repair of Heart Valves	4. Kidney Failure Requiring Regular Dialysis
5. Major Organ/ Bone Marrow Transplant	6. Coronary Artery Bypass Graft (Open, Keyhole or minimally invasive or Robotic Cardiac CABG)
7. Multiple Sclerosis with persisting symptoms	8. Stroke resulting in permanent symptoms
9. Coma of specific severity	10. Permanent Paralysis of Limbs
11. Motor Neuron Disease with Permanent Symptoms	12. Benign Brain Tumor
13. Blindness	14. Deafness
15. End stage lung failure	16. End stage liver failure
17. Loss of Speech	18. Loss of Limbs
19. Major Head Trauma	20. Primary (idiopathic) pulmonary hypertension
21. Third Degree Burns	22. Alzheimer's Disease
23. Aplastic Anaemia	24. Medullary Cystic Kidney Disease
25. Parkinson's Disease	26. Systemic Lupus Erythematosus (SLE) with Lupus Nephritis
27. Apallic Syndrome	28. Major Surgery of Aorta
29. Brain Surgery	30. Fulminant Viral Hepatitis
31. Cardiomyopathy	32. Muscular dystrophy
33. Poliomyelitis	34. Pneumonectomy
35. Severe Rheumatoid Arthritis	36. Progressive Scleroderma

Annexure I

DEFINITIONS OF CRITICAL ILLNESSES

Critical Illness means illness, the signs or symptoms of which first commence more than 90 days following the Issue Date or Commencement Date or the date of any reinstatement of this Contract, whichever is the latest and shall include either the first diagnosis of any of the following illnesses or first performance of any of the covered surgeries stated below:

1. Cancer of Specified Severity

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than Rai stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial infarction (First heart attack of specified severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Other acute Coronary Syndromes
- Any type of angina pectoris
- A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Open Heart Replacement or Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

4. Kidney Failure Requiring Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

5. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

6. Coronary Artery Bypass Graft (Open, Keyhole or minimally invasive or Robotic Cardiac CABG)

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

7. Multiple Sclerosis with persisting symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

- Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Neurological damage due to SLE is excluded.

8. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

- Transient ischemic attacks (TIA)

- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

9. Coma of specified severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- No response to external stimuli continuously for at least 96 hours;
- Life support measures are necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

10. Permanent paralysis of limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

11. Motor Neuron Disease with Permanent Symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

12. Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist:

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:

- Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

- Corrected visual acuity being 3/60 or less in both eyes or ;
- The field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

14. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total

means “the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing” in both ears.

15. End stage lung failure

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO₂ < 55mmHg); and
- Dyspnea at rest.

16. End stage liver failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

17. Loss of speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18. Loss of limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

19. Major head trauma

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

- Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa; Mobility: the ability to move indoors from room to room on level surfaces;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level

of personal hygiene;

- Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

- Spinal cord injury

20. Primary (idiopathic) pulmonary hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

- Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

22. Alzheimer's Disease

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by the Company's appointed doctor. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life assured. There must also be an inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following 6 “Activities of Daily Living” for a continuous period of at least 3 months:

Activities of Daily Living are defined as:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa;
- Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding – the ability to feed oneself once food has been prepared and made available.
- Mobility – the ability to move from room to room without requiring any physical assistance.

The following are excluded:

- Any other type of irreversible organic disorder/dementia
- Alcohol-related brain damage.

23. Aplastic Anaemia

Chronic Irreversible persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least TWO of the following:

- Regular blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis and suggested line of treatment must be confirmed by a Haematologist acceptable to the Company using relevant laboratory investigations, including bone-marrow biopsy. Two out of the following three values should be present:

- Absolute neutrophil count of 500 per cubic millimetre or less;
- Absolute erythrocyte count of 20 000 per cubic millimetre or less; and
- Platelet count of 20 000 per cubic millimetre or less.

Temporary or reversible aplastic anaemia is excluded.

24. Medullary Cystic Kidney Disease

Medullary Cystic Kidney Disease where the following criteria are met:

- The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
- Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
- The Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

25. Parkinson's Disease

The unequivocal diagnosis of primary idiopathic Parkinson's disease (all other forms of Parkinsonism are excluded) made by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

- The disease cannot be controlled with medication; and
- Objective signs of progressive impairment; and
- There is an inability of the Life assured to perform (whether aided or unaided) at least 3 of the following six (6) "Activities of Daily Living" for a continuous period of at least 6 months.

The Activities of Daily Living are:

- Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa; Mobility: the ability to move indoors from room to room on level surfaces;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding: the ability to feed oneself once food has been prepared and made available. Drug-induced or toxic causes of Parkinsonism are excluded.

26. Systemic Lupus Erythematosus (SLE) with Lupus Nephritis

A multi-system, multifactorial, autoimmune disease characterized by the development of auto-antibodies directed against various

self-antigens. In respect of this Contract, Systemic Lupus Erythematosus (SLE) will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology. There must be positive antinuclear antibody test.

Other forms, discoid lupus, and those forms with only haematological and joint involvement will be specifically excluded. WHO Classification of Lupus Nephritis:

- Class I: Minimal change Lupus Glomerulonephritis - Negative, normal urine.
- Class II: Mesangial Lupus Glomerulonephritis - Moderate Proteinuria, active sediment
- Class III: Focal Segmental Proliferative Lupus Glomerulonephritis - Proteinuria, active sediment
- Class IV: Diffuse Proliferative Lupus Glomerulonephritis - Acute nephritis with active sediment and / or nephritic syndrome.
- Class V: Membranous Lupus Glomerulonephritis - Nephrotic Syndrome or severe proteinuria.

27. Apallic Syndrome

Universal necrosis of the brain cortex, with the brain stem remaining intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

28. Major Surgery of Aorta

The actual undergoing of surgery for a disease or injury of the aorta needing excision and surgical replacement of the diseased part of the aorta with a graft.

The term "aorta" means the thoracic and abdominal aorta but not its branches

Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

29. Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy with removal of bone flap to access the brain is performed. The following are excluded:

- Burr hole procedures, transphenoidal procedures and other minimally invasive procedures such as irradiation by gamma knife or endovascular embolizations, thrombolysis and stereotactic biopsy
- Brain surgery as a result of an accident

30. Fulminant Viral Hepatitis

A submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

- Rapid decreasing of liver size as confirmed by abdominal ultrasound; and
- Necrosis involving entire lobules, leaving only a collapsed reticular framework (histological evidence is required); and
- Rapid deterioration of liver function tests; and
- Deepening jaundice; and
- Hepatic encephalopathy.

Hepatitis B infection carrier alone does not meet the diagnostic criteria.

This excludes Fulminant Viral Hepatitis caused by alcohol, toxic

substance or drug.

31. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent for at least six (6) months, based on the following classification criteria:

Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

32. Muscular dystrophy

A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle based on three (3) out of four (4) of the following conditions:

- Family history of other affected individuals;
- Clinical presentation including absence of sensory disturbance, normal cerebro- spinal fluid and mild tendon reflex reduction; Characteristic electromyogram; or
- Clinical suspicion confirmed by muscle biopsy.

The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist.

The condition must result in the inability of the Life Assured to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living' as defined, for a continuous period of at least six (6) months. Activities of Daily Living are defined as:

- Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- Mobility: the ability to move indoors from room to room on level surfaces;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding: the ability to feed oneself once food has been prepared and made available.

33. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

- Poliovirus is identified as the cause and is proved by Stool Analysis,
- Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

The diagnosis of Poliomyelitis must be confirmed by a Registered Medical Practitioner who is a neurologist.

34. Pneumonectomy

The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung for any physical injury or disease.

35. Severe Rheumatoid Arthritis

The Severe Rheumatoid Arthritis with all of the following factors:

- Is in accordance with the criteria on Rheumatoid Arthritis of the American College of Rheumatology and has been diagnosed by the Rheumatologist.
- At least 3 joints are damaged or deformed such as finger joint, wrist, elbow, knee joint, hip joint, ankles, cervical spine or feet toe joint as confirmed by clinical and radiological evidence and cannot perform at least 3 types of daily routines permanently for at least 180 days.

36. Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following conditions are excluded:

- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilic fasciitis; and
- CREST syndrome.

Exclusions for Critical Illness Benefit

Apart from the disease specific exclusions given along with definitions of diseases above, no benefit will be payable if the critical illness is caused or aggravated directly or indirectly by any of the following:

- Diagnosis of any of the listed critical illness and/or hospitalization and/or treatment (availed or advised) within 90 days of the risk commencement date or reinstatement date whichever is later.
- Any Pre-existing disease, that is any condition, ailment, injury or disease:
 - a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
 - b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
- Any illness due to external congenital defect or disease which has manifested or was diagnosed before the Insured attains age 18. Where, external congenital defect or disease is a congenital anomaly which is in the visible and accessible parts of the body.
- Suicide or attempted suicide or intentional self-inflicted injury, by the life insured, whether sane or not at that time.
- Life assured being under the influence of drugs, alcohol, narcotics or psychotropic substance, not prescribed by a Registered Medical Practitioner
- War, invasion, hostilities (whether war is declared or not), civil war, rebellion, terrorist activity, revolution or taking part in a riot or civil commotion, strikes or industrial action.
- Participation by the life assured in a criminal or unlawful act with criminal intent or committing any breach of law including involvement in any fight or affray.
- Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate exposure to exceptional danger.
- Any underwater or subterranean operation or activity. Racing of any kind other than on foot

- Existence of any sexually Transmitted Disease (STD)
- Failure to seek or follow medical advice, the Life assured has delayed medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy.
- Nuclear reaction, Biological, radioactive or chemical contamination due to nuclear accident.
- Any treatment of a donor for the replacement of an organ;
- Diagnosis and treatment outside India.

Waiting Period for Critical Illness Benefit

- No benefit shall be paid in case the Life Assured is diagnosed with any of the applicable listed Critical Illnesses within 90 days from the date of commencement or revival of cover, whichever occurs later except in cases where the Critical Illness occurs as a result of an accident (such as Major Head Trauma).
- All of the evidence needed to make a claims assessment in accordance with the definitions above, is made available before the death of the life assured.
- The insured has to survive 30 days after the 'complete diagnosis' of the defined critical illness condition being claimed and subject to fulfilment of policy definitions. Failure to do so entitles the Insurance Company to refuse any claim under this cover.
- No payment under Critical Illness benefit would be made if the diagnosis of the condition is made after the death of the life insured. The time of diagnosis is the point in time at which the insured first satisfied all of the requirements of the definition AND all of the test results and medical reports required to support the diagnosis in accordance with the definition are available in a form suitable for sending to the insurer.

Annexure II

Accidental Death Benefit (ADB) Option

Definitions

Accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means. Accidental Death means death by or due to a bodily injury caused by an Accident, independent of all other causes of death. Accidental Death must be caused within 180 days of any bodily injury.

“Accidental death” shall mean death:

- which is caused by bodily injury resulting from an accident and
- which occurs due to the said bodily injury solely, directly and independently of any other causes and
- which occurs within 180 days of the occurrence of such accident but before the expiry of the cover and
- is not a result from any of the causes listed in the exclusions for accidental death benefit.

“Bodily Injury” means Injury must be evidenced by external signs such as contusion, bruise and wound except in cases of drowning and internal injury.

“Injury” means accidental physical bodily harm excluding any Illness, solely and directly caused by an external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

“Medical Practitioner” means a person who holds a valid registration from the medical council of any State of India or Medical Council of India or any other such body or Council for Indian Medicine or for homeopathy set up by the Government of India or by a State Government and is thereby entitled to practice medicine within its jurisdiction and is acting within the scope and jurisdiction of his license, provided such Medical Practitioner is not the Life Insured covered under this Policy or the Policyholder or is not a spouse, lineal

relative of the Life Insured and/or the Policyholder or a Medical Practitioner employed by the Policyholder/Life Insured.

Exclusions for Accidental Death benefit

Additional accidental death benefit will not be payable, if death is caused directly or in-directly from any of the following:

- If the death occurs after 180 days from the date of the accident
- Injury occurred before the risk commencement date
- Suicide or attempted suicide or intentional self-inflicted injury, by the life insured, whether sane or not at that time.
- Life assured being under the influence of drugs, alcohol, narcotics or psychotropic substance, not prescribed by a Registered Medical Practitioner.
- War, invasion, hostilities (whether war is declared or not), civil war, rebellion, terrorist activity, revolution or taking part in a riot or civil commotion, strike or industrial action.
- Participation by the life assured in a criminal or unlawful act with criminal intent or committing any breach of law including involvement in any fight or affray.
- Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate exposure to exceptional danger.
- Any underwater or subterranean operation or activity. Racing of any kind other than on foot
- Services in any military, air force, naval, police, paramilitary or similar organisation including service in the armed forces in time of declared or undeclared war or while under orders for warlike operations or restoration of public order,
- Participation by the insured person in any flying activity other than as a bona fide passenger (whether paying or not), in a licensed aircraft provided the life insured does not, at the time, have any duty on board such aircraft.
- Violation or attempted violation of the law or resistance to arrest.
- Nuclear reaction, Radioactive or chemical contamination due to nuclear accident.

Rider Options

We offer the following Rider options (as modified from time to time) to help you enhance your protection

Protection:

Rider	UIN	Scope of Benefits**
HDFC Life Income Benefit on Accidental Disability Rider	101B013V03	A benefit equal to 1% of Rider Sum Assured per month for the next 10 years, in case of an Accidental Total Permanent Disability. There is no maturity benefit available under this rider.
HDFC Life Critical Illness Plus Rider	101B014V02	A lump sum benefit equal to the Rider Sum Assured shall be payable in case you are diagnosed with any of the 19 Critical Illnesses and survive for a period of 30 days following the diagnosis. There is no maturity benefit available under this rider.
HDFC Life Protect Plus Rider	101B016V01	A benefit as a proportion of the Rider Sum Assured shall be payable in case on accidental death or partial/total disability due to accident or if you are diagnosed with cancer as per the option chosen under this rider. No maturity benefit is payable under this rider.

Health:

Rider	UIN	Scope of Benefits**
my: Health Hospital Cash Benefit (Add-on)	HDFHLIA21271 V022021	A comprehensive fixed benefit product for each day of hospitalization, to help the insured meet additional expenses over and above hospitalization expenses. In respect of this add-on, the Company will pay the Sum Insured as opted for each completed 24 hours of hospitalization, for ICU and towards expenses of accompanying person
my: Health Critical Illness (Add-on)	HDFHLIA22141 V032122	A fixed benefit provided, as opted by the insured, on diagnosis of specifically defined critical illness, manifestation of medical event or surgical procedure over and above the benefits from the base product
Individual Personal Accident Rider	HDHHLIP2134 6V042021	Provides Lump sum pay out in case of Accidental Death, Permanent Total Disablement and Permanent Partial Disablement. Sum Insured shall be 5 (five) times the Sum Insured of Base Plan up to a maximum of Rs.1 Crore
Unlimited Restore (Add on)	HDFHLIA2218 8V012122	Unlimited restoration in a Policy Year

**For all details on Riders, kindly refer to the Rider Brochures available on our website

Annexure A

Schedule of Benefits

Section*	Plans	Optima Suraksha	Optima Secure	Optima Super Secure	Optima Secure Global	Optima Secure Global Plus
	Base Sum Insured	5/10/15/20/ 25/50 Lakhs	5/10/15/20/25/ 50/100/200 Lakhs	10/15/20/25/ 50/100/200 Lakhs	100/200Lakhs	100/200Lakhs
	^Geography	India only	India only	India only	Worldwide including India	Worldwide including India
Base Coverages						
1	Hospitalization Expenses	100%	100%	100%	100%	100%
1.1	Room Rent	At Actuals	At Actuals	At Actuals	At Actuals	At Actuals
1.2	Road Ambulance	Covered	Covered	Covered	Covered	Covered
1.3	Dental Treatment	Covered	Covered	Covered	Covered	Covered
1.4	Plastic surgery	Covered	Covered	Covered	Covered	Covered
1.5	Day Care Treatment	Covered	Covered	Covered	Covered	Covered
2	Home Healthcare	Covered	Covered	Covered	Covered (India only)	Covered (India only)
3	Domiciliary Hospitalization	Covered	Covered	Covered	Covered (India only)	Covered (India only)
4	AYUSH Treatment	Covered	Covered	Covered	Covered	Covered
5	Pre-Hospitalization	60 days	60 days	60 days	60 days (India only)	60 days
6	Post-Hospitalization	180 days	180 days	180 days	180 days (India only)	180 days
7	Organ Donor Expenses	Covered	Covered	Covered	Covered	Covered
8	Cumulative Bonus	Covered	Not Covered	Not Covered	Not Covered	Not Covered

Optional Covers						
1	Emergency Air Ambulance	Covered Up to 5 L	Covered Up to 5 L	Covered Up to 5 L	Covered Up to 5 L	Covered Up to 5 L
2	Daily Cash for Shared room	Covered 800 per day max up to 4800	Covered 800 per day max up to 4800	Covered Rs. 1000 per day max up to 6000	Covered (India only) Rs. 800 per day max upto 4800	Covered (India only) Rs. 800 per day max upto 4800
3	Secure Benefit	Not Covered	Covered 100%	Covered 200%	Covered (India only) 100%	Covered (India only) 100%
4	Automatic Restore Benefit	Covered	Covered	Covered	Covered (India only)	Covered (India only)
5	Protect Benefit	Not Covered	Covered	Covered	Covered	Covered
6	Plus Benefit	Not Covered	Covered	Covered	Covered	Covered
7	**Aggregate Deductible	25k/50k/1L/2L/3L/5L/10L/20L/25L	25k/50k/1L/2L/3L/5L/10L/20L/25L	25k/50k/1L/2L/3L/5L/10L/20L/25L	25k/50k/1L/2L/3L/5L/10L/20L/25L (India only)	25k/50k/1L/2L/3L/5L/10L/20L/25L (India only)
8	E Opinion for Critical Illness	India	India	Global	Global	Global
9	Global Health Cover (Emergency Treatments Only)	Not Covered	Not Covered	Not Covered	Covered (Outside India only)	Not Covered
10	Global Health Cover (Emergency & Planned Treatments)	Not Covered	Not Covered	Not Covered	Not Covered	Covered (Outside India only)
11	**Overseas Travel Secure	Not Covered	Not Covered	Not Covered	Covered (Outside India only)	Covered (Outside India only)
Wellbeing Cover						
1	Preventive Health Check-up	Defined Limits	Defined Limits	Defined Limits	Defined Limits (India only)	Defined Limits (India only)

Note:

- Optional Covers (except Aggregate Deductible & Overseas Travel Secure) are inbuilt in Plans as per the above table. Premium of such Optional covers are included in the premium of the respective Plan.
- **Aggregate Deductible & Overseas Travel Secure are not an inbuilt feature in any of the above Plans. However, these cover can be separately opted at inception of the Policy or at subsequent Renewals. Aggregate Deductible if opted, shall apply only for claims arising in India. However, a Per Claim Deductible of Rs. 10,000 will apply separately for each and every claim arising out of India in Global plans
- 5L / 10L Deductible can only be opted with Sum Insured > = 25 L
- 20L / 25L Deductible can only be opted with Sum Insured > = 50 L
- ^Claims shall be payable as per geography mentioned unless explicitly stated otherwise in a specific cover.
- Preventive Health Check-up benefit will not be available under the policy if Aggregate Deductible of INR 5 Lakhs is in force.
- Preventive Health Check-up, Secure Benefit, Cumulative Bonus / Plus Benefit, Automatic Restore Benefit, Daily Cash for Shared Room and Unlimited Restore (Add-on) benefits will not be available under the policy if Aggregate Deductible of INR 10 Lakhs or more is in force.

Annexure B

List I - Items for which Coverage is not available in the Policy (Non-Medical Expenses)

S. 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

S. No.	Item
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

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	Conveyance charges
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	Surcharges
30	Medical certificate
31	Medical records
32	Photocopies charges
33	Mortuary charges
34	Walking aids charges

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	Trolley cover
66	Urometer, urine jug
67	Ambulance
68	Vasofix safety

This Policy is subject to Regulation 12 of IRDAI (Protection of Policyholder's Interests) Regulations 2017.

Premium Computation Illustration

Illustration 1

- Plan Name - Optima Secure
- Tenure - 1 Year
- Location - Delhi - Tier 1

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of 10% (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater discount of 55% applied on all the members except the oldest member	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
5	8,500	10	8,500	850	7,650	10	8,500	4,675	3,825	10
25	12,500	10	12,500	1,250	11,250	10	12,500	6,875	5,625	10
35	14,500	10	14,500	1,450	13,050	10	14,500	7,975	6,525	10
45	16,500	10	16,500	1,650	14,850	10	16,500	9,075	7,425	10
55	32,500	10	32,500	3,250	29,250	10	32,500	17,875	14,625	10
65	58,000	10	58,000	5,800	52,200	10	58,000	0	58,000	10
	1,42,500				1,28,250				96,025	

Total premium for all members of the family is Rs. 1,42,500, when each member is covered separately. Sum Insured available for each individual is Rs. 10 Lakhs.	Total premium for all members of the family is Rs. 1,28,250, when they are covered under a single policy. Sum Insured available for each individual is Rs. 10 Lakhs.	Total premium when policy is opted on floater basis is Rs. 96,025. Sum Insured of Rs. 10 Lakhs is available for the entire family.
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Illustration 2

- Plan Name - Optima Secure
- Tenure - 1 Year
- Location - Delhi - Tier 1

Age of the members insured (in Years)	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (only one Sum Insured is available for the entire family)			
	Premium (Rs.)	Sum Insured in Lakhs (Rs.)	Premium (Rs.)	Family Discount of 10% (if any)	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)	Premium or consolidated premium for all family members of the family (Rs.)	Floater discount of 55% applied on all the members except the oldest member	Premium after discount (Rs.)	Sum Insured in Lakhs (Rs.)
10	9,500	10	9,500	950	8,550	10	9,500	5,225	4,275	10
24	12,300	10	12,300	1,230	11,070	10	12,300	6,765	5,535	10
45	16,500	10	16,500	1,650	14,850	10	16,500	9,075	7,425	10
55	32,500	10	32,500	3,250	29,250	10	32,500	17,875	14,625	10
65	58,000	10	58,000	5,800	52,200	10	58,000	31,900	26,100	10
75	93,000	10	93,000	9,300	83,700	10	93,000	0	93,000	10
	2,21,800				1,99,620				1,50,960	
	Total premium for all members of the family is Rs. 2,21,800, when each member is covered separately. Sum Insured available for each individual is Rs. 10 Lakhs.		Total premium for all members of the family is Rs. 1,99,620, when they are covered under a single policy. Sum Insured available for each individual is Rs. 10 Lakhs.				Total premium when policy is opted on floater basis is Rs. 1,50,960. Sum Insured of Rs. 10 Lakhs is available for the entire family.			

Terms & Conditions

A. Tax Benefits:

Protection-

Tax benefits under this plan may be available. Premiums paid by an individual or HUF under this plan and the benefits received from this policy may be eligible for tax benefits as per the applicable sections of the Income Tax Act, 1961, as amended from time to time.

You are requested to consult your tax advisor for advice on Tax Benefits.

Health -

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

B. Cancellation in a free-look period:

Protection :

The free-look period for policies purchased through distance marketing/Online (specified below) will be 30 days.

Protection & Health

In case you are not agreeable to the any policy terms and conditions, you have the option of returning the policy to us stating the reasons thereof, within 15 days from the date of receipt of the policy. On receipt of your letter along with the original policy documents, we shall arrange to refund you the premium, subject to below mentioned conditions:

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

- 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
- where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

Distance Marketing refers to insurance policies sold over the telephone or the internet or any other method that does not involve face-to-face selling.

C. Revival:

Protection:

You can revive your lapsed/ paid-up policy within the revival period (specified below) subject to the terms and conditions we may specify from time to time. For revival, you will need to pay all the outstanding premiums and interest on the outstanding premiums and taxes and levies as applicable. Interest rate will be as prevailing from time to time. The current interest rate used for revival is 9.5% p.a. compounded annually.

The revival period shall be of five years as specified by the current Regulations. The revival period may be changed as specified by Regulations from time to time.

The revival interest shall be reviewed half-yearly and it will be reset to: Average Annualized 10-year benchmark G-Sec Yield (over last 6 months & rounded up to the nearest 50 bps) + 2%. The change in revival rate shall be effective from 25th February and 25th August each year. Any change on basis of determination of interest rate for revival will be done only after prior approval of the Authority.

Once the policy is revived, you are entitled to receive all contractual benefits.

Health:

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

- a. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal
- b. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years
- c. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period
- d. 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
- e. No loading shall apply on renewals based on individual claims experience.

D. Nomination as per Section 39 of the Insurance Act 1938 as amended from time to time:

Protection

- 1) The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.
- 2) Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
- 3) Nomination can be made at any time before the maturity of the policy.
- 4) Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.
- 5) Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.
- 6) A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.
- 7) Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
- 8) A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
- 9) The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act, 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply

Health-

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

Protection & Health

E. Assignment as per Section 38 of the Insurance Act 1938 as amended from time to time:

- 1) This policy may be transferred/assigned, wholly or in part, with or without consideration.
- 2) An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
- 3) The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
- 4) The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
- 5) The transfer or assignment shall not be operative as against an Insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy thereof certified to be correct by both transferor and transferee or their duly authorized agents have been delivered to the Insurer.
- 6) Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
- 7) On receipt of notice with fee, the Insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
- 8) The Insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is (a) not bonafide or (b) not in the interest of the policyholder or (c) not in public interest or (d) is for the purpose of trading of the insurance policy.
- 9) In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

Section D (Nomination) and E (Assignment or Transfer) are simplified versions prepared for general information only and hence are not comprehensive. For full texts of these sections please refer to Section 38 and Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

F. Policy Loan: No policy loans are available.

G. Prohibition of Rebates: In accordance with Section 41 of the Insurance Act, 1938 as amended from time to time :

- 1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer.

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

H. Non-Disclosure: In accordance with Section 45 of the Insurance Act, 1938 as amended from time to time :

- 1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later.
- 2) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based.
- 3) Notwithstanding anything contained in sub-section (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer: Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive.
- 4) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued: Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based: Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation.
- 5) Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

I. Taxes:

Indirect Taxes

Taxes and levies as applicable shall be levied . Any taxes, statutory levy becoming applicable in future may become payable by you by any method including by levy of an additional monetary amount in addition to premium and or charges.

Direct Taxes

Tax will be deducted at the applicable rate from the payments made under the policy, as per the provisions of the Income Tax Act, 1961, as amended from time to time.

- J.** For Policies purchased through online channel, a discount of 5.5% on premiums paid towards both Life & Health will be offered as compared to the individual policy purchased under Life & Health. For Policies purchased through other than online channel, a discount of 5% on premiums paid towards Life & Health will be offered as compared to the individual policy purchased under Life & Health. At any time during the validity of the policy, the Customer decides to opt out of the insurance coverage of one of the Insurer, the discount, if any, being offered to such Customer under the Combi-Product(s) shall not be available to the Customer going forward.
- K.** Where the risk is not accepted by one of the Parties, the Combi-Product(s) shall not be issued and the other Insurer shall be free to issue their respective policy individually to the Customers, if the Customer so desires, as if the business was done by that respective Insurer individually without any obligation of confirmation being taken from the other Insurer. Provided that if the Customer desires to take a policy individually from either of the Parties; the Customer shall not be entitled to the discount, if any, being offered under the Combi-Product(s) and would be governed by the terms and conditions of the individual policy being offered by either of the Parties.
- L.** Any insurer may terminate this tie up wholly or in part only with cause and after making a joint application for the requisite approval from IRDAI. The insurers agree that upon receipt of such approval from IRDAI, the insurers may terminate this tie up within a period of 90 (ninety) days from the date of such approval. The insurers may mutually decide to terminate the Agreement and intimate the same to you ninety (90) day prior to the termination of the relationship. However, Your Policy will continue until the expiry or termination of the coverage in accordance with the policy wordings for respective coverage.
- M.** Upon termination of the arrangement, each insurer has equal rights over the Customers sourced under this arrangement and it shall be at the sole discretion of the Customer with whom she/ he would like to continue his/ her insurance. However, both the insurer shall also mutually agree for Customer engagement/ servicing programme post termination of the arrangement. Each insurer shall remain liable for its respective portion of Click 2 Protect Optima Secure for all policies in force at the time of termination of the tie up until their expiry or lapsation.
- N.** The legal/ quasi legal disputes, if any, are dealt by the respective insurers for respective benefits. For protection benefits all the legal disputes will be handled by HDFC Life Insurance Company Limited and for health benefits all the legal disputes will be handled by HDFC ERGO General Insurance Company Limited
- O.** All policy servicing requests pertaining to Click 2 Protect Optima Secure shall be received by either of the insurer. Other than the requests impacting premium or terms and conditions of the policy towards the policy of the respective Insurer all other requests shall be serviced by the receiving insurer. All requests impacting premium or policy terms towards the policy of a respective Insurer shall be serviced by the respective Insurer and the receiving Insurer shall only facilitate in receiving such requests. Both Insurers will fulfill servicing request received by them as per Protection of Policyholders' Interests Regulations, 2002. Both the Parties are responsible for the pro-active and speedy settlement of claims and other obligations in accordance with the terms and conditions of their respective line of business - health or life coverage/ plan of Click 2 Protect Optima Secure . Claim process is available on the website of both the companies.
- P.** Customer can lodge a grievance for either or both products at branches of both Insurers.
- Complaint belonging to any product shall be routed to the respective insurer who shall then respond / address to the Customer directly. Complaints shall be forwarded by the receiving Insurer to the respective Insurer within T+ 2 days, T being the complaint receivable date. In case the Customer is not satisfied with the resolution offered, Customer can also approach the Insurance Ombudsman in his region. Please refer relevant grievance redressal mechanism section mentioned under each policy document.
- Q.** It is advised to familiarize with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.
- R.** Premium Component of both the products is separate and at the time of renewal customer can discontinue either part of the policy during the policy term and migrate into a similar individual policy with the respective insurer. The terms and conditions of the portion will be similar to the terms and conditions of the product, if it would have been sold in isolation.
- S.** According to Guidelines on Insurance repositories and electronic issuance of insurance policies issued by IRDAI dated 29th April, 2011, a policyholder can now have his life insurance policies in dematerialized form through a password protected online account called an electronic Insurance Account (eIA). This eIA can hold insurance policies issued from any insurer in dematerialized form, thereby facilitating the policy holder to access his policies on a common online platform. Facilities such as online premium payment, changes in address are available through the eIA. Furthermore, you would not be required to provide any KYC documents for any future policy purchase with any insurer. For more information on eIA visit <http://www.hdfclife.com/customer-service/life-insurance-policy-dematerialization>

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1800-266-9777 (Toll free)
(Available all days 10am to 7pm)

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Sar utha ke jyo!

HDFC Life Insurance Company Limited ("HDFC Life"). CIN: L65110MH2000PLC128245. IRDAI Registration No. 101.

Registered Office: 13th Floor, Lodha Excelus, Apollo Mills Compound, N. M. Joshi Marg, Mahalaxmi, Mumbai - 400 011.

Email: service@hdfclife.com, Tel. No: 1860 267 9999 (Mon-Sat 10 am to 7 pm) Local charges apply. Do NOT prefix any country code. e.g. +91 or 00. Website: www.hdfclife.com
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Registered & Corporate Office: 1st Floor, HDFC House, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai - 400 020.

Email id: care@hdfcergo.com, Customer Care: 0120 6234 6234 / 022 6234 6234.

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- IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.