IndiaFirstLife
PROMOTED BY
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Bank of Baroda

Comprehensive healthcare for the ones you truly care!

IndiaFirst Life Group Living Benefits Plan

(A Non-linked Non-participating Group, Fixed Benefit, Health Insurance Plan)

Before You Start Reading

Important Note

IndiaFirst Life Group Living Benefits Plan is referred to as the Policy throughout the brochure.

How Will This Brochure Help You?

This brochure gives you details of how this policy works throughout its lifetime. It's an important document to refer to.

To Help Your Understanding

We've done our best to explain everything as simply as possible; however, you're likely to come across some terms you're unfamiliar with. Where possible, we've explained these.

We have used plain language that's easy to understand and believe this brochure is a good place to start when planning your future under this health insurance policy.

About IndiaFirst Life Insurance

Headquartered in Mumbai, IndiaFirst Life Insurance Company Limited (IndiaFirst Life), with a paid-up share capital of INR 754 crores, is one of the country's youngest life insurance companies. Its current shareholders include Bank of Baroda, Union Bank of India, and Carmel Point Investments India Private Limited, which hold 65%, 09%, and 26% stakes in the company. Carmel Point Investments India Pvt Ltd. is incorporated by Carmel Point Investment Ltd, a body corporate incorporated under the laws of Mauritius and owned by private equity funds managed by Warburg Pincus LLC, New York, United States. The company's key differentiator is its simple, easy-to-understand products that are fairly priced and efficiently serviced. For details, please visit https://www.indiafirstlife.com/.

Introduction

Health insurance is a vital safety cushion for one's hard-earned savings in today's age of mounting healthcare costs. For you as the Master Policy Holder, a health insurance plan should be designed to meet the specific healthcare needs of your members and offers wide-ranging yet affordable coverage options for a financially secured future.

Presenting, IndiaFirst Life Group Living Benefits Plan, a comprehensive plan that provides necessary financial assistance to your members / employees / customers in an event of hospitalization, fracture, disability or on Cancer, Vector Borne diseases or COVID-19 or SARS-CoV-2.

Executive Summary

For the Master Policyholder

- You can now provide financial support to all your members / customers / employees on occurrence of any of the covered medical exigencies
- Enjoy tax benefits as per applicable tax laws

For the Member

- You can avail the cover at reasonable premium
- You get a customized health insurance plan, as per your healthcare requirements
- You can protect yourself from the financial impact of rising healthcare costs
- Enjoy tax benefits as per applicable tax laws

1. What is IndiaFirst Life Group Living Benefits Plan?

IndiaFirst Life Group Living Benefits Plan is a non-linked, non-participating, group fixed benefit health insurance plan that offers lumpsum payout in the event of hospitalization, fracture, disability or on diagnosis of Cancer, Vector Borne diseases, on positive diagnosis of COVID-19 or SARS-CoV-2 (and being quarantined in any government authorized hospitals or centers), as per the cover option(s) selected by the Master Policyholder/ Member.

2. Who are the people involved in this Policy?

This Policy includes the 'Master Policyholder' and the 'Member'.

Who is the Master Policyholder?

Master Policyholder is you, who offers this Policy to its members / customers / employees in order to secure themselves and their family against uncertainties. The Master Policyholder holds and operates the Policy and may be any of the following:

i) Employees of any organization and/or micro Finance institution.

ii) Any Associations, where the members represent a particular profession/ trade/ domestic worker/ Anganwadi workers;

iii) Any Government Agencies;

iv) Any Co-operative Societies;

v) Parents of School/College Students as members;

vi) Any other groups as may be approved by IRDAI from time to time.

Who is the Member?

The Member, at the time of applying for cover for the first time, could be an individual in the age group of 18 to 65 years (last birthday) and s/he is the member / customer / employee of the Master Policyholder.

The age limits for a member are -

Minimum age at entry	18 years as on last birthday
Maximum age at entry	65 years as on last birthday
Maximum Cover Ceasing age	For Cancer Cover & Coronavirus Cover options – 66 years as on last birthday For other cover options – 80 years as on last birthday

3. What types of cover are available under this policy?

The policy provides health insurance cover to members of a group, on an individual or family floater basis.

A family floater policy shall only be applicable with Daily Hospital Cash Benefit (DHCB) cover option. The member can include his /her legally wedded spouse, dependent unemployed children, unmarried daughters including divorcee and widowed daughters. The maximum number of persons to be covered under the family floater option will be 4 including the member and the combinations possible are:

1) 2 Adult(A)
2) 2A + 1 Child (C)
3) 2A + 2C
4) 1A + 1C
5) 1A + 2C

Children shall only be covered under Daily Hospital Cash Benefit option, subject to following age limits:

Minimum age at entry	91 days
Maximum age at entry	24 years as on last birthday
Maximum Cover Ceasing age	25 years as on last birthday

DHCB chosen will be applicable for all the members covered in the family.

4. What is the group size to whom the cover can be offered?

Minimum Group Size	7 members
Maximum Group Size	No limit

5. What are the minimum and maximum annualized premium under this policy?

Minimum annualized premium applicable under this policy is INR 100 p.a.

There is not limit on the Maximum annualized premium applicable under this policy, subject to Board Approved Underwriting Policy. Premium will be based on rating factor eg. Sum Assured or Cover amount, Commission rate, Age of Life Assured, Size of the group, type of master policyholder and any other rating factors as applicable.

6. What is the minimum and maximum Sum Insured under this policy?

The minimum and maximum Sum Insured options available are as follows:

Cover Option/ Event	Minimum Sum Insured (in INR)	Maximum Sum Insured (in INR)
Daily Hospital Cash Benefit	1,000 per day	10,000 per day
Broken Bones Cover	10,000	1,00,000
Accidental Total Permanent Disability	10,000	1,00,000
Accidental Partial Permanent Disability	10,000	1,00,000
Cancer Cover	10,000	50,00,000
Vector Borne Diseases Cover	5,000	1,00,000
Coronavirus Cover	25,000	2,00,000

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

The Sum insured for Daily Hospitalization Cash Benefit if admitted in ICU will be twice the Daily Hospitalization Cash Benefit (normal) payable per day.

Sum Insured can be chosen in multiples of INR 500. Maximum Sum Insured offered under the cover will be as per Board approved underwriting policy. In case multiple cover options are selected, Master Policyholder/ Member shall have to select separate Sum Insured for each selected cover option.

7.What are the policy period options available under this policy?

A fixed policy period of 12 months is available under this policy.

8. What is the mode/frequency of payment of premiums?

Master Policyholder/ Member can pay premiums on a monthly, quarterly, half yearly or yearly basis.

9. What are the cover options available under this policy?

IndiaFirst Life Group Living Benefits Plan provides flexibility to choose from 6 cover options. Master policyholder /member can choose any one of the below options or combination of options at policy commencement.

A. Daily Hospitalization Cash Benefit (DHCB)

B. Broken Bones Cover

C. Disability Cover

D. Cancer Cover

E. Vector Borne Diseases Cover

F. Coronavirus Cover

A. Daily Hospital Cash Benefit (DHCB)

If the life insured is Hospitalized during the policy period, for a minimum period of 24 'In-patient Care' hours, then Daily Hospital Cash Benefit (DHCB) as selected at inception, will be payable irrespective of the actual hospitalization expenses incurred. On hospitalization for a minimum period of 24 'In-patient Care' hours in ICU, twice the DHCB amount as selected at inception will be payable per day.

The member can avail this benefit for maximum 60 days during the policy period after which the cover will cease till renewal of the policy. In case of family floater option, the entire family will be covered for maximum 60 days during the year after which the cover will cease till renewal of the policy.

Sum Insured will be reinstated in full at the beginning of next policy commencement date irrespective of the member having claimed the hospitalization benefit or not in the previous policy period.

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

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;

iii. has qualified Medical Practitioner(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out

v. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

B. Broken Bones Cover

Sum Insured under this cover option, as chosen at inception of policy is payable in case of any kind of accidental bodily injury resulting in any kind of fracture (hand, leg, etc.). The benefit payable on first claim will be 50% of sum insured and the remaining will be paid if claimed for the second time during the policy period. Sum Insured will be reinstated in full at the beginning of next policy commencement date irrespective of the member having claimed the benefit in the previous policy period.

C. Disability Cover

This option provides cover against:

- Accidental Total Permanent Disability (ATPD), if the member is totally and permanently disabled as a result of an accident during the policy period, or as
- Accidental Permanent Partial Disability (APPD), i.e. if the member is partially and permanently disabled as a result of an accident during the policy period,

as chosen by the policyholder at the inception of policy.

- The Master Policyholder/ Member may choose any one of the benefits, ATPD or APPD
- For ATPD, the master policyholder/ member can choose disability benefit up to 125% of sum insured selected under this cover option, and for APPD the master policyholder/member can choose disability benefit up to 100% of sum insured selected under this cover option.
- The disability benefit will be payable only once during the policy period.

Please note that the benefits under "Broken Bones Cover" and "Disability Cover" are payable independently on happening of the incidents covered subsequent to accident".

The definitions of terminologies used are as follows:

a) Accident: An accident is a sudden, unforeseen and involuntary event caused by external and visible means

b) Injury: Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner

c) Medical Practitioner: Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The Medical practitioner should not be:

i. the policyholder/insured person himself/ herself; or

ii. an authorized insurance intermediary (or related persons) involved with selling or servicing the insurance contract in question; or

iii. employed by or under contractual engagement with the insurance company;

iv. related to the policyholder/ insured person by blood or marriage

d) Total and Permanent Disability should occur within 90 days of the accident independent of any other causes from the date of the Accident. We will have the right to evaluate the insured to confirm total and permanent disability.

Definition 1: Loss of use of limbs or visual loss

As a result of accidental bodily injury the Life insured has suffered

- Loss of the use of both limbs; or
- Loss of the sight in both eyes (Blindness); or
- Loss of the use of one limb and the sight of one eye

The loss of a limb means the physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury. This will include medically necessary amputation necessitated by injury. The separation has to be permanent without any chance of surgical correction. Loss of a limb resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded. The loss of use of the particular limb must be certified by a relevant Medical Practitioner and documented for an uninterrupted period of at least six months.

1. The total loss of vision in one eye means total, permanent and irreversible loss of all vision in an eye as a result of accident.
2. Loss of sight in both eyes – (Blindness) evidenced by:

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

i. corrected visual acuity being 3/60 or less in both eyes or;

ii. the field of vision being less than 10 degrees in both eyes

II. The diagnosis of blindness or the total loss of vision in one eye must be confirmed and must not be correctable by aids or surgical procedure

Definition 2:

Loss of independent living

Permanent Loss of ability through an injury caused solely by an accident, to do at least 3 of the 6 tasks listed below ever again. Total and Permanent Disability should occur within ninety 90 days of the accident independent of any other causes.

For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The insured person must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. Loss of independent living must be medically documented for an uninterrupted period of at least six months.

The tasks are:

i. 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;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

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

Proof of the same must be submitted to us while the Person Insured is alive and permanently disabled. The relevant specialist Medical Practitioner and the Insurer's appointed Medical Practitioner, both must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends. The Insurer will have the right to evaluate the insured person to confirm total and permanent disability

e) Accidental Permanent Partial Disability: A member shall be regarded as being partially & permanently disabled, only if that life, as a result of accident subject to the following PPD:

- Loss of sight in one eye: Total, permanent and irreversible loss of all vision in an eye as a result of accident. it is evidenced by:
  i. corrected visual acuity being 3/60 or less in the affected eye or;
  ii. the field of vision being less than 10 degrees in the affected eye. The diagnosis of loss of sight must be confirmed and must not be correctable by aids or surgical procedure
- Loss of Hearing: Total and irreversible loss of hearing in both ears as a result of 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 90decibels across all frequencies of hearing" in both ears.
- Loss of Speech: Total and irrecoverable loss of the ability to speak as a result of injury 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. All psychiatric related causes are excluded.
- Loss of hand or foot: The physical separation of hand or foot at or above the wrist or ankle level limbs as a result of injury. This will include

medically necessary amputation necessitated by injury. The separation has to be permanent without any chance of surgical correction.

- In order for opted benefit to be payable under APPD, such disability must have persisted for a period of at least 180 days and must in opinion of a specialized medical practitioner, appointed by the company, be deemed permanent. If the Partial & Permanent Disability is due to accident/injury, then claim needs to be admitted within 90 days of accident/injury. However, if there is valid reason of late claim reporting then same may be verified on case to case basis and will honour the claim accordingly. In case of physical severance of the hand at or above the wrist or foot at or above the ankle joint the 180 days deferment period shall not be applicable.

D. Cancer Cover

On diagnosis of early stage of cancer, 20% of sum insured under this cover option, chosen at inception of policy is payable and remaining 80% is payable on advanced stage during the policy period. If cancer is detected at advanced stage, then 100% of sum insured chosen is payable during the policy term.

There is a waiting period of 180 days from the member risk commencement date for eligibility of the benefit i.e. no benefit will be payable for diagnosis during this period. This benefit can be claimed only once and hence will terminate on payment of 100% of sum insured or policy term whichever is earlier.

Early Stage Cancer shall mean the presence of one of the following malignant conditions:

- Prostrate tumour histologically described as TNM Classification T1a or T1b or T1c or of another equivalent or lesser classification.
- Chronic Lymphocytic Leukaemia classified as RAI Stage I or II;
- Hodgkin's Lymphoma Stage I
- Papillary Carcinoma of the thyroid histologically classified as T1aN0M0/T1bN0M0 according to the TNM classification. The benefit will be paid only when total thyroidectomy is performed to treat this condition.

The Diagnosis must be established by histopathological evidence and confirmed by a Pathologist. Pre-malignant lesions and conditions, unless listed above, are excluded.

Advanced Stage Cancer means all Stage IV malignant tumour with the presence of distant metastasis. A spread to lymph nodes only is not covered under this definition. The diagnosis of malignancy must be confirmed by histological evidence.

E. Vector Borne Diseases Cover

On diagnosis of Malaria, Dengue, Filariasis, Kala-azar, Japanese Encephalitis or Chikungunya, sum insured as chosen at inception of policy under this cover option, is payable. Member can claim upto two

times under this cover option, within the policy period. The benefit payable on first claim will be 50% of sum insured and the remaining will be paid if claimed for the second time during the policy period. Sum Insured will be reinstated in full at the beginning of next policy commencement date irrespective of the member having claimed the benefit in the previous policy period

The definitions of diseases are as follows:

a) **Malaria** which is confirmed by a medical practitioner with confirmatory tests indicating presence of Plasmodium falciparum/ vivax/ malaria in the his/her blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

b) **Dengue** Fever which is confirmed by Medical Practitioner along with laboratory examinations results countersigned by a Pathologist/microbiologist indicating 1. Decreasing platelet levels- less than 100,000 cells/mm3; and 2. Immunoglobulins /Polymerase Chain Reaction (PCR) test showing positive results for Dengue 3. Concurrent to the above two conditions the final diagnosis should be confirmed as Dengue Fever.

c) **Filariasis** commonly known as elephantiasis must be confirmed by a Medical Practitioner with laboratory examination with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following Clear and visible manifestation of the disease: 1. lymphoedema, 2. elephantiasis and 3. scrotal swelling 4. Concurrent to the above three conditions the final diagnosis should be confirmed as Filariasis. If the Insured Person is already infected with Filariasis prior to first Policy inception then this benefit will not be extended for lifetime 2. Once the Sum Insured is paid for any Insured Person, no other claim for this particular condition shall be paid to the Insured Person in his/her entire lifetime.

d) **Kala Azar** with the diagnosis of Visceral Leishmaniosis, also known as kala-azar which is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver and anaemia and same must be confirmed by a Medical Practitioner by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for kala azar indicating presence of this disease.

e) **Japanese Encephalitis:** is characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis and same must be confirmed by a Medical Practitioner by positive serological

test for Japanese Encephalitis by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

f) **Chikungunya:** is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue and rash and same must be confirmed by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies.

F. Coronavirus Cover

On positive diagnosis of COVID-19 or SARS-CoV-2 and being quarantined in the Government authorised centers or hospitals specific to Coronavirus, Sum Insured applicable under this option shall be payable. Member can claim upto two times under this cover option, within the policy period. The benefit payable on first claim will be 50% of sum insured and the remaining will be paid if claimed for the second time during the policy period. Sum Insured will be reinstated in full at the beginning of next policy commencement date irrespective of the member having claimed the benefit in the previous policy period.

Currently no benefit will be payable in case of home quarantine on positive diagnosis of COVID-19 or SARS-CoV-2. In future if home quarantine on positive diagnosis of COVID-19 or SARS-CoV-2 is prescribed and approved as a quarantine center by the Central or the State Government or Local Authority then benefit as mentioned above will be payable.

Note - Quarantine shall mean isolation which is prescribed by the Central or the State Government or local authority; and in a place arranged and approved as a quarantine center by the Central or State Government or Local Authority.

10. What is the maturity benefit payable under this Policy?

There is no maturity benefit payable under the policy.

11. What is the death benefit in this Policy?

There is no death benefit payable on death of the member till the end of policy term or prior to terminal date. If death occurs before registering the claim for any benefit eligible as per the plan option chosen, then the same will be paid to the nominee/ appointee/ legal heir.

12. What is the surrender benefit payable under this Policy?

There is no surrender benefit under this policy.

However, you, the Master Policyholder can surrender the Policy anytime. In case of surrender of the policy within the policy period, the member shall get an option to continue the policy as an individual policy till their coverage is terminated as per Certificate of Insurance.

13. What are the tax benefits under this Policy?

Tax benefits may be available on premiums paid and benefits receivable as per prevailing Income Tax Laws. These are subject to change from time to time as per the Government Tax laws. Please consult your tax consultant before investing.

14. Is there a grace period for missed premiums in this policy?

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to continue a policy. If a valid claim has occurred during grace period, then the chosen benefit will be paid after deducting due premium. 15 days of grace period will be allowed under monthly premium mode and 30 days for all other premium modes, wherever applicable.

In case of renewal of the policy 30 days grace period is allowed to the Master policyholder/member in force without loss of continuity benefits such as waiting periods. If a claim has occurred during this grace period (i.e the grace period between previous policy end date and renewal policy commencement date), then the chosen benefit will not be paid.

15. Can you cancel this policy (Free-look)?

You the Master Policyholder / Member can return this Policy Document if you disagree with any of the terms and conditions within the first 30 days from receipt of your Policy Document / Certificate of Insurance, whether received electronically or otherwise. You are required to send us the Policy Document / Certificate of Insurance and a written request stating the reasons for cancellation. In case there is any claim paid out during this period, Master Policyholder/ Member shall not be eligible to free-look the policy.

Do you get any refund when you cancel your policy?

Yes. We will refund an amount within 7 days of receipt of the request equal to the –

Premium paid

Less: i. Pro-rata risk premium and rider premium, if any for the time the policy was in force

Less ii. Any stamp duty paid

Less iii. Expenses incurred on medical examination, if any

16. What are your options to revive the policy?

In case of non-payment of premium within the grace period for non-annual premium payment mode, the policy lapses and cover ceases on expiry of the grace period.

There is no revival in this fixed benefit health insurance policy as this is an yearly renewable product.

17. What is the Waiting Period & Survival Period under this Policy?

Waiting period under different cover options is applicable as follows:

Cover Option/ Event	Waiting Period (in days)
Daily Hospitalization Cash Benefit (DHCB)	30 (not applicable on hospitalization due to accident)
Broken Bones Cover	Not Applicable
Disability Cover	Not Applicable
Cancer Cover	180
Vector Borne Diseases Cover	30
Coronavirus Cover	15

Waiting Period is not applicable from second policy period onwards in case of continuous renewal of the policy.

For Cancer Cover option, Survival period of 5 days is applicable, i.e. for a claim to be eligible; the life insured should have survived for a period of 5 days from the date of diagnosis of Early/Advanced Stage Cancer.

18. What are the exclusions under this Policy?

Below are the exclusions in the policy:

1) Hospitalization primarily for diagnostic / Evaluative procedures where no active regular treatment is given by a doctor or hospitalization for such treatments or procedures customarily and usually performed by Medical Practitioners in the Out Patient Departments or clinics and casualty settings. For COVID-19 the diagnosis done at unauthorized testing centers or inconclusive medical report.
2) If the member or Nominee or anyone acting on their behalf advances any claim knowing the claim to be false, dishonest or fraudulent, then this Cover shall be void and any amounts paid or potentially payable under the Cover shall be forfeited.
3) **For Daily Hospital Cash Benefit:**

1.Pre-Existing disease:

Pre-Existing disease is defined as any condition, ailment, injury or diseases:

a. That is/are diagnosed by a physician within 36 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 36 months prior to the effective date of the policy issued by the insurer or its reinstatement

The above pre-existing exclusion is not under permanent exclusion. Hence, after completion of 36 months from date of issuance or reinstatement, as the case may be, pre-existing exclusion clause will not be applicable.

2. For any medical condition or medical procedure resulting directly or indirectly from self-

inflicted injuries, attempted suicide, while sane or insane;

3. Any existing external congenital anomaly will not be covered, and policy will not be issued for such members having external congenital anomaly. Other than external congenital anomaly all other congenital anomaly will be covered.

   Where External Congenital Anomaly means a condition, which is visible and accessible parts of the body and present since birth, and which is abnormal with reference to form, structure or position.

4. For any medical condition or any medical procedure arising from the donation of any of the life insured's organs;
5. Alcohol or Solvent abuse or taking of Drugs, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner;
6. For any medical condition or any medical procedure arising from nuclear contamination; the radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature;
7. Treatment for injury or illness caused by avocations or 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;
8. Participation by the life insured in a criminal or unlawful act with a criminal intent;
9. Taking part in any naval, military or air force operation during peace time;
10. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, civil commotion, strikes;
11. Participation by the life insured in any flying activity, except as a bona fide, fare-paying passenger, pilot, air crew of a recognized airline on regular routes and on a scheduled timetable.
12. Hospitalisation which is not medically necessary;
13. Any hospitalisation (except due to accident) during the waiting period;
14. Purely investigative procedure not resulting, during the same continuous hospitalization, in any treatment or Elective surgery or treatment which is not medically necessary;
15. Treatment for weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition;
16. Study and treatment of sleep apnoea;

17. Any dental care or surgery of cosmetic nature, extraction of impacted tooth/teeth, orthodontics or orthognathic surgery, or tempero-mandibular joint disorder except as necessitated by an accidental injury;
18. Treatment for infertility or impotency, sex change or any treatment related to it, abortion, sterilization and contraception including any complications relating thereto;
19. Hospitalisation for treatment arising from pregnancy and it's complications which shall include childbirth or miscarriage and ectopic pregnancy;
20. Hospitalisation primarily for diagnosis, X-ray examinations, general physical or medical check-up not followed by active treatment during the hospitalisation period;
21. Stay in hospital where no active treatment is given by specialist medical practitioner, where active treatment means treatment which is Medically Necessary and is directed to the cure of the disease or injury;
22. Alternative therapies or experimental or unproven procedures or treatments, devices or pharmacological regimens of any description (not recognized by Indian Medical Council) or hospitalisation for treatment under any system other than allopathy;
23. Treatment at institutions that do not fall within the scope of hospitals which include places for rest cures, convalescence cures, custodial care in a sanatorium, Homes for persons declared incapable of managing their own affairs, homes for the aged, alcoholics, drug addicts, mentally-disturbed persons and persons in need of care;
24. Admission to a nursing home or home for the care of the aged unless related to the treatment of an acute medical condition;
25. Cosmetic or plastic surgery except to the extent that such surgery is necessary for the repair of damage caused solely by accidental injuries; treatment of xanthelesema, syringoma, acne and alopecia; circumcision unless necessary for treatment of a disease or necessitated due to an accident;
26. Deliberate exposure to exceptional danger (except in an attempt to save human life);
27. Any hospitalisation outside of Republic of India;
28. Removal of any material that was implanted in a former surgery before Date of Risk commencement of the continuous cover; After completion of 36 months from date of issuance or reinstatement, as the case may be, pre-existing exclusion clause will not be applicable

29. Hospitalization for correction of birth defects, congenital anomalies or genetic disorders
30. Rehabilitation or convalescent care or length beyond customary length of stay

4) **For Disability Cover:**

Disability occurring directly or indirectly due to or caused, occasioned, accelerated or aggravated by any of the following will not be covered:

- Suicide or self-inflicted injury, whether the life assured is medically sane or insane.
- War, terrorism, invasion, act of foreign enemy, hostilities, civil war, martial law, rebellion, revolution, insurrection, military or usurper power, civil commotion. War means any war whether declared or not.
- Service in the armed forces, or any police organization, of any country at war or service in any force of an international body
- Taking part in any naval, military or air force operation during peace time.
- Committing an assault, a criminal offence, an illegal activity or any breach of law with criminal intent.
- Alcohol or Solvent abuse or taking of Drugs, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner
- Poison, gas or fumes (voluntary or involuntarily, accidentally or otherwise taken, administered, absorbed or inhaled).
- Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger, pilot, air crew of a recognized airline on regular routes and on a scheduled timetable.
- Taking part in professional sport(s) or any adventurous pursuits or hobbies. "Adventurous Pursuits or Hobbies" includes any kind of racing (other than on foot or swimming), potholing, rock climbing (except on man-made walls), hunting, mountaineering or climbing requiring the use of ropes or guides, any underwater activities involving the use of underwater breathing apparatus including deep sea diving, sky diving, cliff diving, bungee jumping, paragliding, hand gliding and parachuting.
- Nuclear Contamination; the radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

5) **For Vector Borne Diseases Cover:**

Any Treatment other than for vector borne diseases as listed in the Part C of section 9 above. Admission to hospital for less than 24 hours.

6) **For Cancer Cover:**

No benefit shall be payable under the policy in respect of Early Stage Cancer or Advanced Stage Cancer, resulting directly or indirectly from or caused or contributed by (in whole or in part):

- Any pre-existing Cancer including Carcinoma in Situ
- Nuclear, biological or chemical contamination (NBC)
- The policy shall terminate and no benefit shall be payable under the policy if the diagnosis or signs or symptoms (related to the diagnosed Cancer) first occurred during the waiting period.

  Pre-existing cancer means any condition as follows:

  Pre-Existing disease is defined as any condition, ailment, injury or diseases
- That is / are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement or
- For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.
- The above pre-existing exclusion is not under permanent exclusion. Hence, after completion of 36 months from date of issuance or reinstatement, as the case may be, pre-existing exclusion clause will not be applicable Diagnosis and treatment outside India

  Suicide Exclusion: This is not applicable under this policy.

19. What are the conditions under which the cover shall terminate?

By "terminal date" we mean the cover ceasing date. i.e. In case the member is not eligible for further coverage based on the scheme rules, the premium for that member will not be paid. Consequently, the cover will cease.

The insurance coverage will also cease at the earliest of:

1. Member with age 66 years as on last birthday for Cancer Cover & Coronavirus Cover and 80 years for other cover options
2. Termination of contract with the Master Policyholder and member does not wants to continue as individual member till end of term as per Certificate of Insurance
3. Non-payment of regular premium during the grace period
4. Occurrence of death of the member
5. DHCB for the child on attaining age 25 years

20. Nomination: The member can appoint a nominee as per section 39 of the Insurance Act, 1938 as amended from time to time. For more details please refer to our website www.indiafirstlife.com.

21. Assignment: As per the provisions of Section 38 of the Insurance Act, 1938 as amended from time to time. For more details please refer to our website www.indiafirstlife.com.

22. You are prohibited from accepting rebate in any form

Prohibition of Rebate: Section 41 of the Insurance Act, 1938, as amended from time to time, states

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person, to take 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.

23. What happens in case of submission of information which is false or incorrect?

Fraud/Misstatement would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938, as amended from time to time.

A Policy may be called into question as per the provisions of Section 45 of Insurance Act, 1938. A simplified version of the provisions of Section 45 is provided below:

1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 years from
   a. the date of issuance of policy or
   b. the date of commencement of risk or
   c. the date of revival of policy or
   d. the date of rider to the policy whichever is later.
2) On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
   a. the date of issuance of policy or
   b. the date of commencement of risk or
   c. the date of revival of policy or
   d. the date of rider to the policy whichever is later.

   For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.
3) Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b. The active concealment of a fact by the insured having knowledge or belief of the fact;
   c. Any other act fitted to deceive; and
   d. Any such act or omission as the law specifically declares to be fraudulent.

4) Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.

5) No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6) Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.

7) In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.

8) Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.

9) The insurer can call 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 of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not the exact text of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.]

24. Policy Servicing & Grievance Handling Mechanism

You may contact us in case of any grievance at any of our branches or at Customer Care, IndiaFirst Life Insurance Company Ltd, 12th & 13th floor, North [C] Wing, Tower 4, Nesco IT Park, Nesco Center, Western

Express Highway, Goregaon (East), Mumbai – 400 063, Contact No.: 1800 209 8700, Email id: customer.first@indiafirstlife.com. IRDAI Regn No. 143. CIN: U66010MH2008PLC183679

a. An acknowledgment to all such grievances received will be sent immediately from the date of receipt of the grievance

b. A written communication giving reasons of either redressing or rejecting the grievance will be sent to you within 14 days from the date of receipt of the grievance. In case We don't receive a revert from You within 8 weeks from the date of registration of grievance, We will treat the complaint as closed.

However, if you are not satisfied with our resolution provided or have not received any response within 14 , then, you may approach our Grievance Officer at the nearest IndiaFirst Life Insurance's branch or you may write to our Grievance Redressal Officer at grievance.redressal@indiafirstlife.com.

c. If you are not satisfied with the resolution or have not received any response within 14 days then you can contact the insurance ombudsman. For the list of ombudsman office please refer Annexure B

d. Further, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

IRDAI Grievance Call Centre (IGCC)
TOLL FREE NO: 155255/ 1800 4254 732

Email ID: complaints@irdai.gov.in

You can also register your complaint online athttps://bimabharosa.irdai.gov.in/

Address for communication for complaints by post:

Policyholder Protection & Grievance Redressal Department (PPGR) – Grievance Redressal Cell,

Insurance Regulatory and Development Authority of India,

Sy. No. 115/1, Financial District, Nanakramguda

Gachibowli, Hyderabad- 500032, Telangana

IRDAI TOLL FREE NO: 18004254732

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IndiaFirst Life Insurance Company Limited, IRDAI Regn No.143, CIN: U66010MH2008PLC183679, Address: 12th & 13th floor, North Tower, Building 4, Nesco IT Park, Nesco Centre, Western Express Highway, Goregaon (East), Mumbai – 400 063. Toll free No – 18002098700. Advtg. Ref. No.: IndiaFirst Life Group Living Benefits Plan /Brochure/001

BEWARE OF SPURIOUS PHONE CALLS AND FICTIOUS/ FRAUDULENT OFFERS

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