

Proposal No: _____

INDUSIND GROUP HOSPI CASH INSURANCE (PLAN - A) CERTIFICATE OF INSURANCE

Please Note:

1. To be filled and signed by Proposer and all fields are mandatory to be filled.
2. This Proposal shall be the basis of contract for Policy issuance.
3. IndusInd General Insurance Company Limited (the "Company") is under no obligation to accept any proposal for insurance. The liability of the Company commences only when this proposal is accepted by the Company and the premium is received. If the Company accepts a proposal for insurance, it shall be subject to Policy Terms and Conditions.

INTERMEDIARY DETAILS (To be filled in BLOCK LETTERS)

Intermediary Name	Code
IMD Branch Name	Code
IMD Employee Code	

Proposer's Details (To be filled in BLOCK LETTERS)

Name of the Proposer	☐ Mr. ☐ Ms. ☐ Mrs. F I R S T M I D D L E L A S T		
Permanent Address			
City	Pin Code	State	
Contact No.	Mobile		
Correspondence Address			
City	Pin Code	State	
Contact No.	Primary No.	Secondary No	
E-mail Id	DOB		DD/MM/YYYY
Nationality	Gender	☐ Male ☐ Female ☐ Transgender	
Marital Status	☐ Married ☐ Single ☐ Other		
Maiden Name			
Occupation	☐ Salaried ☐ Self-employed ☐ Other, pls specify		
Monthly Income	☐ Upto Rs. 20,000 ☐ Rs. 20,001 to Rs. 50,000 ☐ Rs. 50,001 to Rs. 1,00,000 ☐ Rs. 1,00,001 & above		
Source of Income	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others		
Pan No.	Aadhar No.	(Please fill at least one)	
GST Registration			

NOMINATION DETAILS

The nominee as declared hereunder shall become eligible for payment under the Policy as per the terms and conditions of the Policy, in the event of the death of the Policyholder. The receipt of proceeds by the nominee would be sufficient discharge to the Company. Nominee for all other person(s) proposed shall be the proposer himself/herself

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Name of Nominee	Date of Birth (DD/MM/YYYY)	Relationship with Insured	Address of Nominee

POLICY DETAILS

Cover Type	Type of Policy	Policy Period*	Required Policy Start Date	Daily Cash Amount (Please specify required option in Rs)	Number of Days (Tick the required options)	Personal Accident Sum Insured (Please specify the required option in Rs)
Individual	☐ Credit Linked Insurance Policy ☐ Non-Credit Linked insurance Policy	1 year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐	DD/MM/YYYY	(ranging from 500 to 10000)	30days ☐ 60days ☐ 90days ☐ 180days ☐	(ranging from 5 lakhs to 1 crore)

*Policy Period for only Credit Linked Insurance Policy shall be available for maximum upto five year. Non-Credit Linked Policy shall have one-year Policy Period.

PROPOSER BANK DETAILS

Name of the Bank Account Holder:	☐ Mr. ☐ Mrs. ☐ Ms.	FIRST MIDDLE LAST
Name of the Bank		
Bank Account No.:	Account Type: ☐ Saving ☐ Current	
Branch		
IFSC Code (11 character code appearing on your cheque leaf)		
MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)		
☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*		
*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.		

DETAILS OF PERSON(S) PROPOSED TO BE INSURED

Section A : Personal Details

Details	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Name of Insured Person								
Gender (M/F/Other)								
Date of Birth								
Relationship with Proposer								
Nationality								
Occupation								

ABHA ID or ABHA Address	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No	Yes or No
if yes, please specify the details -								
CKYC No. (for Individual customer)								
CIN No. (for corporate customer)								

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued IndusInd General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request IndusInd General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)? ☐ Yes ☐ No

If yes, please mention the position held

Is any of your close relation or family member a PEP? ☐ Yes ☐ No

If yes, please mention the name and relation and the position held by such close relative/family member.

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to IndusInd General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

Signature of Proposer

Medical Questions	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Are all persons proposed to be insured in good health and entirely free from any mental illnesses, any physical impairments or deformities?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
The following Medical questions are compulsory for each proposal. Where any of the below responses are positive (Yes), the list of PED questions shall be triggered attached in Annexure-1								
Is any person proposed to be insured on (or prescribed to be on) regular medication (Medication prescribed for more than two weeks)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed to be insured presently suffering (or suffered in the past 15 days) from any disease/illness/accident/injury other than common cold or fever?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is any person proposed to be insured been advised to undergo any investigation or further tests other than routine health check-up or pre-employment check-up or routine maternity check-up in last 3 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has any person proposed to be insured, undergone any surgery in the last 3 years or is planned to undergo any surgery at present or in the near future?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Was any person proposed to be insured diagnosed with any of these medical conditions with or without any follow-up tests/medications?								
• Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Hypertension	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• High Cholesterol or High Triglyceroids	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Hypothyroidism or Pituitary disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Liver Cirrhosis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• HIV/AIDS	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
• Unexplained Weight loss (> 5kg) in last 6 months	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Note: If you have ticked 'Yes' for any of the above options, please give details in the attached Annexure-1

Section B: Current / Previous Policy - Insurance Details

Details		Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Name of Insurer									
Policy No.									
Policy Period	Start Date	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)
	End Date	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)	(DD/MM/YYYY)
Daily Cash Amount (₹)									
No. of Days Options									
Type of Cover	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater	☐ Individual ☐ Floater
Is there is any specific condition, Exclusion under the Policy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there is any specific condition, Exclusion under the Policy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have any of the persons to be insured ever filed a claim with their current/previous insurer? If yes, please provide details on a separate sheet	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has any proposal of life, critical or health insurance been declined, cancelled or charged a higher premium?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are any of the persons proposed for insurance covered under any other health insurance policy with the Company?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PREMIUM PAYMENT DETAILS

Payment by:	☐ Cheque ☐ DD ☐ Credit Card ☐ Debit Card ☐ NEFT ☐ Net Banking
Cheque or DD amount in figures: Rs.	Cheque / DD Date
Cheque or DD amount in words:	
Cheque / DD / Card No	
Bank Name	
Name of Premium Payer	

Note - In case the payment is made through Cheque/DD then please issue an ale payee instrument in favour of "IndusInd General Insurance Company Limited" In case the payment is made through Credit/Debit Card the Card needs to be in the name of Proposer

DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- i. I hereby declare, on my behalf and on behalf of all persons proposed to be insured, that the above statements, answers and / or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/are authorized to propose on behalf of these other persons.
- ii. I understand that the information provided by me will form the basis of the insurance policy, is subject to the Board approved underwriting policy of the insurance company and that the policy will come into force only after full payment of the premium chargeable. www.indusindinsurance.com 022 4890 3009 (Paid) 74004 22200 (WhatsApp)
- iii. I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured / proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- iv. I/We declare and consent to the company seeking medical information from any doctor or hospital who at any time has attended on the person to be insured/ proposer or from any past or present employer concerning anything which affects the physical or mental health of the person to be assured / proposer and seeking information from any insurance company to which an application for insurance on the life to be assured / proposer has been made for the purpose of underwriting the proposal and / or claim settlement.
- v. I/We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and / or claims settlement and with any Governmental and / or Regulatory authority.
- vi. I/We consent to receive information from the Company through physical, electronic or telecommunication means from time to time.
- vii. I/We hereby state that the above-mentioned address shall be taken as address on record for the purpose of GST.
- viii. I/We hereby confirm that the contents of the proposal form and connected documents have been fully explained to me/us and I/ We have fully understood the significance of the proposed contract.
- x. I understand that the Policy shall become void at the Company's option, in the event of misrepresentation, mis-description or non-disclosure of any material fact in the Proposal form/personal statement, declaration and connected documents or any material information having been withheld by me or anyone acting on my behalf.
- x. I hereby declare that the person(s) proposed to be insured would submit to medical examinations, before the nominated doctors of the Company, or undergo diagnostic or other medical tests, as suggested by the Company for its underwriting.
- xi. I consent to provide a valid age proof and identity proof at the time of claims or any other time when required by the Company.
- xii. I agree and undertake to convey to the Company any change/alterations carried out in the risk proposed for insurance after submission of this Proposal form.
- xiii. I further consent and authorize IndusInd General Insurance Company and/or any of their authorized representatives to seek medical information from any Hospital / Medical Practitioner /Insurer /any of the related entity that I have attended or may attend in future concerning any disease/illness/injury.
- xiv. To protect the environment and save paper, I hereby give my consent to IndusInd General Insurance Company Limited to send me the executed Policy copy and all related documents and other communications in electronic form by way of email to the aforesaid email id instead of physical form and also to share all such documents and any updates & alerts via Whatsapp on my registered mobile number with the Company.

Place: _____

Date: DD / MM / YYYY

Signature of the Insured



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VERNACULAR DECLARATION FOR INTERMEDIARY AND PROPOSER

The contents of this Proposal form have been read over and fully explained to me in _____ language. I further confirm and declare that the contents read over and explained to me have been understood by me.

Place: _____

Date: DD/MM/YYYY

Signature/Thumb impression of (Proposer)

Explained By Intermediary (Name): _____

Place: _____

Date: DD/MM/YYYY

Signature of Intermediary

PROHIBITION OF REBATES - SECTION 41 OF THE INSURANCE ACT, 1938 AS AMENDED BY INSURANCE LAWS (AMENDMENT) ACT, 2015.

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.

ACKNOWLEDGEMENT FOR PORPOSAL

Bank Account Number

Date

DD/MM/YYYY

Proposal No.

We acknowledge the receipt of payment of Rs.

vide cheque / DD No.

from ☐ Mr. ☐ Mrs. ☐ Ms.

Please note that this is only an acknowledgement receipt and does not amount to acceptance of risk or commencement of Policy. IndusInd General Insurance Company Limited in not liable for any claim between the time the proposal amount is received and Policy Start Date. The validity of receipt is subject to realization of proposal amount. Acceptance of proposal and issuance of policy shall be subject to receipt of completed proposal for premium payment, medical reports(wherever applicable) and underwriting decision of the Company.

Name of the Employee

Signature of Employee

Company Seal and Stamp



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Annexure-1 attached to the Proposal Form

PED Questions	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6	Member 7	Member 8
Has the person proposed to be insured suffered from (or undergone) any of the following illnesses/sickness/ medical conditions/ medical procedures during the past 3 years? (Yes/No, Date of First Diagnosis):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chest Pain or Heart Attack or any ailment/ diseases/ surgery of the Heart or arteries or other blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Lung transplant, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis, Tuberculosis, Asthma, Bronchitis, Breathing difficulties or disorder of the lung/ respiratory track requiring surgery or hospitalization within the past 3 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any sexually transmitted diseases including Syphilis, Gonorrhoea, Genital Herpes, Chlamydia?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Liver Cirrhosis, Alcoholic Liver disease, Oesophageal Varises and Fibrosis, Pancreatic Disease, Hepatitis B, Hepatitis C or any other disorder of the liver or pancreas, or Liver transplant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Inflammatory Bowel Disease, Crohn's disease, Systemic Lupus Erythematosus or any other ailment of the digestive system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Cancer, Leukemia, Papulosquamous disorder of skin, Tumor - malignant, or any growth or cyst anywhere in the body?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Rheumatoid arthritis, Avascular Necrosis, Ankylosing Spondylitis, Spinal Stenosis, Spondylosis, Multiple Sclerosis, Muscular Dystrophy or any other disorder of bone, muscles or joints?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Kidney transplant, Kidney / Renal Failure, Stone in urinary tract, Prostate disorder or any other kidney disorder whether or not requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Stroke, Epilepsy (fits), Paralysis, Demyelinating disease, Alzheimers Disease, Parkinsons Disease or any other disorder of the brain, spinal chord or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Severe Anemia, Hemophilia, Idopathic Thrombocytopenia Purpura, Thalassemia (major), Peripheral Vascular Disease, Deep Vein Thrombosis, Lymphoma or any other blood/ Lymphatic system disease or Sarcoidosis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cerebral Palsy, any internal deformity or sickness from birth / early childhood?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Loss of Hearing	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No



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Detoxication therapy for alcohol, narcotics, or any other habit-forming drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other Illness/ Injury: Please Specify	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

COVER DETAILS (For Reference Only)
Daily Cash Amount: options ranging from Rs. 500 to Rs. 10000

Benefit Title	Payout	Sub-limits / Deductible	Maximum Liability
Base Covers			
1. In Patient Treatment	Daily Cash Amount per day (24 hours) of continuous In-patient hospitalization This shall also include the AYUSH Treatment, maximum upto 15days of In-Patient Treatment.	Option of 30/60/90/180 days AYUSH Treatment, maximum upto 15days of In-Patient Treatment	Daily Cash Amount *Selected max. no. of days
2. ICU Cover	Additional 100% of Daily Cash Amount per day (24 hours) of continuous ICU hospitalization Amount shall be payable maximum for 15 days if Policy-holder has opted 30 days of In-Patient Treatment and 30 days if Policyholder has opted 60/90/180 days of In-Patient Treatment	Option of 15/30 days	Daily Cash Amount *100% *Selected max. no. of days
3. Day Care Treatments	Lump sum amount equal to Daily Cash Amount for each Incidence of Day Care Treatment	Payable five times in a Policy Period	Daily Cash Amount *5
Optional Covers			
4. Convalescence Cover	Selected Lump sum amount, where In-patient Hospitalization is for minimum 10 days. Options: 3 times, 5 times, 10 times of Daily Cash Amount	Payable once in a Policy Period	Daily Cash Amount *(3 or 5 or 10)
5. Personal Accident Cover	Lumpsum amount up to selected Personal Accident Sum Insured for: - Accidental death - Permanent Total Disability, - Permanent Partial Disability	Personal Accident cover for dependent child shall be limited to 20% of selected Personal Accident Sum Insured of the Policyholder	Personal Accident Sum Insured

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	Personal Accident Sum Insured Options-ranges from 5 lakhs to 100 lakhs (in multiples of 5 lakhs)		
6. Accidental Medical Expenses*	Medical expenses on indemnity basis for: - In-Patient Treatment - OPD - Day Care Treatment	20% of the Personal Accident Sum Insured, maximum upto Rs. 5 lakhs. Deductible of Rs. 1000 applicable on each and every OPD claim.	PA Sum Insured *20%, or Rs. 5 lakhs, whichever is lower
7. Companion Cover	Additional 50% of Daily Cash Amount per day (24 hours) of continuous In-patient hospitalization	Same as opted under Benefit 1	Daily Cash Amount *50% *Selected max. no. of days
8. Maternity Cover	Lumpsum payment of 5 times of Daily Cash or Rs 35000 whichever is less	Maximum two claims payable in a lifetime	5 times of Daily Cash Amount or Rs 35000 whichever is less lifetime
9. Time Deductible	Selected Time Deductible shall be applicable on each and every In-Patient Hospitalization claim Time deductible Options: 24/48/72 hours Time Deductible shall not be applicable to Benefit-3 (Day Care Treatments), Benefit-4 (Convalescence Cover), Benefit-5 (Personal Accident Cover), Benefit-6 (Accidental Medical Expenses) and Benefit-8 (Maternity Cover)		
10. Waiver of Waiting Period for PreExisting Disease	This Cover shall reduce the Waiting Period for Pre-Existing Diseases to zero ,12 months or 24 months as the case may be.		
11. Waiting Period for Specified disease / procedure	This Cover shall reduce the Waiting Period for Specified Disease/Procedure to 12 months.		

*Benefit-6 Accidental Medical Expenses shall only be available if Benefit -5 Personal Accident Cover has been opted under the Policy

Note - The Total Liability of the Company with respect to any one Insured Person during a given Policy Year shall be limited to the total of the cover wise(as opted) maximum liability listed in the above table.

The above descriptions are indicative. Please refer the Policy Wordings for complete description, terms and conditions relating to the Covers listed above

Note - The Policy copy and all related documents shall be sent to the email ID provided above. If you wish to receive the Policy copy and related documents in physical form to the aforesaid communication address, please drop us an email at services@indusindinsurance.com.