PARIVAR – Mediclaim for Family

PROSPECTUS

1.1 Product
The policy is a Family Floater Health Insurance Policy, wherein entire family will be covered under single sum insured. The policy covers hospitalisation expenses (cashless/reimbursement) incurred for treatment of illness/diseases or injury contracted/sustained by the insured person during the policy period. In the event of any claim admissible under the policy, the Company shall either pay directly to the insured person or pay to the hospital through TPA the amount of such expenses subject to limits as would fall under different heads mentioned below, as are reasonably and necessarily incurred in respect thereof anywhere in India by or on behalf of such Insured Person but not exceeding Sum Insured (all claims in aggregate) for that family as stated in the Schedule in any one period of insurance.

1.2 Coverage
A. In-patient hospitalisation – Expenses for hospitalisation more than 24 (twenty four) hrs subject to following sub limits
   1. Room charges subject to 1% of sum insured per day, intensive care unit charges subject to 2% of sum insured per day (including nursing care, RMO charges, IV fluids / blood transfusion / injection administration charges)
   2. Surgeon, anaesthetist, medical practitioner, consultants and specialist Fees.
   3. Anaesthesia, blood, oxygen, operation theatre charges, any disposable surgical appliances subject to maximum of 10% of the sum insured, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, artificial limbs and cost of stent and implants
B. Day care procedures – Expenses for 140+ day care procedures, listed in the policy, which require less than 24 (twenty four) hours hospitalisation
C. Pre and post hospitalisation – Expenses related to medical diagnosis or procedure that resulted in hospitalisation and incurred during the period up to 15 (fifteen) days prior to hospitalisation and up to 30 (thirty) days after discharge from hospital. Pre & post hospitalisation expenses will be considered as part of hospitalisation claim
D. Hospitalisation expenses of person donating an organ during the course of organ transplant will also be payable subject to the sub limits applicable for any one illness within the Sum insured
E. Total expenses incurred for any one illness is limited to 50% of sum insured.

Co-payment
Co-payment of 10% shall apply to all the admissible claims arising out of Diabetes and/or Hypertension, in case Diabetes or Hypertension is a pre existing disease.
Co-payment of 25% shall apply to all the admissible claims arising out of Diabetes and/or Hypertension, in case Diabetes and Hypertension are pre existing diseases.

1.3 Hospitalisation Options
The policy provides for cashless facility and/ or reimbursement of hospitalisation expenses for treatment of disease, illness or injury.
Cashless facility is available only in network providers, subject to prior approval by the TPA. Preferred Provider Network (PPN) is a hospital which has agreed to a cashless packaged pricing for certain procedures for the insured persons. The list is available with the company/TPA and subject to amendment from time to time.

2 Other benefits
2.1 Tax rebate
The insured person can avail tax benefits for the premium paid, under Section 80D of Income Tax Act 1961.

2.2 Eligibility
i. Policy can be availed by persons between the age of 18 (eighteen) years and 60 (sixty) years.
ii. Policy can be availed for self and the following family members
   a. Spouse
   b. Two dependent children
      • Dependent child up to 18 (eighteen) years of age
      • Dependent male child above 18 (eighteen) years and up to 25 (twenty five) years, if a bona-fide student and not employed
      • Dependent female child if not employed, till marriage

2.3 Sum insured (SI)
   i. The SI options available range from `200000 (two lacs) to `500000 (five lacs) in multiple of `50000 (fifty thousand).
   ii. The entire family will be covered under single sum insured.

2.4 Policy period
The policy is issued for a period of one year.

2.5 Buying the policy
The policy can be bought
2.6 Completion of proposal form
i. The proposal form is to be completed in all respects (including personal details, medical history of insured person) and to be submitted to the office or to the agent.
ii. If a person is insured under health insurance policy of any other non life insurance company and wants to port (switch) to the policy, the portability and proposal form will have to be completed and submitted to the office or to the agent.

2.7 Payment of premium
i. Premium is based on age of the eldest member of the family and sum insured.
ii. Premium as per the premium table attached is to be paid in full before the commencement of the policy.
iii. Premium can be paid online for both, new policy and renewals.

2.8 Renewal of policy
i. Policy can be renewed annually till 65 (sixty five) years of the insured person.
ii. The policy may be renewed by mutual consent before the expiry of the policy.
iii. The company is not bound to send renewal notice.
iv. Renewal of policy can be denied on grounds of fraud, moral hazard or misrepresentation or noncooperation.
v. In the event of break in the policy a grace period of 30 (thirty) days is allowed. Coverage is not available during the grace period.

3 Policy definition

3.1 Any one illness means continuous period of illness and it includes relapse within 45 (forty five) days from the date of last consultation with the hospital where treatment has been taken.

3.2 Break in policy occurs at the end of the existing policy period when the premium due on a given policy is not paid on or before the renewal date or within grace period.

3.3 Grace period means 30 (thirty) days immediately following the premium due date during which a payment can be made to renew or continue the policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing disease. Coverage is not available for the period for which no premium is received.

3.4 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 (ten) in-patient beds in towns having a population of less than 1000000 (ten lacs) and at least 15 (fifteen) in-patient 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.

Hospital shall not include an establishment which is a rest home or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institution.

3.5 Hospitalisation means admission in a hospital as an inpatient for a minimum period of 24 (twenty four) consecutive hours. However, this time limit is not applicable to
i. day care treatment, stitching of wound/s, close reduction of fractures and application of POP cast, dilatation & curettage (D & C), tonsillectomy, chemotherapy, radiotherapy, arthroscopy, laparoscopic surgery, dialysis, eye surgery, ENT surgery, angiography, endoscopy, lithotripsy (kidney stone removal), minor surgical procedures.
ii. treatment that necessitates hospitalisation and the procedure involves specialized infrastructural facilities available in hospitals and due to technological advances hospitalisation is required for less than 24 (twenty four) hours only.

3.6 In-patient means an insured person who is admitted in hospital upon the written advice of a duly qualified medical practitioner for more than 24 (twenty four) continuous hours, for the treatment of covered disease/ injury during the policy period.

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

3.8 Medical practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.
3.9 **Network provider** means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured person on payment by a cashless facility.

3.10 **Pre-existing disease** means any condition, ailment or injury or related condition(s) for which the insured person had signs or symptoms and/or was diagnosed and/or received medical advice/ treatment within 48 months prior to the first policy issued by the company.

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

3.12 **TPA** means any entity, licensed under the IRDA (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee by the company for the purpose of providing health services.

3.23 **Waiting period** means a period from the inception of the first policy during which specified diseases/treatment is not covered. On completion of the period, diseases/treatment will be covered provided the policy has been continuously renewed without any break.

4 **Exclusions**
The company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of:

4.1 **Pre-existing diseases**
All pre-existing diseases when the cover incepts for the first time until 48 (forty eight) months of continuous coverage has elapsed. Any complication arising from pre-existing ailment/disease/injuries will be considered as a part of the pre existing health condition or disease. Diabetes and Hypertension, if pre-existing disease, will be covered on payment of additional premium by the insured person.

4.2 **First 30 days waiting period**
Any disease contracted by the insured person during the first 30 (thirty) days from the inception of the first policy. This shall not apply in case the insured person is hospitalised for injuries, suffered in an accident which occurred after inception of the first policy.

4.3 **Two years waiting period**
Following diseases/treatment are subject to a waiting period of two years.

<table>
<thead>
<tr>
<th>No.</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>Cataract</td>
</tr>
<tr>
<td>ii</td>
<td>Benign prostatic hypertrophy</td>
</tr>
<tr>
<td>iii</td>
<td>Hysterectomy</td>
</tr>
<tr>
<td>iv</td>
<td>Hernia</td>
</tr>
<tr>
<td>v</td>
<td>Hydrocele</td>
</tr>
<tr>
<td>vi</td>
<td>Internal congenital anomaly</td>
</tr>
<tr>
<td>vii</td>
<td>Fistula in anus</td>
</tr>
<tr>
<td>viii</td>
<td>Piles</td>
</tr>
<tr>
<td>ix</td>
<td>Chronic fissure in anus</td>
</tr>
<tr>
<td>x</td>
<td>Pilonidal sinus</td>
</tr>
<tr>
<td>xi</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>xii</td>
<td>Calculus disease</td>
</tr>
<tr>
<td>xiii</td>
<td>Benign lumps / growths in any part of the body</td>
</tr>
<tr>
<td>xiv</td>
<td>CSOM (Chronic Suppurative Otitis Media)</td>
</tr>
<tr>
<td>xv</td>
<td>Joint replacement of any kind unless arising out of accident</td>
</tr>
<tr>
<td>xvi</td>
<td>Surgical treatment of tonsils &amp; adenoids</td>
</tr>
<tr>
<td>xvii</td>
<td>Deviated nasal septum and related disorder</td>
</tr>
</tbody>
</table>

If the insured person is aware of the existence of congenital internal disease/defect before inception of the policy, the same will be treated as pre-existing.

4.4 **Circumcision unless necessary for treatment of a disease (if not excluded otherwise) or necessitated due to an accident.**

4.5 **Vaccination or inoculation.**

4.6 **Cosmetic, plastic surgery, sex change**
Cosmetic or aesthetic treatment of any description, change of life or sex change operation. Expenses for plastic surgery other than as may be necessitated due to illness/ disease/ injury.

4.7 **Spectacles, contact lens, hearing aid.**

4.8 **Dental treatment**
Dental treatment or surgery which is a corrective, cosmetic or aesthetic procedure, including wear and tear, unless arising from an accident and requiring hospitalization for treatment.

4.9 **General debility, external congenital anomaly**
Convalescence, general debility, run down condition or rest cure, external congenital anomaly.

4.10 **Sterility, venereal disease, intentional self inflicted injury**
4.11 Drug/alcohol abuse  
Treatment arising out of illness/disease/injury due to misuse or abuse of drugs/alcohol or use of intoxicating substances.

4.12 AIDS  
Expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus type III (HTLV-III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.13 Hospitalisation for the purpose of diagnosis and evaluation, irrelevant investigations charges  
Expenses incurred at hospital primarily for diagnostic, x-ray or laboratory examinations or other diagnostic studies not consistent with nor incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a hospital.

4.14 Vitamins, tonics  
Vitamins and tonics unless forming part of treatment for illness/disease/injury as certified by the attending medical practitioner.

4.15 Maternity  
Treatment arising from or traceable to pregnancy/childbirth including caesarean section, miscarriage, abortion or complications thereof other than ectopic pregnancy which may be established by medical reports.

4.16 Non allopathic treatment.

4.17 War group perils  
Injury or disease directly or indirectly caused by or arising from or attributable to war invasion act of foreign enemy, warlike operations (whether war be declared or not) and injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

5 Policy conditions  

5.1 Disclosure of information  
The policy shall be void and all premium paid hereon shall be forfeited to the company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.

5.2 Communication  
i. All communication should be in writing.
ii. ID card, PPN/network provider related issues to be communicated to the TPA at the address mentioned in the schedule. The policy related issues, change in address to be communicated to the policy issuing office at the address mentioned in the schedule.
iii. The company or TPA will communicate to the insured person at the address mentioned in the schedule.

5.3 Claim procedure  

5.3.1 Claim intimation  
In case of a claim, the insured person/insured person’s representative shall intimate the TPA in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

<table>
<thead>
<tr>
<th>Claim intimation in case of cashless facility</th>
<th>TPA must be informed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In case of planned hospitalisation</td>
<td>At least 72 (seventy two) hours prior to the insured person’s admission to network provider/PPN</td>
</tr>
<tr>
<td>In case of emergency hospitalisation</td>
<td>Within 24 (twenty four) hours of the insured person’s admission to network provider/PPN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim intimation in case of reimbursement</th>
<th>TPA must be informed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In case of planned hospitalisation</td>
<td>At least 72 (seventy two) hours prior to the insured person’s admission to network provider/PPN</td>
</tr>
<tr>
<td>In case of emergency hospitalisation</td>
<td>Within 24 (twenty four) hours of the insured person’s admission to hospital</td>
</tr>
</tbody>
</table>

5.3.2 Procedure for cashless claims  
i. Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA.
ii. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization.
iii. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN will issue pre-authorization letter to the hospital after verification.
iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
v. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor’s advice and submit the claim documents to the TPA for reimbursement.

5.3.3 Procedure for reimbursement of claims
For reimbursement of claims the insured person may submit the necessary documents to TPA within the prescribed time limit.

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

i. Completed claim form
ii. Original bills, payment receipts, medical history of the patient recorded, discharge certificate/summary from the hospital etc.
iii. Original cash-memo from the hospital(s)/chemist(s) supported by proper prescription
iv. Original payment receipt, investigation test reports etc. supported by the prescription from attending medical practitioner
v. Attending medical practitioner’s certificate regarding diagnosis and bill receipts etc.
vi. Surgeon’s original certificate stating diagnosis and nature of operation performed along with bills/receipts etc.
vii. Any other document required by company/TPA

Note
In the event of a claim lodged as per clause 5.9 of the policy and the original documents having been submitted to the other insurer, the company may accept the documents listed under clause 5.6.4 of the policy and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>Time limit for submission of documents to TPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement of hospitalisation and pre hospitalisation expenses</td>
<td>Within 15 (fifteen) days of date of discharge from hospital</td>
</tr>
<tr>
<td>Reimbursement of post hospitalisation expenses</td>
<td>Within 15 (fifteen) days from completion of post hospitalisation treatment</td>
</tr>
</tbody>
</table>

5.3.5 Claim settlement
i. On receipt of the final document(s) or investigation report (if any), as the case may be, the company shall within a period of 30 (thirty) days offer a settlement of the claim to the insured person.
ii. If the company, for any reasons, decides to reject a claim under the policy, shall communicate to the insured person in writing and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be.
iii. Upon acceptance of an offer of settlement as stated above by the insured person, the payment of the amount due shall be made within 7 (seven) days from the date of acceptance of the offer by the company.
iv. In the cases of delay in the payment, the company shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

5.3.6 Services offered by a TPA
The services offered by a TPA shall not include

i. Claim settlement and rejection with respect to the policy; However, TPA may handle claims admission and recommend to the company for the payment of the claim settlement
ii. Any services directly to the insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the company.

Waiver
Time limit for claim intimation and submission of documents may be waived in cases where it is proved to the satisfaction of the company, that the circumstances under which insured person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

5.4 Payment of claim
All medical treatments for the purpose of this insurance will have to be taken in India only. All claims under the policy shall be payable in Indian currency only.

5.5 Fraud
The company shall not be liable to make any payment under the policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

5.6 Cancellation
The company may at any time cancel the policy (on grounds of fraud, moral hazard or misrepresentation or noncooperation) by sending the insured person 30 (thirty) days notice by registered letter at insured person’s last known address and in such event the company shall not allow any refund.

The insured person may at any time cancel the policy and in such an event the company shall allow refund of premium at company’s short period rate mentioned below provided no claim occurred up to the date of cancellation.

<table>
<thead>
<tr>
<th>PERIOD OF RISK</th>
<th>RATE OF PREMIUM TO BE CHARGED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to one month</td>
<td>¼th of the annual rate</td>
</tr>
</tbody>
</table>
5.7 Portability
In the event of the insured person porting to any other insurer, the insured person must apply with details of the policy and claims to the insurer where the insured person wants to port, at least 45 (forty five) days before the date of expiry of the policy. Portability shall be allowed in the following cases:
   i. All individual health insurance policies issued by non-life insurance companies including family floater policies.
   ii. Individual members, including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an individual health insurance policy or a family floater policy with the same insurer. One year thereafter, the insured person shall be accorded the right to port to another non-life insurance company.

5.8 Withdrawal of product
In case the policy is withdrawn in future, the company shall provide the option to the insured person to switch over to a similar policy at terms and premium applicable to the new policy.

5.9 Revision of terms of the policy including the premium rates
The company, in future, may revise or modify the terms of the policy including the premium rates based on experience. The insured person shall be notified three months before the changes are affected.

5.10 Free look period
The insured person is allowed a period of 15 (fifteen) days from date of receipt of policy to review the terms and conditions of the policy, and to return the same if not acceptable.

   If the insured person has exercised the option of free look period and has not made any claim during the free look period, the insured person shall be entitled to:
   i. a refund of the premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges; or
   ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period on cover.

The free look provision is not applicable to renewal of the policy.

6 Redressal of grievance
In case of any grievance relating to the servicing the Policy, the insured person may approach the Grievance cell of the company set up at divisional offices, regional offices and head office. For more information on grievance mechanism, and to download grievance form, visit our website.

The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance.

Disclaimer
The prospectus contains salient features of the Policy. For details reference is to be made to the Policy. In case of any difference between the prospectus and the Policy, the terms and conditions of the Policy shall prevail. The prospectus and proposal form are part of the Policy. Hence please read the prospectus carefully and sign the same. The proposal form is to be completed in all respects for each insured person. Both the prospectus and the proposal form are to be submitted to the office or to the agent.

Place

Signature

Date

Name

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### Premium Chart

<table>
<thead>
<tr>
<th>Sum Insured (()</th>
<th>Up to 35 years</th>
<th>36 to 45 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self</td>
<td>Spouse</td>
</tr>
<tr>
<td>2,00,000</td>
<td>2469</td>
<td>617</td>
</tr>
<tr>
<td>2,50,000</td>
<td>2956</td>
<td>739</td>
</tr>
<tr>
<td>3,00,000</td>
<td>3444</td>
<td>861</td>
</tr>
<tr>
<td>3,50,000</td>
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<td>968</td>
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<tr>
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<td>4297</td>
<td>1074</td>
</tr>
<tr>
<td>4,50,000</td>
<td>4723</td>
<td>1181</td>
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<tr>
<td>5,00,000</td>
<td>5151</td>
<td>1288</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46 to 50 years</td>
<td>Self</td>
<td>Spouse</td>
</tr>
<tr>
<td>2,00,000</td>
<td>4290</td>
<td>1502</td>
</tr>
<tr>
<td>2,50,000</td>
<td>5200</td>
<td>1820</td>
</tr>
<tr>
<td>3,00,000</td>
<td>6108</td>
<td>2138</td>
</tr>
<tr>
<td>3,50,000</td>
<td>6942</td>
<td>2430</td>
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<tr>
<td>4,00,000</td>
<td>7776</td>
<td>2722</td>
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<tr>
<td>4,50,000</td>
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<tr>
<td>5,00,000</td>
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<td>3305</td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56-60 years</td>
<td>Self</td>
<td>Spouse</td>
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<td>4,50,000</td>
<td>10436</td>
<td>4175</td>
</tr>
<tr>
<td>5,00,000</td>
<td>11466</td>
<td>4586</td>
</tr>
</tbody>
</table>

### Service tax extra

**Note**

- In case any member of the family is suffering from hypertension or diabetes, 10% extra premium to be charged on the total premium.
- In case any member of the family is suffering from hypertension and diabetes, 25% extra premium to be charged on the total premium.
- If the policy is extended beyond 60 years, 25% loading on the premium for 56-60 years band is to be charge.