2. PART B

Tata AIA Life Insurance Group Loan Protect is a Non-Linked, Non-Participating, Group Pure Risk Credit Life Insurance Plan.

2.1. Basic definitions

In this Policy, where consistent with the contents, the singular shall include the plural and the plural the singular; words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following meanings:

"Accident" refers to a sudden, unforeseen and involuntary event caused by external, violent and visible means, but excludes illness and diseases.

"Accidental Death" means the death of the Insured Member which results directly, solely and independently of any other causes from bodily injury and occurs within 180 days of the date of Accident.

"Certificate of Insurance" means the certificate issued by the Company to an Insured Member to confirm his coverage under the Policy. Coverage in respect of an Insured Member shall commence from the Effective Date of Coverage mentioned therein.

"Claimant" means Nominee(s) (if valid nomination is effected) assignee(s) or their heir, proposer (in case of minor member), legal representative or holder(s) of succession certificate granted by a competent court of law in case Nominee(s) or assignee(s) is/are not alive at the time of submitting claim.

"Critical Illness" mean illnesses, the signs or symptoms of which first commence more than ninety (90) days following the Date of Commencement of Risk (which is same as inception date) or Effective Date of Coverage of Insured Member or Revival Date whichever is later, and shall include either the first Diagnosis of any of the illnesses listed herein or first performance of any of the covered surgeries stated in this document.

This is an optional benefit applicable for Insured Member of 18 years and above, and is payable if the Policy is in force as on date of first Diagnosis or occurrence of any of the covered 35 Critical Illnesses listed below:

(i) Cancer of Specified Severity

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

The following are excluded –

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not Limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

- Chronic lymphocytic leukemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- All tumors in the presence of HIV infection.

(ii) Stroke resulting in Permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae.

This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:
i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

(iii) Multiple Sclerosis with Persistent Symptoms

The unequivocal Diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
- Investigations including typical MRI findings which unequivocally confirm the Diagnosis to be multiple sclerosis and
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as Systemic Lupus Erythematosus (SLE) and Human Immunodeficiency Virus (HIV) are excluded.

(iv) Permanent Paralysis of Limbs(Paraplegia)

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

(v) Coma of Specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs.

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

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

(vi) Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact. Diagnosis must be confirmed by a Neurologist and condition must be documented for at least one month.

(vii) Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

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

The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

(viii) Motor Neuron Disease with Permanent Symptoms

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

(ix) Parkinson's Disease

Unequivocal Diagnosis of progressive degenerative Parkinson's disease by a Registered Medical Practitioner who is a neurologist where the condition:

- Cannot be controlled with medication;
- Shows signs of progressive impairment; and
- Activities of daily living assessment confirms the inability of the Insured Member to perform at least three (3) of the Activities of daily living for a continuous period of at least 6 months, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

The Activities of daily living are: -
- Transfer - Getting in & out of a chair without requiring physical assistance.
- Mobility - The ability to move from room to room without requiring any physical assistance
- Continence - The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
- Dressing - Putting on and taking off all necessary items of clothing without requiring assistance of another person.
- Bathing/Washing - The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.
- Eating - All tasks of getting food into the body once it has been prepared.

(x) Brain Surgery

The actual undergoing of surgery to the brain, under general anesthesia, during which a craniotomy is performed.

Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

(xi) Alzheimer's Disease

Alzheimer's disease is a progressive degenerative disease of the brain characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.

Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's Disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured Member. This Diagnosis must be supported by the clinical confirmation of an appropriate Registered Medical Practitioner who is also a Neurologist and supported by an independent Specialized Medical Practitioner.

The following are excluded:
- Nonorganic disease such as neurosis and psychiatric illnesses;
- Alcohol related brain damage.
- Any other type of irreversible organic disorder/dementia

(xii) Poliomyelitis

The occurrence of Poliomyelitis where the conditions are met:
- Poliovirus is identified as the cause and is provided by stool analysis
- Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months

(xiii) Muscular Dystrophy

Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:
- Family history of other affected individuals;
- Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
- Characteristic electromyogram; or
- Clinical suspicion confirmed by muscle biopsy.

Activities of daily living assessment should confirm the inability of the Insured Member to perform at least three (3) of the Activities of daily living for a continuous period of at least 6 months, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

The Activities of daily living are: -
- Transfer - Getting in & out of a chair without requiring physical assistance.
- Mobility - The ability to move from room to room without requiring any physical assistance
- Continence - The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
- Dressing - Putting on and taking off all necessary items of clothing without requiring assistance of another person.
- Bathing/Washing - The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.
- Eating - All tasks of getting food into the body once it has been prepared.

(xiv) SLE (Systemic Lupus Erythematosus) with Lupus Nephritis

Multi-system, autoimmune disorder characterized by the development of autoantibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

The final Diagnosis must be confirmed by a certified doctor specializing in hematology and Immunology.
Abbreviated ISN/RPS classification of lupus nephritis (2003):
Class I - Minimal mesangial lupus nephritis
Class II - Mesangial proliferative lupus nephritis
Class III - Focal lupus nephritis
Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis
Class V - Membranous lupus nephritis
Class VI - Advanced sclerosing lupus nephritis

(xv) Myocardial Infarction (First Heart Attack of specified severity)

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

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

The following are excluded:

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

(xvi) Open Chest CABG (Coronary Artery Bypass Graft)

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

The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

(xvii) Open Heart Replacement or Repair of Heart Valves

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

(xviii) Surgery to Aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this definition, Aorta shall mean the thoracic and abdominal Aorta but not its branches.

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

(xix) Cardiomyopathy

The unequivocal Diagnosis by a consultant cardiologist of cardiomyopathy causing impaired ventricular function suspected by ECG abnormalities and confirmed by cardiac echo of variable etiology and resulting in permanent physical impairments to the degree of at least class IV of the New York Heart Association (NYHA) classification of cardiac impairment for at least six (6) months.

NYHA class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echo-graphic findings of compromised ventricular performance.

Cardiomyopathy directly related to alcohol or drug abuse is excluded.

(xx) Primary (Idiopathic) Pulmonary Hypertension

An unequivocal Diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization.

There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

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

Symptoms may be present even at rest.

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

(xxi) Bacterial Meningitis resulting in Permanent Neurological Deficit

A definite Diagnosis of Meningitis confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in permanent neurological deficit documented for at least 90 continuous days from the date of diagnosis. All other forms of meningitis other than those caused by bacterial infection are excluded.

(xxii) Kidney Failure requiring regular Dialysis

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

(xxiii) Major Organ/Bone Marrow Transplant

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

The following are excluded:
- Other stem-cell transplants
- Where only islets of Langerhans are transplanted

(xxiv) Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
The Blindness is evidenced by:
- Corrected visual acuity being 3/60 or less in both eyes or
- The field of vision being less than 10 degrees in both eyes.

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

(xxv) End Stage Lung Failure (Chronic Lung Disease)

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$);
- Dyspnea at rest.

(xxvi) End Stage Liver Disease

Permanent and irreversible failure of liver function that has resulted in all three of the following:
- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

(xxvii) Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease.

This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

(xxviii) Third Degree Burns (Major Burns)

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

(xxix) Major Head Trauma

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident.

This Diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

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

The Activities of daily living are:

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

Spinal Cord injuries are excluded.

(xxx) Aplastic Anemia

Irreversible persistent bone marrow failure which results in anemia, neutropenia and Thrombocytopenia requiring treatment with at least one (1) of the following:

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

The Diagnosis of aplastic anemia must be confirmed by a bone marrow biopsy.
Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimeter or less;
- Absolute Reticulocyte count of 20,000 per cubic millimeter or less; and
- Platelet count of 20,000 per cubic millimeter or less.

(xxxi) Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident.

This Diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

(xxxii) Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords.

The inability to speak must be established for a continuous period of 12 months. This Diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

All psychiatric related causes are excluded.

(xxxiii) Medullary Cystic Disease

A progressive hereditary disease of the kidneys characterized by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anemia, polyuria and renal loss of sodium, progressing to chronic renal failure.

Diagnosis must be supported by renal biopsy.

(xxxiv) Encephalitis leading to Permanent Neurological Deficit

A definite Diagnosis of encephalitis by a Consultant Neurologist supported by investigations like MRI/CT scan, cerebrospinal fluid screening and other tests like Electroencephalography (EEG).
Encephalitis should result in permanent neurological deficit with persisting clinical symptoms documented for at least 90 continuous days from the Date of Diagnosis.

(xxxv) Chronic Pancreatitis

Chronic, progressive inflammatory disease of the pancreas, characterized by irreversible morphologic changes where all of the following criteria are met:

- The necessary treatment is surgical clearance of diseased tissue or pancreatectomy; and
- The Diagnosis is based on characteristic findings in ERCP/MRCP and other Abdominal Radiography tests (like CT scan of abdomen/Endoscopic or Transabdominal USG, etc.) and is confirmed by a Registered Medical Practitioner who is a gastroenterologist.

Pancreatitis due to alcohol or drug abuse is excluded.

"**Date of Commencement of Risk**" shall mean the date as specified in the Policy Schedule attached hereto.

"Diagnosis" refers to the act or process of identifying or determining the nature and cause of a disease or injury, by a registered Medical Practitioner, through evaluation of patient's history, examination, and review of laboratory data. It must be supported by clinical, radiological, histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable.

"Effective Date of Coverage" shall mean the commencement date of the insurance coverage in respect of each Insured Member under this Policy, as specified in his Certificate of Insurance.

"Enrolment Form(s)" shall mean, unless otherwise specified in the Policy Schedule, form furnished by the Policyholder for the enrolment of the Insured Member, in the format prescribed by Us, the record of which shall be retained by the Policyholder.

"Eligible Member(s)" shall mean those members who satisfy and continue to satisfy the eligibility criteria specified in, Section 2.2.1 of this Policy, and are eligible to participate in the insurance plan under this Policy.

"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 in-patient beds, in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places
(iii) Has qualified Medical Practitioner (s) in charge round the clock
(iv) Has fully equipped operation theatre of its own where surgical procedures are carried out.
(v) Maintains daily records of patient and will make these accessible to the Insurance Company's authorized personnel

"Insured Member(s)" shall mean those Member(s) who are and continue to be Eligible Members and who, in accordance with the provisions of this Policy, are participating in the Insurance plan under this Policy.

"IRDAI" means the Insurance Regulatory and Development Authority of India established under sub-section (1) of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999).

"Joint Insured Members" shall mean Eligible Members who, in accordance with the provisions of Part C Section 3.2 are participating for Joint Life insurance under a single loan.

"**Master Policyholder**" means all types of scheduled banks (including co-operative banks) regulated by Reserve Bank of India, Non-Banking Financial Companies registered with Reserve Bank of India, National Housing Bank regulated Housing Finance Companies, National Minority Development Finance Corporation, it's State Channelizing Agencies and Small Finance Banks regulated by Reserve Bank of India, to whom this Policy is issued by Us, as specified in the Schedule.

"Medical Advice" refers to any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council of the Indian Medicine or for Homoeopathy 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 license; but excluding a Physician who is the Insured Member himself or an agent of the Insured Member, an Insurance agent, business partner(s) or employer/employee of the Insured Member or a member of the Insured Member's immediate family. Insured Member's immediate family will mean his Spouse, Father (including step father) or Mother (including step mother), Son (including step son), Son's wife, Daughter, Daughter's husband, Brother (including step brother) and Sister (including step sister).

"Member or Members" shall mean the person or persons who have availed a loan with the Policyholder on or after the Date of Commencement of Risk.

"Moratorium Period" shall mean a period of time during the loan tenure when the Insured Member does not make any payment towards the principal component of the loan, but may/may not make payments towards the interest component of the loan. The Insured Member may choose a Moratorium Period of 3, 5 or 7 years.

"Moratorium Period with Interest" shall mean where Insured Member has opted to pay interest during the Moratorium Period, the Sum assured during the Moratorium Period is the initial loan amount;

"Moratorium Period without Interest" shall mean where Insured Member has opted not to pay interest during the Moratorium Period, the Sum assured during the Moratorium Period is the initial loan amount plus the accrued interest during the Moratorium Period;

"Nominee(s)" shall mean the person(s) nominated by the Insured Member to receive the Insurance benefits payable in the event of the death of the Insured Member.

"Policy" shall mean this agreement, any supplementary contracts or endorsements therein, whenever executed, any amendments thereto signed by the Company, the application attached hereto of the Policyholder, the Policy Schedule, the member enrolment forms of the Insured Members and the Certificate of Insurances issued hereunder together constitute the entire contract between the parties.

"Policy Term" is the period in years for which the Policy can remain in-force and is mentioned on the Policy Schedule.

"Premium Payment Term" is the number of years that premium is payable for and is mentioned on the Policy Schedule.

"Pre-existing Disease" refers to any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received, Medical Advice / treatment within 48 months prior to the first policy issued by the Insurer and renewed continuously thereafter.

"Revival of the Policy" means restoration of the Policy, which was discontinued due to the non-payment of premium, by Us with all the benefits mentioned in the policy document, upon receipt of all the premiums due along with interest, charges, late fees if any, as per the terms and conditions of the Policy, upon being satisfied as to the continued insurability of the Insured Member on the basis of the information, documents and reports furnished by the Policyholder/Insured Member, in accordance with the Board approved Underwriting Guidelines.

"**Revival Period**" means the period of five consecutive years from the date of discontinuance of the Policy, during which period the Policyholder is entitled to revive the Policy which was discontinued due to the non-payment of premium.

"Sum Assured", shall mean the amount of benefit payable on the occurrence of an insured event, and shall be as mentioned in Policy Schedule.

"**Specialized Medical Practitioner**" is a person who holds a Masters' degree in the field of Medicine or Surgery and valid registration from the Medical Council of any state of India and is thereby entitled to practice Medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

"Surgery or Surgical Procedure" means manual and / or operative procedure(s), required for treatment of an illness or injury, correction of deformities or defects, Diagnosis and cure of disease, relied of suffering or prolongation of life, performed in a Hospital or Daycare center by a Medical Practitioner.

"Terminal Illness" is defined as an advanced or rapidly progressing incurable and un-correctable medical condition, which in the opinion of the treating physician is highly likely to lead to death within the next six months. An independent Medical Practitioner specializing in the relevant field of medicine also needs to opine that the life expectancy of the Insured Member is less than six months.

"Total Permanent Disability" means disablement of the Insured Member. The Insured Member has become totally and irreversibly disabled as a result of accident or illness and can be in any one of the below forms:

1) The total and permanent loss by severance or loss of use of both hands, and both feet, or both eyes, and a combination of any two (i.e. severance or loss of one hand and loss of sight of one eye or loss of one foot

and loss of sight of one eye or loss of one hand and one foot), will also result in the Insured Member being regarded as totally and permanently disabled;

2) The Insured Member must be totally incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit; or
3) The Insured Member must be unable to perform (whether aided or unaided) at least 3 of the following 6 "Activities of daily living".

Activities of Daily Living

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

The above disability must have lasted without interruption for at least six consecutive months (180 days) and must be deemed permanent by a Medical Practitioner appointed by the Company.

If the disability is due to amputation/dismemberment, the loss of hand will mean amputation/dismemberment above wrist, the loss of arm will mean amputation/ dismemberment above elbow, the loss of feet will mean amputation/dismemberment above ankle and the loss of leg will mean amputation/dismemberment above knee.

If the disability is not due to amputation/dismemberment, the loss will mean loss of usage of limbs and the limbs should have motor power grade 0/5, 1/5 or 2/5 only.

Loss of sight means total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. The Blindness is evidenced by:
- corrected visual acuity being 3/60 or less in both eyes or;
- the field of vision being less than 10 degrees in both eyes.
The Diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

"Total Premiums Paid" means total of all the Premiums received, excluding any extra premium, any rider premium and taxes, if any.

"Waiting Period for Critical Illness" or "Waiting Period for Total Permanent Disability" - shall mean period of ninety (90) days from the Date of Commencement of Risk or Effective Date of Coverage of Member or Date of Revival, whichever is later, of this Policy. The Waiting Period for Total Permanent Disability is applicable due to illness only and no Waiting Period for any Total Permanent Disability due to accident.

"Waiting Period for Terminal Illness" shall mean period of hundred and eighty days (180) days from the Date of Commencement of Risk or Effective Date of Coverage of Member or Date of Revival, whichever is later, of this Policy.

"**We**", "**Us**", "**Our**" or "**Company**" refers to Tata AIA Life Insurance Company Limited.

"**You**" or "**Your**" means the Policyholder.

2.2. ELIGIBILITY AND TERMINATION

2.2.1. ELIGIBILITY

Each Member of the Policyholder shall be eligible to apply for insurance coverage under this Policy subject to fulfilment of the following conditions:

1. The Member is a natural person
2. He has attained the Minimum Entry Age but is not over Maximum Entry Age as defined in the Policy Schedule attached hereto, at his last birthday.
3. The proposed term of insurance coverage at his Effective Date of Coverage shall not be less than the Minimum Coverage Term or more than the Maximum Coverage Term as defined in the Policy Schedule attached hereto.
4. The initial Sum Assured at the Effective Date of Coverage shall not be less than the Minimum Sum Assured or more than the Maximum Sum Assured as defined in the Policy Schedule attached hereto.
5. The Member is a primary borrower or a co-borrower of the loan being covered hereunder. A maximum of one co-borrower may become eligible under Joint Life insurance hereunder with respect to any one Single loan.
6. A minimum of 50 Insured Members are required to avail this Group Insurance Policy. The membership can be compulsory or voluntary in nature.

2.2.2. TERMINATION OF THE COVER

The insurance coverage hereunder of any Insured Member shall automatically cease on the earliest of the following dates:

1. The date of the expiration of the Policy Term for which the premium payment is made on account of the Insured Member's insurance, as specified in his Certificate of Insurance.
2. When Insured Member attains the Maximum Coverage Age as set out in the Policy Schedule attached hereto.
3. Date of death of the Insured Member during the Coverage Term.
4. The date communicated to the Policyholder by the Company as the date when the Policy ceases to operate in a geographical area on account of war or an act of war, such date being determined at the discretion of the Company. The Policy may, at the discretion of the Company, continue to be valid in those geographical areas which are as determined by the Company, unaffected by war or act of war."
5. When surrender value is paid to the Insured Member.
6. In case of full repayment of the loan before the expiry of the Policy Term, the cover will continue for the benefit set at the outset unless the Insured Member receives the surrender benefit as defined in the Policy Schedule attached hereto.
7. This Policy may be terminated by either the Policyholder or by the Company by providing ninety (90) days' prior written notice of termination to the other party. In the event of such termination coverage of the Insured member shall continue for the duration for which premium payment is made on account of his coverage.

3. PART C

3.1. Benefits

I. Depending upon the option selected in the Policy Schedule, in case of 'Death or Accelerated Terminal Illness', 'Critical Illness' or 'Total Permanent Disability' (as opted), provided the coverage is in force, We will pay in accordance with the following:

1. **Level cover/Reducing cover as opted at the inception of policy:** We will pay Sum Assured as selected in the Certificate of Insurance and as per the loan repayment schedule.
2. **Reducing Cover with Moratorium with Interest as opted at the inception of policy:** We will pay Sum Assured as per the loan repayment schedule provided along with the Certificate of Insurance.
3. **Reducing Cover with Moratorium without Interest as opted at the inception of policy:** We will pay Sum Assured as per the loan repayment schedule provided along with the Certificate of Insurance.

The above benefits shall not be payable if the insured event occurs within waiting period applicable for respective options, i.e. 'Death or Accelerated Terminal Illness', 'Critical Illness' or 'Total Permanent Disability'.

II. Accidental Death Benefit:

If the death is caused by Accident under Level Cover, provided the Policy is in force, We shall pay an additional amount equal to the Sum Assured payable under 'Death or Accelerated Terminal Illness'. The benefit of additional Accidental Death benefit can be availed only under Level Cover and is not available under Reducing Cover.

Where Accident leading to death has occurred during the Coverage Term but Accidental Death has occurred after the expiry of Coverage Term, however within 180 days from the date of Accident, we shall pay the Accidental Death benefit. No Sum Assured shall be payable since the Coverage Term has expired.

In the event of the death of the Insured Member after 180 days of occurrence of Accident, the Company shall not be liable to pay this benefit.

III. Maturity Benefit and Survival Benefit

No Maturity or Survival benefit are payable under the Policy.

3.2. Benefits in case of Joint Life cover:

Joint Life shall mean a person, who is also insured along with the primary loan borrower, being spouse of the primary loan borrower or any person other than spouse of the primary loan borrower, where the loan is jointly held in the names of both the lives.

Under Joint Life option only two (2) borrowers are allowed to be covered including the primary loan borrower.

Under Joint Life option, the product also proposes to offer coverage to the co-borrower against death (including Accidental Death), Terminal Illness, Critical Illness or Total Permanent Disability, as the case may be. In case of joint life covered under a Certificate of Insurance, below benefits shall be given:

a) When each borrower is insured for entire loan amount:
Each of the co-borrowers will be insured for 100% of the Sum Assured. In case claim is paid for one co-borrower, cover ceases for the surviving joint borrower. In this option only spouse of the primary loan borrower can be the co-borrower.
If the insured event is triggered on both joint Insured Members at the same time, only one benefit equal to Sum Assured shall be payable in respect of the first Insured Member as stated on the Certificate of Insurance.

b) When each of the joint borrowers is Insured up to his / her respective loan share:
Each of the joint borrowers is insured up to his/her loan share. If the claim is paid on occurrence of insured event of a joint borrower, then the cover shall cease only for that Insured Member. However, the cover shall continue for the other joint borrower to the extent of his/her loan share.
If the insured event is triggered on both joint Insured Members at the same time, the Sum Assured shall be payable once to each, as per the Insured Member's loan share stated on the Certificate of Insurance.

3.3. Effect of Full or Partial Repayment of Loan:

3.3.1. Level Cover: In case of partial repayment of the loan, the cover will continue for the benefit set at the outset (i.e. Sum Assured). In case of full repayment of the loan, the cover will continue for the benefit set at the outset (i.e. Sum Assured), unless the Insured Member opts to surrender.

3.3.2. Reducing Cover: In case of partial repayment of the loan, the cover will continue for the benefit set at the outset (i.e. as per the loan repayment schedule). In case of full repayment of the loan, the cover will continue for the benefit set at the outset (i.e. as per the loan repayment schedule) unless the Insured Member opts to surrender.

3.4. Exclusions

3.4.1. Exclusions for Terminal Illness benefit

The member will not be entitled to any Terminal Illness benefits if Terminal Illness results either directly or indirectly from HIV infection;

3.4.2. Exclusions for Critical Illness Benefit:

Apart from the exclusions specified in each of the diseases above, the following exclusions shall apply to the Policy benefits.

- Pre-Existing Disease: Any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which Medical Advice / treatment was received, within 48 months from the first policy issued by the Insurer and renewed continuously thereafter;
- Any covered event or its signs or symptoms having occurred within the Waiting Period for Critical Illness;
- Unreasonable failure to seek or follow Medical Advice, the Insured Member has delayed medical treatment in order to circumvent the Waiting Period for Critical Illness or other conditions and restriction applying to this Policy;
- Self-inflicted injuries, attempted suicide, insanity, and deliberate participation of the Insured Member in an illegal or criminal act;
- Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified Medical Practitioner;
- War – whether declared or not, civil commotion, breach of law, invasion, hostilities (whether declared or not), rebellion, revolution, military or usurped power or willful participation in acts of violence with criminal intent;
- Sexually transmitted diseases, Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS);
- Radioactive contamination due to nuclear accident;
- Any treatment of a donor for the replacement of an organ;
- Diagnosis and treatment outside India. However, this exclusion shall not be applicable in the following countries: Canada, Dubai, Hong Kong, Japan, Malaysia, New Zealand, Singapore, Switzerland, USA, UK, and countries of the European Union. The Company may review the above list of accepted foreign countries from time to time on the basis of board approved underwriting policy & board approved claims manual. Claims documents from outside India are only acceptable in English language unless specifically agreed otherwise, and duly authenticated;
- Any condition directly or indirectly related to External Congenital Anomaly of the Insured; or
- Engaging in hazardous sports / pastimes, i.e. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off pastel skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport, bungee jumping, hand gliding etc. or Any injury, sickness or disease received as a result of aviation (including parachuting or skydiving), gliding or any form of aerial flight other than as a fare-paying passenger on regular routes and on a scheduled timetable unless agreed by special endorsement. However Pilots, Cabin crew, Aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per board approved underwriting policy.

3.4.3. Exclusions under Total Permanent Disability

The below exclusions shall apply in case of Total Permanent Disability benefit:

- Attempted suicide or self-inflicted injury, whether the Insured Member is medically sane or insane;
- Pre-Existing Disease: Any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which Medical Advice / treatment was received, within 48 months from the first policy issued by the Insurer and renewed continuously thereafter;
- Infection with Human Immunodeficiency Virus (HIV) or conditions due to any Acquired Immune Deficiency Syndrome (AIDS);
- Unreasonable failure to seek or follow Medical Advice or treatment under reasonable circumstances from any registered and qualified Medical Practitioner.
- War, terrorism, invasion, act of foreign enemy, hostilities, civil war, martial law, rebellion, revolution, insurrection, military or usurper power or civil commotion;
- Radioactive contamination due to nuclear accident;
- Service in the armed forces, 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;
- Engaging in or taking part in hazardous activities, including but not limited to, diving or riding or any kind of race; martial arts; hunting; mountaineering; parachuting; bungee-jumping; underwater activities involving the use of breathing apparatus or not;
- Hazardous Activities mean any sport or pursuit or hobby, which is potentially dangerous to the Insured Member whether he is trained or not;
- 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; or
- Participation by the Insured Member in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.

3.4.4. Exclusions for Accidental Death benefit

Death due to Accident should not be caused by the following:

- Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Insured Member is under the influence of any narcotic substance or drug or intoxicating liquor unless taken in accordance with the lawful directions and prescription of a registered Medical Practitioner;
- Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy;
- The Insured Member with criminal intent, committing any breach of law;
- Due to war, whether declared or not or civil commotion; or
- Engaging in hazardous sports or pastimes, e.g. taking part in (or practicing for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

3.5. Bonus

There is no bonus payable in this plan. This Policy shall not participate in any surplus distribution by the Company.

3.6. Premium details

3.6.1. Premium Payment

- A Single/ Limited/ Regular premium is payable in respect of each Insured Member at the time his enrolment, to the Company at either the issuing office or at its Head Office, based on the premium rates as determined by the Company and specified in the Policy Schedule. The Company reserves the right to impose additional premium in respect of Insured Members that represent a substandard risk, as determined by the Company based on its underwriting guidelines and practices.
- In the case of Joint Life option, premiums will be calculated separately for each Joint Insured Member as per their respective entry age with applicable Joint Life Option specified in the Policy Schedule attached hereto.
- Collection of advance premium shall be allowed within the same Financial Year for the premium due in that Financial Year. However, where the premium due in one financial year is being collected in advance in earlier financial year, the Company may collect the same for a maximum period of three months in advance of the due date of the premium.
- The Premium so collected in advance shall only be adjusted on the due date of the premium.
- In case of failure of the Master Policyholder to remit the premium to Us, provided the premium is received from Insured Member within the Grace Period, the insurance coverage of the Insured Member, even after expiry of Grace Period, shall continue, provided the Insured Member establishes that he had paid the premium and secured a proper receipt for the same.

3.6.2 Change of frequency of premium payment

You may change the frequency of premium payments by written request. Subject to Our minimum premium requirements, premiums may be paid on Annual, Half- yearly, Quarterly or Monthly mode at the premium rates applicable on the Issue Date.

3.6.3 Grace period

A Grace Period of fifteen (15) days for monthly mode and thirty (30) days for all other modes, from the due date will be allowed for payment of each subsequent premium. The Policy will remain in force during this period. If the full premium for the first 2 policy years remains unpaid at the end of their grace period for limited / regular pay 5 years, the policies shall lapse from the due date of the first unpaid premium. If any claim occurs during the grace period, any due premium (without interest) of the policy will be deducted from the claim pay out.

3.6.4 Deduction of premium at claim

If a claim is payable under this Policy, any balance of the premiums due for the full Policy year in which death occurs shall be deducted from the proceeds payable under the Policy.

3.6.5 Other benefits and features

Modal Loading

The Limited Premium can be paid either Annually, Half-yearly, Quarterly or Monthly mode. Modal loading on premiums is as mentioned below:

Annual Premium Rate	: Multiply Annual Premium Rate by 1 (i.e. No loading).
Half-Yearly Premium Rate	: Multiply Annual Premium Rate by 0.51 (i.e. loading of 2%)
Quarterly Premium Rate	: Multiply Annual Premium Rate by 0.26 (i.e. loading of 4%)
Monthly Premium Rate	: Multiply Annual Premium Rate by 0.0883 (i.e. loading of 6%)

4 PART D

4.1 Revival

If a premium remains unpaid beyond the Grace Period and subject to the Policy not having been surrendered, it may be revived, as per the Board approved underwriting policy within five years after the due date of the first unpaid premium and before the end of the policy term subject to:

(i) A written application for revival is received from the Insured Member by the Company, together with revival fee (including applicable interest), evidence of insurability of the Insured Member and

(ii) Payment of all overdue premiums with applicable interest charged by the Company to revive this cover;

The cost incurred by the Company for the medical examination of the Insured Member to revive the Insurance cover shall also be borne and paid by the Insured Member to the Company.

Interest on premiums will be at a simple annual rate which we shall determine. The applicable interest rate for revival is determined using the State Bank of India (SBI) [or any other public sector undertaking bank] domestic term deposit rate for tenure '1 year to 455 days', plus 2%. Any alteration in the formula will be subject to prior approval of IRDAI. The current simple interest rate on revival from 1st October 2019 is 8.50% p.a. (i.e. SBI interest rate of 6.50% + 2%).

Any evidence of insurability requested at the time of revival will be based on the Board approved underwriting policy the Board approved underwriting policy.

The member cover which is not revived by the end of the revival period shall be terminated. There is no revival option for Single Premium.

4.2 Loan

Loan facility is not allowed under this Plan.

4.3 Non-Forfeiture Benefit

If the Insured Member prepays, his loan with the Policyholder, in full he will be entitled for surrender value. Surrender Value for Single Premium policy is payable at any point during the Policy Term. In such case the surrender value will be calculated by using the formula specified in the section 4.5. Surrender Benefit.

When the due premium for the policy (not a Reduced Paid-up policy) is not paid within the grace period, the policy shall lapse from the due date of unpaid premium and no benefits will be payable.

4.4 Reduced Paid-Up

At any time during the Policy Term, if the premiums are not paid within the Grace Period, the policy will lapse. This will only be true in case of those Limited Pay 5 policies for which premiums have been paid for less than 2 years. Such policy may be revivied, within five years from the due date of the first unpaid premium, as per Section 4.1. However, if the policy is not revivied, no further benefit will be payable and the policy will terminate.

The policy will be converted into a Reduced Paid-up policy by default, provided premiums for at least full 2 years is paid for Limited Pay 5 policies and subsequent premiums remain unpaid.

Reduced Paid-up policy is a default non forfeiture benefit. Such Reduced Paid-up policies can be revived within five years from the due date of first unpaid premium by payment of all due premiums together with interest as mentioned in section 4.1. Once Policy becomes Reduced Paid-up and is not revived till the end of the revival period, as per section 4.1 it will continue to be in Reduced Paid-up status.

The benefits to be paid in case of Reduced Paid up policies are as follows:

Death/ Accidental Death /Accelerated Terminal Illness/Accelerated Critical Illness/Accelerated Total Permanent Disability Benefit (as the case may be)

= Benefit payable as per the option chosen (as given under section 3.1 above) *multiplied by* RPU Factor*

*RPU Factor = (Number of Premiums paid) *divided by* (Number of Premiums Payable during the entire premium payment term)

4.5 Surrender Benefit

By Insured Member - The Insured Member also has the right to surrender the Insurance Cover, only if the member repays the outstanding loan amount in full and submits a surrender request with the Company. In case of limited premium option, the surrender benefit will be available provided at least two full year's premiums have been paid. There is no surrender value available in the regular premium option.

By Policyholder - The Policyholder can terminate the Policy at any time by giving a written intimation to the Insurer under Clause No. 2.2.2 (7). In such cases, post surrender, new enrolments will cease and existing members will be given an option to surrender his/her membership as per terms and conditions mentioned above, avail surrender benefit and terminate the Insurance cover or Individual members of the Group can continue the policy as an individual policy on same terms and condition that of the Policy.

On surrender of the coverage Insured Member will be entitled for a surrender value. Amount of Surrender value will be calculated by using below formula under Level Sum Assured or Reducing Sum Assured benefit option:

Surrender value = (50% of the premium paid less applicable taxes, levies and cesses) *multiplied by* (unexpired policy term *divided by* total Policy Term) *multiplied by* (Coverage at the time of surrender *divided by* Sum Assured at inception)

PART E

Not Applicable for this Product

PART F

4.6 Duties of the Policyholder

4.6.1 You shall always keep a record of all information of each Insured Member in the Register of Members including the Insured Member's name, gender, date of birth, Age, occupation/designation, address, details of the Premium paid in respect of the Member, Date of Commencement of Risk, Coverage Expiry Date as per Certificate of Insurance, date of exit of Insured Member, death benefit payable, Coverage Term, Nominees, Certificate of Insurance number and other information required to carry out the terms of this Policy. You shall provide Us with an updated and complete copy of the Register of Members on the last day of every calendar month.

4.6.2 In the event the Register of Members is amended, such amendment shall become effective only if the same has been intimated to Us within 30 (Thirty) days of such amendment and if the same is approved by Us. Any amendment to the terms and conditions of this Policy due to any amendment to the Register of Members or otherwise will be effective on issuance of duly signed endorsements.

4.6.3 You will give Us all information, documentation and evidence with respect to the Policy as required by Us from time to time. All documents furnished to You by any Member and other records with respect to the Policy, shall be informed to Us and shall be open for Our inspection at all reasonable times.

4.6.4 It shall be the responsibility of the Policyholder to ensure that the personal information provided to the Company is accurate. The Policyholder shall indemnify and keep indemnified the Company against any and all losses, costs, expenses, third party actions, proceedings suffered by the Company as a result of the Policyholder's failure to provide accurate information as aforesaid.

4.6.5 Any personal information collected or held by the Company with respect to each Insured Member under this Policy may be held, used and disclosed by the Company to individuals or organizations associated with the Company with regard to matters pertaining to the Insured Member's coverage.

4.6.6 Any clerical error in keeping the records shall not invalidate the Policy or the insurance coverage of an

Insured Member otherwise validly in force, nor continue a Policy or the insurance coverage of an Insured Member otherwise validly terminated; but upon the discovery of such error, it shall be rectified at the earliest.

4.7 Fraud, Misrepresentation and Forfeiture

Fraud, Misrepresentation and forfeiture would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938 as amended from time to time. The simplified version of the provisions of Section 45 is enclosed in Annexure 3 for reference.

4.8 Suicide

In case of death due to suicide within 12 months from the Date of Commencement of Risk or Effective Date of Coverage of Insured Member or from the date of revival of the coverage, as applicable, the nominee or beneficiary shall be entitled to at least 80% of the Total Premiums Paid for the coverage till the date of death or the surrender value available as on the date of death whichever is higher, provided the coverage is in force.

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4.9 Misstatement of age and gender

Subject to Section 45 of the Insurance Act, 1938 as amended from time to time, the Premiums are calculated on the basis of the Age and/ or gender of the Insured Member(s). If the Age and/or gender declared in the Proposal Form and/or Insured Member enrolment application form is found to be incorrect anytime during the Policy Term and/or at the time of claim, then We may adjust the premium, along with interest thereon, payable by You/the Insured Member or benefits payable, based on the true Age and/or gender of the Insured Member.

4.10 Nomination

Nomination allowed as per provisions of Section 39 of the Insurance Act 1938 as amended from time to time.
The simplified version of the provisions of Section 39 is enclosed in Annexure 2 for reference.

4.11 Assignment

Assignment shall be as per provisions of Section 38 of the Insurance Act, 1938, as amended from time to time.

4.12 Currency and place of payment

All amounts payable either to or by Us will be paid in the Indian currency. Such amounts will be paid by a negotiable bank draft or cheque drawn on a bank or NEFT (National Electronic Funds Transfer) or electronic clearing systems. All amounts due from Us will be payable from Our office.

4.13 Freedom from restrictions

Unless otherwise specified, this Policy is free from any restrictions upon the Insured Member as to travel, residence or occupation.

4.14 Taxes

All Premiums are subject to applicable taxes, cesses, levies which will entirely be borne by You and will always be paid by You along with the payment of Premium. If any imposition (tax or otherwise) is levied by any statutory or administrative body on the benefits under the Policy, We have the right to deduct the amount of such imposition from the benefits payable by Us under the Policy. Alternatively, We reserve the right to recover the same from You.

Tax benefits and liabilities under the Policy are subject to prevailing tax laws. Tax laws and the benefits arising thereunder are subject to change. You are advised to seek an opinion of Your tax advisor in relation to the tax benefits and liabilities applicable to You.

4.15 Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and shall be enforced in accordance with the laws of India.

4.16 Claims

In case of lender-borrower groups i.e scheduled banks (including co-operative banks) regulated by Reserve Bank of India, Non-Banking Financial Companies registered with Reserve Bank of India, National Housing Bank regulated Housing Finance Companies, National Minority Development Finance Corporation, it's State Channelizing Agencies' and Small Finance Banks regulated by Reserve Bank of India, the following conditions shall apply to claims payments under the Policy:

- Subject to the authorization from the Insured Member, We shall pay outstanding loan amount to You;
- The Members may provide the said authorisation either on the date of enrolment or at a later date;
- The surplus claim proceeds, if any, will be paid to the Claimant by Us. The amount payable to Master Policyholder shall under no circumstances be more than the outstanding loan amount;
- You shall provide us details of the credit account statement with respect to the Members as per the guidelines issued by IRDAI from time to time;
- We reserve the right to
    - audit or cause an audit into the accuracy of the credit account statements of the Insured Members in respect of which claims will be settled, on completion of every financial year and shall audit or cause an audit into the accuracy of the credit account statement of the deceased Members furnished by You; or
    - You shall provide a certification from Your internal statutory auditors that the outstanding loan balance being shown in the credit account statement/claim discharge form is correct as per the conditions governing the credit account/loan account. In the event of any discrepancy found in the audit report of such credit account statements, the onus of settling the difference amount, if any, to the Insured Member / Claimants, as the case may be, rests with Us.

All cases of claim must be notified to us in writing within 90 days of occurrence of insured event. However, we may condone delay on merit for delayed claims where the reason for delay is proved to be for reasons beyond the control of the claimant. In case of any delay on the part of the Company to process the claim within extant regulatory timeline, We shall pay interest as may be prescribed by the IRDAI from time to time.

Please note that all claims will be payable to the rightful Claimant.

Filing Proof of Claim – Unless otherwise specified, duly filled in requisite forms along with proof of loss shall be furnished to us, at the claimant's expenses. A list of documents required in general, is attached to the Policy. However, submission of such documents, forms or other proof shall not be construed as an admission of liabilities by the Company and we reserve right to request additional proof and/or documents in support.
For processing the claim request under this policy, we will require the following documents:

4.16.1 Death claims requirements

Type of Claim	Requirement

Death (all causes of death other than the Accidental Death)	a) Claim Forms ▪ Part I: Application Form for Death Claim (Claimant's Statement) along with NEFT form ▪ Part II: Physician's Statement - to be filled by last attending physician
	b) Death Certificate issued by a local government body like Municipal Corporation
	c) Medical Records (Admission Notes, Discharge/Death Summary, Indoor Case Papers, Test Reports etc)[1]
	d) Claimant's Photo ID, relationship proof with the Insured Member along with Address proof of the claimant and Cancelled cheque with name and account number printed or cancelled cheque with copy of Bank Passbook / Bank Statement If no nomination - Proof of legal title to the claim proceeds (e.g. legal succession paper)
	e) Outstanding Loan Statement as on the date of event
	f) Credit Account Statement from Policyholder
If Death due to Accident (to be submitted in addition to the above)	g) Postmortem report (Autopsy report) & Chemical Viscera report – if performed
	h) All Police Papers – Panchnama, Inquest, First Information Report (FIR) and Final Investigation Report

[1]*This is applicable if insured was in hospital at the time of death or any time prior to the date of death*

4.16.2 Critical Illness claims requirements

Type of Claim	Requirements for Critical Illness Claim
Critical Illness	A. Claim Forms • Part I: Application Form for Critical Illness Claim (Claimant's Statement) along with NEFT form • Part II: Confidential Medical Report –to be filled by attending physician
	B. Hospital Bills for the confinement.
	C. Attested True Copy of Indoor Case Papers of the Hospital
	D. Discharge Summary of Present and Past Hospitalizations
	E. Photo Identity of Insured Member with age and address proof
	F. Bank Details of the claimant – Cancelled cheque (with printed name and account number)/bank passbook and NEFT Form
	G. Certificate of Diagnosis
	H. Medical Examination Certificate (First Consultation Notes).
	I. All related clinical Reports pertaining to the claim event – • Laboratory test reports, X-Ray / CT Scan / MRI Reports & Plates, Ultrasonography Report • Histopathology Report • Clinical / Hospital Reports • Angiography Reports & Plates

	• Others, as may be required/asked for by Us
	J. All follow-up Consultation Notes in relation to the hospitalized condition.
	K. Outstanding Loan Statement as on the date of event
	L. Credit Account Statement from Policyholder
If Claims is due to accidental causes (submit in addition to the above)	M. All police reports - First Information Report, Final Investigation Report

4.16.3 Total Permanent Disability claims requirements

Type of Claim	**Requirement**
Disability Claim (all causes of disability)	a) Claim Forms • Part I: Application Form for Disability Claim (Claimant's Statement) along with NEFT form • Part II: Confidential Medical Report -to be filled by Attending Physician
	b) Attested True Copy of Indoor Case Papers of the Hospital
	c) Discharge Summary of Present and Past Hospitalizations
	d) Photo Identity of Insured Member with age and address proof
	e) Bank Details of the claimant – Cancelled cheque (with printed name and account number)/bank passbook and NEFT Form
	f) Disability Certificate by attending Physician / Institute for disabled
	g) Rehabilitation Certificate - if applicable
	h) Employer's written confirmation / statement - for Disability claim
	i) All related Medical Examination Reports, e.g. - Laboratory test reports, X-Ray / CT Scan / MRI Reports & Plates Ultrasonography Report, Clinical / Hospital Reports
	j) Clinical Photographs showing the injured areas - if available
	k) Outstanding Loan Statement as on the date of event
	l) Credit Account Statement from Policyholder
If Disability due to Accident (to be submitted in addition to the above)	m) All police reports- First Information Report Final Investigation Report

Please submit copies of the following documents certified / attested by the issuing authority. (Original Seen Verified (OSV) by Branch Personnel will also be accepted) –

- All Police papers – Panchnama, Inquest, First Information Report and Final Investigation Report.
- Medical Records (Admission Notes, Discharge/Death Summary, Indoor Case Papers, Test Reports etc).
- Postmortem report (Autopsy report) & Chemical Viscera report (certified by Police / Magistrate / Court will also be accepted)

Copies of the other documents to be submitted by self-attestation of the claimant

Note-

In case the claim warrants any additional requirement, We reserve the right to call for the same.
Notification of claim & submission of the claim requirements does not mean admission of the claim liability by the Company.
No agent is authorized to admit any liabilities on behalf of the Company, nor to alter this list of documents or any claims requirements called for by the Company.

4.16.4 Claims Intimation Process

Mentioned below is a list of various mediums through which Claimant can contact us.

a. Email - credit.life@tataaia.com or customercare@tataaia.com
b. Call Our helpline number 1-860-266-9966 (local charges apply)
c. Walk into any of the Company branch office
d. Write directly to us on following address:

Tata AIA Life Insurance Company Limited
B - Wing, 9th Floor, I-Think Techno Campus,
Behind TCS, Pokhran Road No.2,
Close to Eastern Express Highway,
Thane (West) – 400 607, Maharashtra.

4.17 Force majeure

If the performance by the Company of any of its obligations herein shall be in any way prevented or hindered in consequence of any act of God or state, strike, Lock out, Legislation or restriction of any Government or other authority or any other circumstances beyond the anticipation or control of the Company, the performance of this contract with prior approval of IRDAI shall be wholly or partially suspended during the continuance of the force majeure event and the Company will resume the contract terms and conditions when such event cease to exist.

5 PART G

CONSUMER INFORMATION

POLICYHOLDER'S SERVICING

With regards to any query or issue related to the Policy, the Policyholder can contact the Company through the following service avenues:

- Contact your Tata AIA Life Agent / Distributor
- Call Our helpline number 1-860-266-9966 (local charges apply)
- E-mail us at customercare@tataaia.com or credit.life@tataaia.com
- Visit the nearest the Tata AIA Life branch or CAMS Service Center
- Log on to Online Customer Portal by visiting www.tataaia.com

GRIEVANCE REDRESSAL PROCEDURE

1) Resolution of Grievances

Customers can register their grievances through Multiple Service Avenues:

- Call Our helpline number 1-860-266-9966 (local charges apply)
- Email us at life.complaints@tataaia.com
- Login to online Policy account on www.tataaia.com
- SMS SERVICE to 58888 to receive a call back from Our Customer Service Representative
- Visit any of the nearest Tata AIA Life branches or CAMS Service Centers
- Contact your Tata AIA Life Agent / Distributor
- Write to us on the following address:

  Grievance Redressal Department
  Tata AIA Life Insurance Company Limited
  B- Wing, 9th Floor, I-Think Techno Campus,
  Behind TCS, Pokhran Road No.2,
  Close to Eastern Express Highway,
  Thane (West) – 400 607, Maharashtra.

- We shall acknowledge a customer's grievance within 3 business days by providing the customer with the name of the Grievance Redressal Executive who is responsible to handle the grievance.
- We shall provide the customer with an equitable resolution within 2 weeks of receipt of the grievance.
- In case customers wishes to contact us during the course of the assessment, they can contact us at any of the above-mentioned touch points.
- All Tata AIA Life branches have a Grievance Redressal Officer who can be contacted for any support during the grievance redressal process.

2) Escalation Mechanism

In case customers are not satisfied with the decision of the above offices, or has not received any response within the stipulated timelines, they may contact the following officials for resolution:

- 1st level of Escalation: Head - Customer Service
- 2nd level of Escalation: Grievance Redressal Officer (GRO)

For escalations, customers can email to **head.customerservice@tataaia.com** or write to –

Tata AIA Life Insurance Company Limited,
B-Wing, 9th Floor, I-Think Techno Campus,
Behind TCS, Pokhran Road No.2,
Close to Eastern Express Highway,
Thane (West) – 400 607, Maharashtra

If you are not satisfied with the response or do not receive a response from us within 15 days, 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
Email ID: complaints@irda.gov.in

You can also register your complaint online at http://www.igms.irda.gov.in /
Address for communication for complaints by fax/paper:
Consumer Affairs Department
Insurance Regulatory and Development Authority of India
Consumer Affairs Department – Grievance Redressal Cell.
Insurance Regulatory and Development Authority of India
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

3) Insurance Ombudsman:

Where the redressal provided by the Company is not satisfactory despite the escalation above, the customer may represent the case to the Ombudsman for Redressal of the grievance, if it pertains to the following:

- Delay in settlement of claim
- Partial or total rejection of claim;
- Dispute with regard to premium;
- Misrepresentation of policy terms and conditions;
- Legal construction of the policy in so far as dispute related to claim;
- Grievance relating to policy servicing;
- Issuance of policy which is not in conformity with proposal form;
- Non- issuance of your insurance document; and
- Any other matter resulting from the violation of provisions of the Insurance Act, 1938 or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned hereinabove.

Please refer to our website www.tataaia.com for further details in this regard.

The list of Ombudsman address is attached as Annexure 1

The complaint should be made in writing duly signed by the complainant or through his legal heirs, nominee or assignee, and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman. As per provision 14(3) of the Insurance Ombudsman Rules, 2017; the complaint to the Ombudsman can be made:

- Only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer; or
- the complainant had not received any reply within a period of one month after the Insurer received the grievance; or
- the complainant is not satisfied with the reply given to him by the Insurer.

Annexure A List of Insurance Ombudsman

AHMEDABAD - Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th Floor, Tilak Marg, Relief Road, Ahmedabad -380 001. Tel.:- 079 - 25501201/02/05/06 Fax : 079-27546142 Email: bimalokpal.ahmedabad@gbic.co.in. (State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.) **BENGALURU** -Office of the Insurance Ombudsman, J24th Main Road, Jeevan Soudha Bldg.,JP Nagar, 1st Phase, Ground Floor Bengaluru – 560 078. Tel.: 080-26652049/26652048 Email: bimalokpal.bengaluru@gbic.co.in. (State of Karnataka) **BHOPAL** - Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, Bhopal(M.P.)-462 003. Tel.:- 0755-2769201/9202 Fax : 0755-2769203 Email: bimalokpal.bhopal@gbic.co.in (States of Madhya Pradesh and Chattisgarh.)

BHUBANESHWAR - Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar-751 009. Tel.:- 0674-2596455/2596003 Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@gbic.co.in (State of Orissa.) **CHANDIGARH** - Office of the Insurance Ombudsman, S.C.O. No.101-103,2nd Floor, Batra Building, Sector 17-D, Chandigarh-160017. Tel.:- 0172-2706468/2772101 Fax : 0172-2708274 Email:bimalokpal.chandigarh@gbic.co.in (States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.) **CHENNAI**- Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, Chennai-600 018.Tel.:- 044-24333668 /24335284 Fax : 044-24333664 Email: bimalokpal.chennai@gbic.co.in [State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).] **DELHI**- Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building., Asaf Ali Road, New Delhi-110 002. Tel.:- 011-011-23234057/23232037 Fax : 011-23230858 Email: bimalokpal.delhi@gbic.co.in (States of Delhi) **GUWAHATI** - Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, S.S. Road, Guwahati-781 001 Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: bimalokpal.guwahati@gbic.co.in (States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.) **HYDERABAD** - Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel : 040-65504123/23312122 Fax: 040-23376599 Email: bimalokpal.hyderabad@gbic.co.in (States of Andhra Pradesh and Union Territory of Yanam – a part of the Union Territory of Pondicherry.) **JAIPUR**- Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, Jaipur – 302005 Tel : 0141-2740363 Email: bimalokpal.jaipur@gbic.co.in (State of Rajasthan) **ERNAKULAM** - Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., M.G. Road, Ernakulam-682 015. Tel : 0484-2358759/2359338 Fax : 0484-2359336 Email: bimalokpal.ernakulam@gbic.co.in [State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.] **KOLKATA** - Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C.R. Avenue, Kolkata-700 072. Tel : 033-22124339/22124346 Fax : 033-22124341 Email: bimalokpal.kolkata@gbic.co.in (States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.) **LUCKNOW**- Office of the Insurance Ombudsman,Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, Lucknow-226 001. Tel : 0522 -2231331/2231330 Fax : 0522-2231310 Email: bimalokpal.lucknow@gbic.co.in (States of Uttar Pradesh and Uttaranchal.) **MUMBAI** - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), Mumbai 400054. Tel : 022-26106960/26106552 Fax : 022-26106052 Email: bimalokpal.mumbai@gbic.co.in (State of Goa and Mumbai Metropolitan Region excluding Navi Mumbai and Thane) **PUNE** - Office of the Insurance Ombudsman,3rd Floor, Jeevan Darshan Bldg,N.C. Kelkar Road,Narayanpet, Pune – 411030. Tel: 020-41312555Email: bimalokpal.pune@gbic.co.in (State of Maharashtra including Navi Mumbai and Thane and excluding Mumbai Metropolitan Region.) **NOIDA** - Office of the Insurance Ombudsman,4th Floor, Bhagwan Sahai Palace,Main Road, Naya Bans, Sector-15,Noida - 201301.Tel: 0120-2514250/51/53Email: bimalokpal.noida@gbic.co.in (State of Uttaranchal and the following Districts of Uttar Pradesh:Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.) **PATNA** - Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna – 800006, Tel No: 06122680952, Email id : bimalokpal.patna@gbic.co.in.(Bihar, Jharkhand.) Page 24 of 27

Annexure 1

Section 38 - Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows: 1. This policy may be transferred/assigned, wholly or in part, with or without consideration.2.An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.4.The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.5.The transfer or assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.6.Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.7.On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.8.If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.9.The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is a. not bonafide; b. not in the interest of the policyholder; c. not in public interest; ord.is for the purpose of trading of the insurance policy.10.Before refusing to act upon endorsement, the insurer should record the reasons in writing and communicate the same in writing to policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.11.In case of refusal to act upon the endorsement by the insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the insurer.12.The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to the Authority.13.Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except a.where assignment or transfer is subject to terms and conditions of transfer or assignment OR b.where the transfer or assignment is made upon condition that i.the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured; orii.the insured surviving the term of the policy. Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.14In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such persona shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment; b. may institute any proceedings in relation to the policy; and c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings15.Any rights and remedies of an assignee or transferee of a life insurance policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by this section.

Annexure 2

Section 39 - Nomination by Policyholder

Nomination of a life insurance policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows: 1. The policyholder of a life insurance policy on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.2.Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment is to be laid down by the insurer. 3. Nomination can be made at any time before the maturity of the policy. 4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.5.Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be. 6.A notice in writing of change or cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.7.Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.8.On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof. 9.A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will get affected to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.10.The right of any creditor to be paid out of the proceeds of any policy of life

insurance shall not be affected by the nomination.11.In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.12.In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s). 13.Where the policyholder whose life is insured nominates his a. parents or b. spouse or c. children or d. spouse and children e.or any of them, the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s). 15.The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act 2015.16.If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.17.The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Act, 1938 as amended from time to time, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply

Annexure 3

Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows: 1.No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs 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

[Disclaimer: This is only a simplified version prepared for general information. You are advised to refer to the Insurance Act, 1938 as amended from time to time for complete and accurate details.]