Shakti Care Policy – Prospectus

This Policy is specially designed for covering Surrogate Mothers And Oocyte Donors as defined under as per The Surrogacy (Regulations) Act 2021 and & ART (Regulations) Act 2021 and any subsequent additions / modifications as may be applicable.

1. ELIGIBILITY CRITERIA

Member insured as Surrogate Mother should be a certificate holder issued by the District Medical Board.

2. AGE

Age eligibility: 25 years to 35 years

3. COVER TYPE

The Policy can be opted on an Individual basis only.

4. POLICY TENURE

This Policy will be available for 3 years for the surrogate mother & 1 year for the oocyte donor.

5. PREMIUM PAYMENT MODE

The premium will be made up-front before the policy inception.

6. SUM INSURED

A standard sum insured of INR 5,00,000/- only

7. WAITING PERIODS

Initial Waiting Period: 30 Days

8. SCOPE OF COVER

a) Inpatient Care:

The Company shall indemnify up to the Sum Insured as specified for the Policy Year in the Policy Schedule towards Medical Expenses incurred during the Policy Period in the event of Hospitalization of the Insured Person during the Policy Year for the below Listed Conditions. The Medical Expenses shall be covered in the following manner:

i. Room Rent, boarding, nursing expenses of a Qualified Nurse as provided by the Hospital / Nursing Home up to 1% of the Sum Insured per day.

ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to maximum of 2% of Sum Insured per day.

iii. Fees towards surgeon, anesthetist, Medical Practitioner, consultants, specialist whether paid directly to the treating Medical Practitioner/ surgeon or to the Hospital.

iv. Expenses incurred towards anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities undertaken at Medical Diagnostic Laboratory and/or Diagnostic Centres, and such similar other expenses.

v. Expenses towards Dental Treatment necessitated due to Injury caused or Illness suffered by the Insured Person.

vi. Expenses towards plastic Surgery necessitated due to Injury caused or Illness suffered by the Insured Person.

vii. All Day Care Treatments.

Note:

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

2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

Coverage applicable for Listed Conditions for Surrogate Mother :

The following complications of pregnancy and abortions, miscarriage and lawful medical termination of pregnancy of the Insured Person shall be covered under this Policy.

Sr No	Complications of delivery
1	Perineal tears during childbirth
2	Postpartum hemorrhage
3	Episiotomy Complications
4	Post partum Endometritis
5	Postpartum depression/Psychosis
6	Anesthesia complications
7	Infection or sepsis

8	Stroke
9	Amniotic fluid embolism
10	Postpartum preeclampsia
11	Pulmonary edema
12	HELLP syndrome
13	Heart related complications
14	Peripartum (postpartum) cardiomyopathy
15	Thrombotic pulmonary embolism (DVT)
17	Postpartum Respiratory Failure
18	Postpartum peritonitis

Coverage applicable for Listed Conditions for Oocyte Donor :

The following complications of oocyte retrieval from the Insured Person shall be covered under this Policy.

Sr No	Complications of Oocyte retrieval
1	Infection or sepsis
2	Bleeding
3	Ovarian hyperstimulation syndrome (OHSS)
4	Injury to surrounding structures due to procedure
5	Anesthesia complications

b) Pre-Hospitalization Medical Expenses:

Where a claim in respect of the Insured Person(s) has been admitted under Clause 4.1 above, the Company shall also indemnify Pre-Hospitalization Medical Expenses incurred for a fixed period of 30 consecutive days prior to the date of admission of the Insured Person in a Hospital or Day Care

Centre upto the Sum Insured for the Policy Year. Such claim shall be admitted only on Reimbursement basis. **c) Post-Hospitalization Medical Expenses:**

Where a claim in respect of the Insured Person(s) has been admitted under Clause 4.1 above, the Company shall also indemnify Post-Hospitalization Medical Expenses incurred for a fixed period of 60 consecutive days post the date of discharge of the Insured Person from the Hospital or Day Care Centre upto the Sum Insured for the Policy Year. Such claim shall be admitted only on Reimbursement basis.

d) Emergency Ground Ambulance

Where a claim in respect of the Insured Person(s) has been admitted under Clause 4.1 above or Clause 4.5 below, the Company will reimburse Reasonable and Customary Charges upto the maximum limit of Rs 2000 per Hospitalization as mentioned against this cover in the Policy Schedule for expenses incurred towards Ambulance charges for transportation of the Insured Person provided that such transportation is advised by the treating Medical Practitioner in writing as an Emergency Care and that such transportation is from the place where the Insured Person suffered an Injury or is suffering from an Illness, to the Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital. Such claim shall be admitted only on Reimbursement basis.

Specific Conditions:

a) The Company will reimburse payments under this benefit provided that.
b) The Ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
c) The original Ambulance bills and payment receipt is submitted to the Company.
d) Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or Diagnostic Centre for evaluation purposes only.

e) Modern Treatments:

The Company will reimburse Reasonable and Customary Charges for expenses incurred towards the Insured Person's treatment provided always that a claim under hospitalisation above is admitted and such treatment is a Medically Necessary Treatment as certified by a Medical Practitioner in writing. The treatments include:

(a) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
(b) Balloon Sinuplasty
(c) Deep Brain Stimulation
(d) Oral Chemotherapy
(e) Immunotherapy - Monoclonal Antibody to be given as injection
(f) Intra-vitreal injections
(g) Robotic Surgeries
(h) Stereotactic radio Surgeries

(i) Bronchial Thermoplasty

(j) Vaporisation of the Prostrate (Green Laser Treatment or Holmium Laser Treatment

(k) IONM - (Intra Operative Neuro Monitoring)

(l) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered..

8. ENDORSEMENTS

Any request for endorsement shall be made in writing by the Policyholder only. Any endorsement would be effective from the date of request as received from the Policyholder, or the date of receipt of premium, whichever is later. (a) Non-Premium Bearing Endorsement

- Correction in name of the Policyholder/Insured Person
- Correction in gender of the Policyholder/Insured Person
- Correction in relationship of the Insured Person with Policyholder
- Correction in date of birth of the Policyholder/Insured Person (if the change of age does not result in change of premium)
- Change in correspondence address of the Policyholder (if the change of address does not result in change of City or District of residence)
- Change in the contact details of the Policyholder/Insured Person ● Change of nominee details of the Policyholder/Insured Person

(b) Premium Bearing Endorsement

- Change in date of birth/ age

9. PRE-POLICY MEDICAL CHECK UP

(a) You may need to undergo pre-Policy medical check-up consisting of Tele-Health Underwriting which typically involves answering to health questions through tele-video call and/or comprehensive medical check-up including undergoing laboratory investigations & physical examination, if deemed necessary by the insurer.

(b) Further, we may request you to undergo a pre-Policy medical check-up to further evaluate the health status. Wherever required we may request for additional medical tests to be conducted based on the results of the initial medical check.

(c) Medical tests will be facilitated by us and conducted at our network of diagnostic centres. We will contact You and fix an appointment for the Medical tests to be conducted at a time convenient to you. Medical tests will be valid for a period of 1 month only. Cost of all such tests will be borne by us for all accepted proposals. In case of rejected proposals then You must bear the 50% cost of medical tests.

10. LOADING

(a) we may apply a risk loading on the premium payable (based upon the declarations made in the Proposal Form and the health status of the persons proposed for insurance);

(b) The maximum risk loading applicable for an individual shall not exceed 100% of premium per person;

(c) We will inform You about the applicable risk loading through a counteroffer letter. Please note that We will issue Policy only after getting Your consent.

11. WAITING PERIOD

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy.

1) First 30 days waiting period- Code- Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

12. PERMANENT EXCLUSIONS

A. Standard Exclusions

1. Investigation & Evaluation- Code- Excl04

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

1. Rest Cure, rehabilitation, and respite care- Code- Excl05

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons. ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

2. Obesity/ Weight Control: Code- Excl06

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

1) Surgery to be conducted is upon the advice of the Doctor.

2) The surgery/Procedure conducted should be supported by clinical protocols.

3) The member must be 18 years of age or older and 4) Body Mass Index (BMI).

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co- morbidities following failure of less invasive methods of weight loss:

i) Obesity-related cardiomyopathy

ii) Coronary heart disease

iii) Severe Sleep Apnoea

iv) Uncontrolled Type2 Diabetes

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

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

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

6. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

7. Excluded Providers: Code- Excl11
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
8. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- **Excl12**

9. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

10. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code- Excl14**

11. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5dioptres.

12. Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

13. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

B. Specific Exclusions

1. Any medical treatment taken outside India.
2. Expenses except those specifically listed under In-patient Care cover under section 4.1.1 & 4.1.2
3. Injury or Illness caused by or contributed to by nuclear weapons/materials.
4. Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.
5. Suicide, Intentional self-injury.
6. Vaccination or inoculation except as post bite treatment for animal bite.
7. Convalescence, general debility, “Run-down” condition, rest cure, Congenital external illness/disease/defect.
8. Outpatient (OPD) diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to domiciliary hospitalization shall not be covered.
9. Dental treatment or Surgery of any kind unless requiring Hosptalization as a result of accidental Bodily Injury.
10. Stem cell storage.

11. Any kind of service charge, surcharge levied by the hospital.

12. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

13. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II

14. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

15. Any medical treatment which is not listed under section 4.

13. GENERAL TERMS & CLAUSES

13.1. Standard General Terms & Clauses

1. Condition Precedent to the contract

i. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any Material Fact by the Policyholder.

ii. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

iii. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her Nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall in all cases be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

iv. Multiple Policies

a) In case of multiple policies taken by an Insured during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

b) Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other Policy / policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.

c) If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

d) Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

v. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this Policy and the premium paid shall be forfeited.

Any amount already paid against the claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/Policyholders(s), who has made the particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the Hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance Policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person having knowledge or belief of the

fact; c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and/ or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / 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 misstatement of or suppression of Material Fact is within the knowledge of the Insurer.

vi. Cancellation

a) The Policyholder may cancel this Policy by giving 15 days' written notice only in case of demise of insured member/s and in such an event, the Company shall refund premium for the unexpired Policy Period on prorate basis. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

b) The Company may cancel the Policy at any time on grounds of misrepresentation, nondisclosure of Material Facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, nondisclosure of Material Facts or Fraud.

vii. Renewal of Policy

This policy will not be eligible for renewal.

viii. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

ix. Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on Renewals or at the time of porting/migrating the Policy. The Insured shall be allowed free look period of 1 month from date of receipt of the Policy document to review the terms and conditions of the Policy, and to return the same if not acceptable.

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

- a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

- where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

- Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

x. **Nomination**:

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

xi. Withdrawal of Policy

(a) In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the Policy.

(b) Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of Renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the Policy has been maintained without a break.

xii. Claim Settlement (Provision of Penal Interest)

(a) The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

(b) In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

(c) However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

(d) In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(e) "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

xiii. Grievance Redressal

In case of any grievance the insured person may contact the company through

Universal Sompo General Insurance Co. Ltd.
Unit no 601-602 A & B Wing 6th Floor Reliable Tech Park
Cloud City Campus, Gut No 31, Mouje, Eltham, Thane Belapur road, Airoli, Navi Mumbai 400708
Website: www.universalsompo.com Toll free: 1800-200-5142
Landline Numbers: (022)- 41659800 Fax : (022) 39171419
E-mail: contactus@universalsompo.com
Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievance@universalsompo.com
For updated details of grievance officer, kindly refer the link https://universalsompo.com/resourse-grievance-redressal
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

13.2. Specific Terms & Conditions

I. Condition Precedent to the contract

a. Material Change The Insured Person shall notify the Company in writing of any material change in the risk in relation to the declaration made in the Proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

b. Notice and Communication

i. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule/certificate of insurance.

c. Records to be Maintained: The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

d. Territorial Jurisdiction: All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

e. Eligibility Criteria

i. Insured Person as Surrogate Mother should be a certificate holder issued by the District Medical Board.

II. Conditions applicable during the contract

i. Alterations in the Policy

The Proposal Form, Policy Schedule constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and the Company. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Company. All endorsement requests will be made by the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except the Company.

ii. Revision and Modification of the Policy Product

i. Any revision or modification will be done with the approval of the Authority. We shall notify You about revision /modification in the Policy including premium payable thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

iii. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule be deemed to form part of the Policy and shall be read together as one document.

14. CLAIMS PROCEDURE

Details of procedure to be followed for cashless service as well as for reimbursement of claim including pre and post hospitalization.

Procedure for Cashless claims:

Treatment may be taken in a network provider and is subject to pre-authorization by the Company or its authorized TPA.

Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

SI No	Type of Claim	Prescribed Time limit
1.	Pre – Authorization for Cashless facility	2 hours from the time of receipt of complete Documents
2.	Cashless Final Bill Authorization	2 hours from the time of receipt of complete Documents

Procedure for reimbursement of claims:
For reimbursement of claims the insured person may submit the necessary documents to Company within the prescribed time limit as specified hereunder.

SI No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre-hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

Notification of Claim
Notice with full particulars shall be sent to the Company as under:

i Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

Provide the details/web link for following:
i. Network Hospital details: Available on website: www.universalsompo.com.
ii. Helpline Number:

Toll Free Numbers: 1-800-224030 (For MTNL/BSNL Users) or 1-800-2004030, Senior Citizen: 1800-267-4030

Landline Numbers: (022) 39133700 (Local Charges Apply)

iii. Hospitals which are blacklisted or from where no claims will be accepted by insurer: Available on website: www.universalsompo.com

15. Premium Details

All Rates below are Exclusive of Taxes Surrogate Mother

1. The Premiums are applicable for the entire policy term of 3 years.
2. The premium will be based on the completed age of the individual insured member.
3. Premium rates are subject to change.
4. Premium rates may change post underwriting of the insured based on medical tests (where applicable) and information provided on the proposal form.
5. Maximum underwriting risk loading based on PPMC test results & proposal form declarations will be 100%.

PREMIUM PER MEMBER – exclusive of taxes (for 3 years)

Age Band\Sum Insured	5L
25-35	78545

Oocyte Donor

1. The Premiums are applicable for the entire policy term of 1 year.
2. The premium will be based on the completed age of the individual insured member.
3. Premium rates are subject to change.
4. Premium rates may change post underwriting of the insured based on medical tests (where applicable) and information provided on the proposal form.
5. Maximum underwriting risk loading based on PPC test results & proposal form declarations will be 100%.
6. **PREMIUM PER MEMBER exclusive of taxes (for 1 year)**

Age Band\Sum Insured	5L
25-35	47,403

Prohibition of Rebates: Section 41 of the Insurance Act, 1938 (and amendments thereof)

1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.
2) Any person making default in complying with the provisions of this section shall be liable for penalty which may extend to ten lakh rupees.

Premium illustration

Age of the Members Insured	Coverage Opted on Individual Basis covering each member of the family seperately (at a single point in time)		Coverage opted on Individual Basis covering multiple members of the family a under single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount (Rs.), if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium premium for all members of family (Rs.)	Floater discount (Rs.), if any	Premium after discount (Rs.)	Sum Insured (Rs.)
25 years	78,545	500,000	NA	NA	NA	NA	NA	NA	NA	NA

*Premium Exclusive of 18% GST	Total Premium for all members of the family is Rs. 78545/-, when each member covered seperately. Sum Insured available for each Individual is Rs. 500,000/-	Total Premium for all members of the family is Rs. -- , when they are covered under single policy. Sum Insured available for each family member is Rs. --	Total Premium when policy opted for family floater basis is Rs. --, Sum Insured of Rs.-- is available for entire family.