

Arogya Sanjeevani Policy, Galaxy Health Insurance Company Limited
Unique Identification No.: GHIHLIP26045V012526**❖ Eligibility:**

Adult: 18 to 65 Years (Parent and Parent-in laws can be covered in a single policy).

Dependent Children: 3 months to 25 years, children can be covered along with parent/s.

- ❖ **Pre-acceptance medical screening:** No pre-acceptance medical screening. For those who declare adverse medical history, company may subject them to undergo pre-policy medical check-up. 100% cost of such medical examination is borne by the company. Notwithstanding this the Company may increase or decrease the age limit for medical screening or may waive screening based on the changes in the underwriting policy following the due procedure applicable for such modification. Prior information will be given to the prospects.

- ❖ **Policy Term:** 1 Year

- ❖ **Policy Type:** Individual and Floater Basis

- ❖ **Sum Insured Options (Rs. In Lakhs):**

0.5 lakh, 1.0 lakh, 1.5 lakhs, 2.0 lakhs, 2.5 lakhs, 3.0 lakhs, 3.5 lakhs, 4.0 lakhs, 4.5 lakhs, 5.0 lakhs, 5.5 lakhs, 6.0 lakhs, 6.5 lakhs, 7.0 lakhs, 7.5 lakhs, 8.0 lakhs, 8.5 lakhs, 9.0 lakhs, 9.5 lakhs, 10.0 lakhs.

- ❖ **Instalment Premium options:** Monthly - 3% /Quarterly- 2% /Half-Yearly-1%

- ❖ **Online Discount:** 5% discount for online purchase first purchase and their renewals. (If the policy is first purchased online and the same is renewed online, then 5% discount will be given for such renewals too).

❖ Coverage**1. Hospitalization**

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.
- iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
- iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

1.1 Other expenses

- i. Expenses incurred on treatment of cataract subject to the sub limits.

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- ii. Dental treatment, necessitated due to disease or injury.
- iii. Plastic surgery necessitated due to disease or injury.
- iv. All the day care treatments.
- v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, 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.

2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to sum insured as specified in the policy schedule in any AYUSH Hospital.

3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per eye in one policy year.

4. Pre Hospitalization

The Company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

5. Post Hospitalization

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

6. **Modern Treatments:** The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

- 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. BronchicalThermoplasty

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- J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
K. ION M - (antra Operative Neuro Monitoring)
L. Stern cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions.
7. The expenses that are not covered in this policy are placed under List-I of Annexure-I. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-I respectively.

8. A. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

- In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
- In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
- CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
- If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
- In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
- If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
- If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
- If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

B. No Claim Discount: (in lieu of Cumulative Bonus): If the insured has opted no claim discount, then the insured person shall be entitled for a discount of % on the renewal premium of each claim free year.

Sum Insured	No claim discount %
Rs.50,000 to Rs.1,50,000	6%

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Rs.2,00,000 to Rs.4,50,000	3%
Rs.5,00,000 and Above	1%

Note:

- Provided, insured has not made any hospitalization claim in a policy year.
- The customer should opt for either cumulative bonus or No claims discount during the first purchase of this policy as well as at the time of renewal of this policy.
- This discount is not cumulative in nature.

9. Co-payment: Each and every claim under the Policy shall be subject to a co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.


Exclusions :

The Company shall not be liable to make any payments under this policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of;

A. Standard Exclusions
1. Pre-Existing Diseases- Code Excl 01

- Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. Specified Disease/Procedures Waiting Period - Code Excl 02

- Expenses related to the treatment of listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- The waiting period for listed conditions shall apply even if contracted after the policy inception or declared and accepted without a specific exclusion.
- If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- List of specific diseases/procedures.

24 Months waiting period

- Benign ENT disorders
- Tonsillectomy

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- iii. Adenoidectomy
- iv. Mastoidectomy
- v. Tympanoplasty
- vi. Hysterectomy
- vii. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
- viii. Benign prostate hypertrophy
- ix. Cataract and age related eye ailments
- x. Gastric/ Duodenal Ulcer
- xi. Gout and Rheumatism
- xii. Hernia of all types
- xiii. Hydrocele
- xiv. Non Infective Arthritis
- xv. Piles, Fissures and Fistula in anus
- xvi. Pilonidal sinus, Sinusitis and related disorders
- xvii. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
- xviii. Calculi in urinary system ,Gall Bladder and Bile duct, excluding malignancy.
- xix. Varicose Veins and Varicose Ulcers
- xx. Internal Congenital Anomalies

36 Months waiting period

- i. Treatment for joint replacement unless arising from accident.
- ii. Age-related Osteoarthritis & Osteoporosis.

3. 30-day Waiting Period – Code Excl 03

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.

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

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

4. Investigation and Evaluation - Code Excl 04

- 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.

5. Rest Cure, rehabilitation and respite care Code Excl 05

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.

6. Obesity/ Weight Control - Code Excl 06

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

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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 has to 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 Apnea
 - iv). Uncontrolled Type 2 Diabetes
7. **Change-of-Gender treatments - Code Excl 07**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
8. **Cosmetic or plastic Surgery - Code Excl 08**
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.
9. **Hazardous or Adventure sports - Code Excl 09**
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.
10. **Breach of law - Code Excl 10**
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
11. **Excluded Providers – Code Excl 11**
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.
12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof - **Code Excl 12**
13. Treatments received in health spas, 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 Excl 13**
14. 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 Excl 14**
15. **Refractive Error - Code Excl 15:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

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16. Unproven Treatments - Code Excl 16

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.

17. Sterility and Infertility - Code Excl 17

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.

18. Maternity Expenses - Code Excl 18

- a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- b) expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

B. Specific Exclusions

- 19. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
- 20. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
 - a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.
 - b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.
 - c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or- biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.
- 21. Any expenses incurred on Domiciliary Hospitalization and OPD treatment (covered if Galaxy Smart Outpatient – Rider is opted).
- 22. Treatment taken outside the geographical limits of India.
- 23. Existing disease/s, disclosed by the insured and mentioned in the policy schedule under permanent exclusion (based on insured's consent), for specified ICD codes. **Code-Excl 38**

❖ Conditions

- 1. **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.
- 2. **Claim Settlement:**

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A. 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.

B. For Cashless Treatment :

- a. Call the 24 hour help-line for assistance – 18002030007. Senior Citizens may call at 18002030007.
- b. Inform the ID number for easy reference.
- c. On admission in the hospital, produce the ID Card issued by the Company at the Hospital Helpdesk.
- d. Obtain the Pre-authorisation Form from the Hospital Help Desk, complete the Patient Information and resubmit to the Hospital Help Desk. (Insurers shall also provide pre-authorization to the policyholder through Digital mode).
- e. The Treating Doctor will complete the hospitalisation/ treatment information, and the hospital will fill up expected cost of treatment. This form is submitted to the Company.
- f. The Company will process the request and call for additional documents / clarifications if the information furnished is inadequate.
- g. Once all the details are furnished, the Company will process the request as per the terms and conditions as well as the exclusions therein and either approve or reject the request based on the merits.
- h. In case of emergency hospitalisation information to be given within 24 hours after hospitalization.
- i. Cashless facility can be availed only in networked Hospitals. For details of Networked Hospitals, the insured may visit www.galaxyhealth.com or contact the nearest branch. KYC (Identity proof with Address) of the proposer, as per AML Guidelines.

In non-network hospitals payment must be made up-front and then reimbursement will be effected on submission of documents.

Note: The Company reserves the right to call for additional documents wherever required. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person can go ahead with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

C. Notification of Claim : Upon the happening of the event, notice with full particulars shall be sent to the Company within 24 hours from the date of occurrence of the event irrespective of whether the event is likely to give rise to a claim under the policy or not.

Note: Conditions C and D are precedent to admission of liability under the policy. The Company will examine and relax the time limit mentioned in these conditions depending upon the merits of the case.

D. Documents to be submitted for reimbursement : The reimbursement claim is to be supported with the following documents in original and submitted within the prescribed time limit.

- i. Duly filled in claim forms with treating doctor signature.
- ii. Pre/Post Hospitalisation investigations and treatment papers.
- iii. All investigations reports including Radiological films (Xray, CT scan, MRI and USG) and Biopsy during hospitalisation.
- iv. Discharge Summary from the hospital.

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- v. Cash receipts from hospital, chemists.
- vi. Cash receipts and reports for tests done.
- vii. Receipts from doctors, surgeons, anaesthetist.
- viii. Certificate from the attending doctor regarding the diagnosis.
- ix. KYC (Identity proof with Address) of the proposer, as per AML Guidelines.
- x. Copy of PAN Card.
- xi. NEFT documents viz., Customer name, Bank Account No., Name of the Bank, IFSC code.
- xii. CKYC No. of the proposer (if available).
- xiii. Legal heir/succession certificate, wherever applicable.

Note:

- i. Call the 24 hour help-line for assistance - 18002030007. Senior Citizens may call at 18002030007.
- ii. The Company authorized doctor may examine the insured if required.
- iii. The Company reserves the right to call for additional documents wherever required.

3. Cancellation

- i. The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall
 - a) refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.
 - b) refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

Note: 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.

- ii. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure 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, non-disclosure of material facts or fraud.

- 4. **Migration:** In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

5. Portability:

- a) A policyholder desirous of porting his/her policy to another insurer shall apply to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the due date for renewal. Insurers are free to consider proposal for portability, but in all such cases acquiring insurer shall ensure that there is no break in policy.
- b) The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

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6. **Renewal of Health Insurance policy:**

- a) A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate.
- b) An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years.
- c) An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
- d) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- e) At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy.
- f) Coverage is not available during the grace period.
- g) No loading shall apply on renewals based on individual claims experience.

7. **Moratorium Period:**

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments and deductibles as per the policy contract.

8. **Withdrawal of policy**

- i. 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.
- ii. 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.

9. **Premium Payment in Instalments:**

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly or Quarterly or Monthly instalments as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy).

- i. The grace period of 15 days (where premium is paid on a monthly instalments) and 30 days (where premium is paid in quarterly/half yearly/annual/instalments) is available on the premium due date, to pay the premium. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
- ii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, Waiting Periods for Pre-Existing Diseases, Moratorium Period etc.) accrued under the policy shall be protected.
- iii. No interest will be charged if the instalment premium is not paid on due date.
- iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.

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- v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
10. **Possibility of Revision of Terms of the Policy including the Premium Rates** The Company may revise or modify the terms of the policy including the premium rates with the extant guidelines. The insured person shall be notified three months before the changes are effected.
11. **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 person shall be allowed free look period of 30 days from date of receipt of the policy document whether electronically or otherwise to review the terms and conditions of the policy, and to return the same if not acceptable.
- If the insured has not incurred any claim during the Free Look Period, the insured shall be entitled to
- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
 - ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
 - iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.
12. **Redressal of Grievance:** In case of any grievance the insured person may contact the Company through
- Website :** www.galaxyhealth.com
- Toll free :** 18002030007
- Senior Citizens may call at** 18002030007
- E-mail :** gro@galaxyhealth.com
- Phone No. :** 044 - 4001 7238
- Courier :** Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 600035.
- Insured person may also approach the Grievance officer 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 redressal officer (GRO) at corporate office - 044 - 4001 7238.

For updated details of grievance officer, kindly refer the link
<https://www.galaxyhealth.com/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. For the details of Insurance Ombudsman, please visit: <https://cioins.co.in/Complaint/Online>.

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Grievance may also be lodged at IRDAI integrated Grievance Management System - <https://bimabharosa.irdai.gov.in/>.

13. Nomination:

- a) The policyholder shall give his nomination for the purpose of payment of claims. In the event of death of the policyholder, the claim proceeds will be paid to the nominee.
- b) Nomination can be changed any time during the term of the policy.

14. Automatic change in Coverage under the policy: The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise. However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.
2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

15. Change of Sum Insured: Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.**16. Relief under Section 80-D:** Insured Person is eligible for relief under Section 80-D of the ITAct in respect of the premium paid by any mode other than cash.**17. Customer Service:** If at any time the Insured Person requires any clarification or assistance, the insured may contact Galaxy Health Insurance Company Limited, Prestige Polygon – 12th Top Floor (P), No. 471, Anna Salai, Nandanam, Chennai – 600035, during business hours of normal working days.**18. Prohibition of Rebates:** Section 41 of Insurance Act 1938 (Prohibition of rebates): No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

ILLUSTRATION (Excluding Tax)										
Benefit Illustration in respect of policies offered on individual and family floater basis										
Age of the Members insured (in yrs)	Coverage opted on individual basis covering each member of the family separately (at a single point of time)		Coverage opted on individual basis covering multiple members of the family under a 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 (in lakhs) (Rs.)	Premium (Rs.)	Discount, (if any)	Premium After Discount (Rs.)	Sum Insured (in lakhs) (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater Discount*, (if any)	Premium After Discount (Rs.)	Sum Insured (in lakhs) (Rs.)
Illustration 1 (2A)										
44	5384	5	5384	Nil	5384	5	9654	1579	8075	5
35	4270	5	4270		4270	5				
Total Premium for all members of the family is Rs.9654/- , when each member is covered separately. Sum insured available for each individual is Rs.5 lakhs			Total Premium for all members of the family is Rs. 9654/- , when they are covered under a single policy. Sum insured available for each family member is Rs.5 lakhs				Total Premium when policy is opted on floater basis is Rs.8075/- , Sum insured of Rs.5 lakhs is available for the entire family (2A)			
Illustration 2 (2A+1C)										
48	7354	5	7354	Nil	7354	5	17008	4161	12847	5
45	5384	5	5384		5384	5				
20	4270	5	4270		4270	5				
Total Premium for all members of the family is Rs. 17008/- , when each member is covered separately. Sum insured available for each individual is Rs.5 lakhs			Total Premium for all members of the family is Rs. 17008/- , when they are covered under a single policy. Sum insured available for each family member is Rs.5 lakhs				Total Premium when policy is opted on floater basis is Rs.12847/- , Sum insured of Rs.5 lakhs is available for the entire family (2A+1C)			
Note: Premium rates specified in the above illustration are standard premium rates.										