CANARA HSBC LIFE INSURANCE

GROUP ADVANTAGE TERM PLUS

Non-Linked Non-Participating Renewable Group Term Insurance Pure Life Insurance Plan

Canara HSBC LIFE INSURANCE

A STRONG TEAM NEEDS A STRONG COVER, PROTECT THEM TODAY.

You treat your employees like family, with our **Group Advantage Term Plus**, you can promise to protect them like one.

- **Life Cover**
- **Hassle-free implementation of the policy**
- **Additional comprehensive benefits through various inbuilt cover options**
- **Flexiblity of choosing policy term of 1 year or less than a year**

SPEAK TO YOUR BANK MANAGER FOR DETAILS

Purchase of any insurance product by a bank's customer is purely voluntary and is not linked to availment of any other facility from the bank.

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Canara HSBC Life Insurance Group Advantage Term Plus

As an organization or an affinity group, one of the most valuable assets that You have are your employees and customers/members, it is they who strive to make You a success. To safeguard their interests and help them focus on the challenges at hand it is imperative that You provide them protection against a range of different risks especially when there are people who are financially dependent upon them.

To meet this need, we bring to You, Canara HSBC Life Insurance Group Advantage Term Plus, which is a Non-Linked Non-Participating Renewable Group Term Insurance Pure Life Insurance Plan. This plan provides life protection at relatively affordable cost to your employees/customers/members, and they can also be covered for contingent event of Death, Accidental Death, Accidental Total and Permanent Disability, Critical Illness and Terminal Illness. It gives peace of mind to them as their family members become financially secured in case of any eventuality.

This plan is offered to both Employer- Employee and Non Employer- Employee or Affinity Groups.

Why should You partner with Us?

Canara HSBC Life Insurance Company Limited is a Company formed jointly by three financial organizations - Canara Bank, Punjab National Bank and HSBC Insurance (Asia Pacific) Holdings Limited.

The shareholding pattern of the Joint Venture is as follows: Canara Bank - 51%, HSBC Insurance (Asia Pacific) Holdings Limited - 26% and Punjab National Bank - 23%.

Our aim is to provide You with a transparent range of Life Insurance products backed by customer service and thereby, making your life simpler.

What are the Key Features of this Plan?

The following features are applicable for this product:

- Non-linked non-participating renewable group term insurance pure life insurance plan, which provides protection against risk of death to the Members of Employer- Employee (EE) and Non- Employer- Employee (NEE) groups.
- Option to add additional protection against Accidental Death, Accidental Total and Permanent Disability, Terminal Illness and Critical Illness
- Flexibility of choosing Policy Term of 1 year or less than 1 year
- Option to get coverage for Full Term to the employees/customers/members joining scheme in middle of Policy Term
- Option to choose the level of benefit for Your employees/customers/members as per a defined criterion
- Option to change the Coverage Amounts during the Policy Term
- Option to backdate the Master Policy
- Flexible Premium payment modes – Single, Yearly, Half-Yearly, Quarterly or Monthly
- No medical examination required up to Free Cover Limit [subject to the Company's Board Approved Underwriting Policy ("BAUP")]
- Simplified and hassle free administration of the Master Policy
- Risk cover in lieu of EDLI Scheme as per the extent provisions of the Employees Provident Fund and Miscellaneous Provisions Act, 1952
- Tax benefits may be available as per extant tax laws as amended from time to time

What are the Benefits under the Plan?

Base Death Benefit

Upon death of the Insured Member, Sum Assured is payable.

Optional In-built Cover Options: The product provides four In-built Cover Options which are optional, i.e. the Master Policyholder can continue with Base Death Benefit only or choose one or more of the optional In-built Cover Options as specified below at inception or at renewal of the Policy in addition to Base Death Benefit.

- **Terminal Illness (TI)**
- **Critical Illness (CI)** (There are three CI variants)
  - CI Classic (10 Critical Illnesses)
  - CI Advantage (20 Critical Illnesses)
  - CI Advanced (40 Critical Illnesses)
- **Accidental Death Benefit (ADB)**
- **Accidental Total & Permanent Disability (ATPD)**

✓ Where all the optional In-built Cover Options have been opted by the Master Policyholder, a maximum of four benefits can be opted by an Insured Member as detailed below:

- Death, TI, CI, ADB
- Death, TI, ADB, ATPD

✓ Cover Options opted by the Master Policyholder will be available to the Insured Member to opt for.

✓ Optional in-built covers chosen at Policy inception can only be changed at subsequent Policy renewal.

✓ Accidental Total & Permanent Disability (ATPD) and Critical Illness (CI) benefit cannot be opted together.

- The Coverage Amounts for various benefits offered under the product for the individual Members will be as per the scheme rules and same could be:
- Based on a pre-decided formula, such as multiple of salary/CTC, Future Service Gratuity calculation, etc.
- Based on grade or band in which the member falls, for example graded term cover as per level/hierarchy in the organization, category of the member, age of the member, etc.
- Flat Sum Assured for all members
- Based on outstanding balance at the time of entry (e.g. cover for housing/vehicle loans)
- Or a combination of some or all of these

Survival/Maturity Benefit

There is no Survival/Maturity benefit under this product.

Surrender Benefit

There is no surrender value upon termination/surrender of the Scheme. However, for Members exiting the Scheme, 100% of the unexpired premium shall be refunded. The unexpired premium for the purpose of refund shall be calculated using following formula:

N/T x Modal Premium (summed for all Insured Members)

Where,

'N' is the number of days remaining in the Member's Coverage Term till the next premium due date.

'T' is the number of days in the Member's Coverage Term for which Modal Premium is paid.

In case the Scheme is terminated by the Master Policyholder, 100% of the unexpired premium shall be refunded.

However, in such a case, the Individual Insured Member(s) will have the option to continue the insurance coverage on individual basis till the termination of insurance coverage or end of the Member Coverage Term whichever is earlier, subject to payment of due premium(s). Further the Company/intermediary if any, shall continue to be responsible to serve such members till their coverage is terminated.

Note: Where the Master Policy is issued under Lender-Borrower category and Master Policyholder falls under regulated entities as per applicable laws, the Insured Member shall give the Company a written authorization to make payment of outstanding loan balance amount to the Master Policyholder on occurrence of the Insured Event. In a scenario where such authorization is received from the Insured Member, on happening of an Insured Event, while the insurance coverage is in force, the Company will pay the outstanding loan balance amount to the Master Policyholder and the remainder of the Sum Assured amount, if any, shall be payable to the Claimant of deceased/affected Insured Member(s). The Company shall, under no circumstance, pay any amount more than the outstanding loan balance to the Master Policyholder. This option shall however be applicable only to the group insurance policies/schemes administered by the following regulated entities as group organizer/Master Policyholder:-

i. Reserve Bank of India (RBI) Regulated Scheduled Commercial Banks (including Co-operative Banks);

ii. NBFCs having Certificate of Registration from RBI;

iii. National Housing Bank (NHB) regulated Housing Finance Companies

iv. National Minority Development Finance Corporation (NMDFC) and its State channelizing agencies

v. Small Finance Banks regulated by RBI

vi. Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies

vii. Microfinance companies registered under section 8 of the Companies Act, 2013.

viii. Any other category as approved by the Competent Authority.

The above entities are subject to change in accordance with IRDAI guidelines as amended from time to time. Where no such authorization is received by the Company from the Insured Member or the Master Policyholder does not fall under the list of regulated entities as mentioned above, We will pay the entire amount (if applicable) directly to the claimant of the deceased/affected Insured Member(s).

Plan at a Glance

Particulars for a Member	Minimum	Maximum
Entry Age[1]	18 years	Base Death Benefit: 79 years Accidental Death Benefit, Accidental Total &Permanent Disability Benefit, Critical Illness and Terminal illness: 64 Years
Maturity age[1]	18 years	Base Death Benefit: 80 years Accidental Death Benefit, Accidental Total &Permanent Disability Benefit, Critical Illness and Terminal illness: 65 Years
Sum Assured	₹10,000 per member	Base Death Benefit: No limit, subject to BAUP Accidental Death Benefit, Accidental Total & Permanent Disability Benefit & Terminal Illness: Rs.2,00,00,000 per member*** Critical Illness: Rs.1,00,00,000 per member***
Modal Factors	**Yearly:** 1.00	**Half-yearly:** 0.51 **Quarterly:** 0.26 **Monthly:** 0.09
Policy Term	a) 1 year b) Less than 1 year (1 month to 11 months)	
Premium Payment Mode[2]	Policy Term of 1 Year: Yearly, Half-Yearly, Quarterly and Monthly Policy Term less than 1 Year: Single or Monthly only	
Group Size	10 members[3]	No limit
Types of Groups Covered	• All Employer-Employee (EE) groups • Non Employer-Employee (NEE) groups where these are defined as any associations where the Member represents a particular profession/trade/domestic workers/anganwadi workers/ASHA workers/government agencies, any co-operative societies, parents of school/college students as members and other groups such as: ◦ Bank account/debit card/credit card holders/group of borrowers, ◦ Mutual fund/asset management companies' customers, ◦ Members of depositor/creditor groups, ◦ Members of subscribers groups (e.g. ET Mobile app, Amazon, Paytm, etc.), ◦ Members of groups such as Clubs, Associations, Loyalty Programs etc. ◦ Any other group provided such a group has a clearly evident relationship between the Member and the Group Master Policyholder for services other than insurance, and has been formed for a lawful purpose other than for availing insurance. ◦ Any other groups as may be approved by the Competent Authority.	

[1] Age as on last birthday.
**** Capped at Sum Assured.*
[2] This can be chosen by Master Policyholder at inception/scheme renewal. Where the Insured Members pay part/full premium, the same will be payable in the premium payment mode as opted by Master Policyholder. Where Full Term Cover is chosen, only single premium payment mode shall be available.
[3] After Master Policy issuance if the group size falls below 10 members, Master Policy will continue until the renewal date, after which it will be terminated.
Note: For Group Term Life requirements in lieu of EDLI, Maximum Entry Age will be as long as the individual is a member of Provident Fund scheme and Maximum Maturity Age will be the day on which he/she ceases to be a member of Provident Fund scheme. Further, Maximum Sum Assured will be as per regulations pertaining to EDLI scheme as amended from time to time.

What is the Coverage Term under the Plan

All Members who join on or after the commencement/renewal of the scheme will be covered from the date of becoming an Insured Member till the next renewal date of the Master Policy.

For instance, if the Master Policyholder chooses a Policy Term of 1 year and a Member joins the scheme after completion of 4 months from the commencement of the scheme, then the Member Coverage Term will be 8 months from his/her date of becoming an Insured Member. Insurance coverage will be provided subject to the member data and pro-rata premium for such Members is made available by the Master Policyholder at periodic intervals as agreed by it.

There will be an additional flexibility with the Master Policyholder to choose Full Term Cover for the Members, as given below:

Full Term Cover: All Members who join on or after the commencement/renewal of the scheme will be covered from the date of becoming an Insured Member for the period of the original Policy Term of the Master Policy.

For instance, if the Master Policyholder chooses a Policy Term of 1 year and a Member joins the scheme after completion

of 4 months from the commencement of the scheme, then under Full Term Cover, Member Coverage Term will be one year from his/her date of becoming an Insured Member.

Insurance coverage will be provided subject to:

- Member data and full premium applicable for the Policy Term for the new Members is made available by the Master Policyholder at periodic intervals as agreed by it.
- The option to choose insurance coverage basis Full Term Cover will only be available with the Master Policyholder at the time of commencement/renewal of the scheme.
- Full Term Cover cannot be co-opted with the option where in the insurance coverage is provided up to the next renewal date.
- If Policy Term is one month, then only Full Term Cover will be provided.

What are Add-on Options in the Plan?

The Plan offers following Optional In-built Cover Options which can be opted at inception of the scheme by the Master Policyholder or at subsequent Policy renewal.

1. **Accidental Death Benefit (ADB):** This will be an additional benefit, which means that in case of Accidental Death, an additional amount equal to the ADB Sum Assured shall be payable.

✓ Three ADB Sum Assured Options:

- 25% of Base Death Sum Assured
- 50% of Base Death Sum Assured
- 100% of Base Death Sum Assured

Where Base Death Sum Assured is equal to Base Death Benefit

✓ Note, for each of the ADB Sum Assured Options, ADB Sum Assured for the Member will be capped at the Maximum Coverage Amount as detailed above.

✓ Master Policyholder can choose one, two or all three ADB Sum Assured Options as specified above; however only one of those chosen options will be applicable for the Insured Member. Further, where the Insured Member has to pay for the ADB benefit, they will have the option to not choose any of the ADB options opted by the Master Policyholder.

✓ ADB Sum Assured shall be payable as lump sum upon Accidental Death of the Insured Member due to an Accident [subject to exclusions in GPP(v)] where such Accident happens while the Member's ADB coverage is in-force. The amount will be equal to the ADB Sum Assured applicable at the time of Accident which resulted in Accidental Death.

✓ If the Accident occurs while the Member's ADB coverage is in-force, however Accidental Death occurs after the end of the Member Coverage Term and within 180 days of the Accident, ADB Sum Assured applicable at the time of such Accident will be payable. In such a case, if the Member's insurance coverage is renewed in the interim, any premiums charged for the ADB benefit at renewal will be refunded along with the ADB claim.

✓ On payment of the ADB Sum Assured, all insurance coverage will terminate for the respective Insured Member.

✓ ADB is payable only once during the life time of the Insured Member.

✓ No ADB Sum Assured is payable in case Member's insurance coverage is in lapsed status.

2. **Accidental Total and Permanent Disability (ATPD):** This will be an additional benefit, which means that on occurrence of Accidental Total & Permanent Disability, an amount equal to the ATPD Sum Assured shall be payable.

- Three ATPD Sum Assured Options:
  - 25% of Base Death Sum Assured
  - 50% of Base Death Sum Assured
  - 100% of Base Death Sum Assured

Where Base Death Sum Assured is equal to Base Death Benefit

Note, for each of the ATPD Sum Assured Options, ATPD Sum Assured for the Member will be capped at the Maximum Coverage Amount as detailed above.

- Master Policyholder can choose one, two or all three ATPD Sum Assured Options; however only one of those chosen options will be applicable for the Insured Member.
- Further, where the Insured Member has to pay for the ATPD benefit, they will have the option to not choose any of the ATPD options opted by the Master Policyholder ATPD Sum Assured shall be payable as lump sum upon occurrence of Accidental Total & Permanent Disability due to an Accident [subject to exclusions under GPP(vi)] where such Accident happens while the Member's ATPD coverage is in-force.
- The amount will be equal to the ATPD Sum Assured applicable at the time of Accident which resulted in Accidental Total & Permanent Disability.
- If the Accident occurs while the Member's ATPD coverage is in-force, however ATPD occurs after the end of the Member Coverage Term and within 180 days of the Accident, ATPD Sum Assured applicable at the time of such Accident will be payable. In such a case, if the Member's insurance coverage is renewed in the interim, any premiums charged for the ATPD benefit at renewal will be refunded along with the ATPD claim.

- On payment of the additional ATPD Sum Assured, the insurance coverage will continue for the remaining Member Coverage Term with all the other benefits available other than ATPD Benefit.
- Once ATPD Sum Assured is payable to the Member, this cover cannot be opted on subsequent cover renewals.
- ATPD benefit is payable only once during the life time of the Insured Member.
- No ATPD benefit is payable in case Member's insurance coverage is in lapsed status.

3. **Critical Illness (CI):** This will be an additional benefit, which means that on occurrence of one of the covered Critical Illness Conditions in respect of the Insured Member, subject to Survival Period, Waiting Period and exclusions as per GPP, an amount equal to the CI Sum Assured shall be payable.
   - There are three CI variants offered under this benefit:
     - CI Classic (10 Critical Illnesses)
     - CI Advantage (20 Critical Illnesses)
     - CI Advanced (40 Critical Illnesses)

   The CIs offered under each variant are as given in table below:

CI Classic (10 CIs)	CI Advantage (20 CIs)	CI Advanced (40 CIs)
1 Cancer Of Specified Severity	1 Cancer Of Specified Severity	1 Cancer Of Specified Severity
2 . Myocardial Infarction (First Heart Attack of specific severity)	2 . Myocardial Infarction (First Heart Attack of specific severity)	2 . Myocardial Infarction (First Heart Attack of specific severity)
3. Stroke Resulting In Permanent Symptoms	3. Stroke Resulting In Permanent Symptoms	3. Stroke Resulting In Permanent Symptoms
4. Major Organ/Bone Marrow Transplant	4. Major Organ/Bone Marrow Transplant	4. Major Organ/Bone Marrow Transplant
5. Kidney Failure Requiring Regular Dialysis	5. Kidney Failure Requiring Regular Dialysis	5. Kidney Failure Requiring Regular Dialysis
6. Open Chest CABG	6. Open Chest CABG	6. Open Chest CABG
7. Open Heart Replacement Or Repair Of Heart Valves	7. Open Heart Replacement Or Repair Of Heart Valves	7. Open Heart Replacement Or Repair Of Heart Valves
8. Permanent Paralysis Of Limbs	8. Permanent Paralysis Of Limbs	8. Permanent Paralysis Of Limbs
9. Third Degree Burns	9. Third Degree Burns	9. Third Degree Burns
10. Coma of Specified Severity	10. Coma of Specified Severity	10. Coma of Specified Severity
	11. Aorta Graft Surgery	11. Aorta Graft Surgery
	12. Motor Neuron Disease With Permanent Symptoms	12. Motor Neuron Disease With Permanent Symptoms
	13. Alzheimer's Disease	13. Alzheimer's Disease
	14. Loss Of Limbs	14. Loss Of Limbs
	15. End Stage Lung Failure	15. End Stage Lung Failure
	16. End Stage Liver Failure	16. End Stage Liver Failure
	17. Benign Brain Tumor	17. Benign Brain Tumor
	18. Apallic Syndrome	18. Apallic Syndrome
	19. Major Head Trauma	19. Major Head Trauma
	20. Multiple Sclerosis With Persisting Symptoms	20. Multiple Sclerosis With Persisting Symptoms
		21. Systemic Lupus Erythematous – with Lupus Nephritis
		22. Loss Of Speech
		23. Aplastic Anaemia
		24. Primary (Idiopathic) Pulmonary Hypertension

CI Classic (10 CIs)	CI Advantage (20 CIs)	CI Advanced (40 CIs)
		25. Parkinson's disease
		26. Blindness
		27. Deafness
		28. Medullary Cystic Disease Type 1 and Type 2
		29. Muscular Dystrophy
		30. Poliomyelitis
		31. Fulminant Viral Hepatitis
		32. Loss of Independent Existence [before age 65]
		33. Encephalitis
		34. Sporadic Creutzfeldt-Jakob Disease (sCJD)
		35. Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
		36.Bacterial Meningitis
		37.Chronic Pancreatitis
		38.Chronic Adrenocortical Insufficiency (Addison's Disease)
		39.Primary Cardiomyopathy
		40.Systemic Sclerosis (Scleroderma)

- Master Policyholder can choose one or two or all three Critical Illness variants as specified above; however only one f hose chosen options will be applicable for the Insured Member. Further, where the Insured Member has to pay for the CI benefit, they will have the option to not choose any of the CI variants from the options selected by the Master Policyholder.
- CI Sum Assured shall be payable as lump sum upon the occurrence of covered Critical Illness Condition in respect of the Insured Member, where such an occurrence happens subject to exclusions mentioned in GPP (viii), while the Member's CI coverage is inforce.
- If the covered Critical Illness Condition occurs while the Member's CI coverage is in-force but the Survival Period ends after the end of the Member Coverage Term, CI Sum Assured applicable at the time of occurrence of covered CI Condition shall be payable. In such a case if the Member's insurance coverage is renewed in the interim, any premiums charged for CI benefit at renewal will be refunded along with the CI claim.
- On payment of the CI Sum Assured, the insurance coverage will continue for the remaining Member Coverage Term with all the other benefits available other than CI Benefit.
- The CI Sum Assured can be chosen independently from the Sum Assured at inception but cannot be more than the Sum Assured.CI Sum Assured once chosen cannot be increased.
- Once CI Sum Assured is payable to the Member, this cover cannot be opted on subsequent cover renewals.
- CI benefit is payable only once during the life time of the Insured Member.
- No CI benefit is payable in case Member's insurance coverage is in lapsed status.

4. **Terminal Illness (TI):** This will be an accelerated benefit, which means that on diagnosis of a Terminal Illness, an amount equal to the TI Sum Assured shall be payable and insurance coverage in respect of this Insured Member for other benefits shall be as detailed below. In case of diagnosis of Terminal Illness, Insured Member will not be covered for any benefits on subsequent renewals.
   - TI Sum Assured shall be payable as lump sum upon the occurrence of Terminal Illness Condition in respect of the Insured Member, where such an occurrence happens while the Member's TI coverage is in-force subject to details in GPP(vii).
   - TI Benefit is a 100% accelerated benefit and is payable only once during the life time of the Insured Member. In case TI Sum Assured is equal to the Sum Assured, Base Death Benefit coverage shall cease upon diagnosis of Terminal Illness. All other insurance coverages (ADB/ATPD/CI, as applicable) shall continue for the remaining Member Coverage Term. In such cases, the Member will not be covered for any benefit on subsequent renewals.
   - In case TI Sum Assured is less than the Sum Assured, once TI Sum Assured is payable, the Coverage Amount under the Base Death Benefit (i.e. Sum Assured) will reduce by the amount of the TI Sum Assured, such change being effective from the date of the occurrence of Terminal Illness Condition. All other insurance coverages (ADB/ATPD/CI, as applicable) shall continue for the remaining Member Coverage Term. In such cases, the Member will not be covered for any benefit on subsequent renewals. TI Benefit is payable only once during the life time of the Insured Member.
   - No TI Sum Assured is payable in case Member's insurance coverage is in lapsed status.
   - Further, where the Insured Member has to pay for the TI benefit, he/she will have the option to not choose the TI benefit if opted by the Master Policyholder.

5. **Flexibility to Increase/Decrease the Coverage Amounts*:** The Coverage Amounts for Base Death Benefit and In-built Cover Options with respect to an Insured Member may be increased or decreased during the term of the Master Policy, subject to below conditions:

- The increase or decrease in the Coverage Amount(s) shall be within the minimum and maximum limits as per plan specifications mentioned above.
- The increase or decrease in Coverage Amount(s) is applied basis defined criterion across all the Insured Members of the Master Policy and as defined in Scheme Rules.
- Receipt of additional premium/refund of excess premium, shall be calculated on a pro-rata basis for the remaining duration of the Members' Coverage Term basis the increase/decrease in the Coverage Amount(s). The pro-rata premium (additional premium/refund of excess premium) shall be calculated using following formula:

  Premium Rate * Change in Coverage Amount * N/T

  Where,

  'N' is the number of days remaining in the Member's Coverage Term till the next premium due date.

  'T' is the number of days in the Member's Coverage Term for which Modal Premium is paid.
- Intimation by the Company to the Master Policyholder on confirming the increase/decrease in the Coverage Amount(s).
- The acceptance of the change in Coverage Amount(s) for each Insured member shall be determined in accordance with the Company's BAUP.
- The Company reserve the right to calculate the additional premium in respect of increase in Coverage Amount(s) at the original terms, modified terms or decline such request, in accordance with the Company's BAUP.
- Increase/decrease in Sum Assured will increase/decrease the ADB/ATPD Sums Assured such that the ratio of the revised ADB/ATPD Sum Assured to the revised Sum Assured remains same as at the inception of Member Coverage Term, subject to being within the minimum and maximum limits as per plan specifications mentioned above.
- Where TI/CI Benefit is applicable, reduction in Sum Assured shall be floored at higher of TI/CI Sum Assured.

The Master Policyholder or the Company is entitled to change the criteria for determining the Sum Assured at the time of policy renewal.

*Note: This option is not applicable on TI/CI Sum Assured offered as an optional in-built cover option.

6. **Option to backdate the Master Policy:** The Master Policyholder has the option of backdating the Policy Commencement Date (PCD) (start date of the Master Policy) to a date prior than the Risk Commencement Date (RCD).

- Where PCD is backdated, pro-rata premium will be payable for the period starting from RCD up to the next renewal date or the next premium due date whichever is earlier and no claims will be admissible which occur prior to the RCD.
- If option of Full Term Cover has been chosen by the Master Policyholder i.e. members will be covered for the original term of the Policy, irrespective of when they join the scheme, then for cases where PCD is backdated, premium applicable for Full Term Cover will be charged for all members.
- Further no claims will be admissible which occur prior to the RCD.
- The PCD can be backdated up to a maximum of 3 months from the RCD and within the same Financial Year.

Critical Illnesses Definitions

1. **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:

i. 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.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. 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

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. 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;

2. MYOCARDIAL INFARCTION (First Heart Attack of specific 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:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. STROKE RESULTING IN PERMANENT SYMPTOMS

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation 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:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

4. MAJOR ORGAN/BONE MARROW TRANSPLANTATION

The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic 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

5. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

6. OPEN CHEST CABG

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.

7. 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.

8. PERMANENT PARALYSIS OF LIMBS

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.

9. THIRD DEGREE 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.

10. 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:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. 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.

11. AORTA GRAFT SURGERY

The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta. Minimally invasive procedures like endovascular repair are covered under this definition. The surgery must be determined to be medically necessary by a Consultant Surgeon and supported by imaging findings.

For the above definition, the following are not covered:

i. Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts)

ii. urgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlos syndrome)

iii. Surgery following traumatic injury to the aorta

12. 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.

13. ALZHEIMER'S DISEASE

A definite diagnosis of Alzheimer's disease evidenced by all of the following:

i. Loss of intellectual capacity involving impairment of memory and executive functions (sequencing, organizing, abstracting, and planning), which results in a significant reduction in mental and social functioning

ii. Personality change

iii. Gradual onset and continuing decline of cognitive functions

iv. No disturbance of consciousness

v. Typical neuropsychological and neuroimaging findings (e.g. CT scan, MRI, PET scan of the Brain)

The disease must require constant supervision (24 hours daily) [before age 65]. The diagnosis and the need for supervision must be confirmed by a Consultant Neurologist.

The disease must result in a permanent inability to perform three or more Activities with "Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days.

For the above definition, the following conditions are however not covered:

a. Non-organic diseases such as neurosis and psychiatric Illnesses;

b. Alcohol related brain damage; and

c. Any other type of irreversible organic disorder/dementia

14. 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.

15. END STAGE LUNG FAILURE

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and

iv. Dyspnea at rest.

16. END STAGE LIVER FAILURE

Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

17. BENIGN BRAIN TUMOUR

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.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. 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.

18. APALLIC SYNDROME

Apallic syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a universal necrosis of the brain cortex with the brainstem remaining intact.

A persistent vegetative state is absence of responsiveness and awareness due to dysfunction of the cerebral hemispheres, with the brain stem, controlling respiration and cardiac functions, remaining intact. The definite diagnosis must be evidenced by all of the following:

i. Complete unawareness of the self and the environment

ii. Inability to communicate with others

iii. No evidence of sustained or reproducible behavioural responses to external stimuli

iv. Preserved brain stem functions

v. Exclusion of other treatable neurological or psychiatric disorders with appropriate neurophysiological or neuropsychological tests or imaging procedures

The diagnosis must be confirmed by a Consultant Neurologist and the condition must be medically documented for at least one month without any clinical improvement.

19. MAJOR HEAD TRAUMA

I. 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.

II. 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.

III. The Activities of Daily Living are:

i. 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;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

iv. Mobility: the ability to move indoors from room to room on level surfaces;

v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:

i. Spinal cord injury;

20. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. 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 SLE are excluded.

21. SYSTEMIC LUPUS ERYTHEMATOUS – WITH LUPUS NEPHRITIS

A definite diagnosis of systemic lupus erythematosus evidenced by all of the following:

i. Typical laboratory findings, such as presence of antinuclear antibodies (ANA) and anti-dsDNA antibodies

ii. Symptoms associated with lupus erythematosus (butterfly rash, photosensitivity, serositis)

iii. Continuous treatment with corticosteroids or other immunosuppressants

iv. Additionally, one of the following organ involvements must be diagnosed:

v. Lupus nephritis with proteinuria of at least 0.5 g/day and a glomerular filtration rate of less than 60 ml/min (MDRD formula)

vi. Libman-Sacks endocarditis or myocarditis

vii. Neurological deficits or seizures over a period of at least 3 months and supported by cerebrospinal fluid or EEG findings. Headaches, cognitive abnormalities are specifically excluded.

viii. The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.

For the above definition, the following are not covered:

i. Discoid lupus erythematosus or subacute cutaneous lupus erythematosus

ii. Drug-induced lupus erythematosus

22. 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, Throat (ENT) specialist.

23. APLASTIC ANAEMIA

A definite diagnosis of aplastic anaemia resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition must be treated with blood transfusions and, in addition, with at least one of the following:

i. Bone marrow stimulating agents

ii. Immunosuppressants

iii. Bone marrow transplantation

iv. The diagnosis must be confirmed by a Consultant Haematologist and evidenced by bone marrow histology.

24. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. 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.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. 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.

25. PARKINSON'S DISEASE

A definite diagnosis of primary idiopathic Parkinson's disease, which is evidenced by at least two out of the following clinical manifestations:

i. Muscle rigidity

ii. Tremor

iii. Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses)

Idiopathic Parkinson's disease must result [before age 65] in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months despite adequate drug treatment.

Activities of Daily Living are:

i. 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.

ii. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.

iii. Feeding oneself – the ability to feed oneself when food has been prepared and made available.

iv. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

v. Getting between rooms – the ability to get from room to room on a level floor.

vi. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist.

The implantation of a neurostimulator to control symptoms by deep brain stimulation is, independent of the Activities of Daily Living, covered under this definition. The implantation must be determined to be medically necessary by a Consultant Neurologist or Neurosurgeon.

For the above definition, the following are not covered:

i. Secondary parkinsonism (including drug, trauma or toxin-induced parkinsonism)

ii. Essential tremor

iii. Parkinsonism related to other neurodegenerative disorders

26. BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or ;

ii. the field of vision being less than 10 degrees in both eyes.

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

27. 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.

28. MEDULLARY CYSTIC DISEASE TYPE 1 AND TYPE 2

A definite diagnosis of medullary cystic disease evidenced by all of the following:

i. Ultrasound, MRI or CT scan showing multiple cysts in the medulla and corticomedullary region of both kidneys

ii. Typical histological findings with tubular atrophy, basement membrane thickening and cyst formation in the corticomedullary junction

iii. Glomerular filtration rate (GFR) of less than 40 ml/min (MDRD formula)

The diagnosis must be confirmed by a Consultant Nephrologist.

For the above definition, the following are not covered:

i. Polycystic kidney disease
ii. Multicystic renal dysplasia and medullary sponge kidney
iii. Any other cystic kidney disease

29. MUSCULAR DYSTROPHY

A definite diagnosis of one of the following muscular dystrophies:

i. Duchenne Muscular Dystrophy (DMD)
ii. Becker Muscular Dystrophy (BMD)
iii. Emery-Dreifuss Muscular Dystrophy (EDMD)
iv. Limb-Girdle Muscular Dystrophy (LGMD)
v. Facioscapulohumeral Muscular Dystrophy (FSHD)
vi. Myotonic Dystrophy Type 1 (MMD or Steinert's Disease)
vii. Oculopharyngeal Muscular Dystrophy (OPMD)

The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

i. 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.
ii. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
iii. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
iv. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
v. Getting between rooms – the ability to get from room to room on a level floor.
vi. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by electromyography (EMG) and muscle biopsy findings.

For the above definition, the following are not covered: Myotonic Dystrophy Type 2 (PROMM) and all forms of myotonia

30. POLIOMYELITIS

A definite diagnosis of acute poliovirus infection resulting in paralysis of the limb muscles or respiratory muscles. The paralysis must be medically documented for at least 3 months from the date of diagnosis.

The diagnosis must be confirmed by a Consultant Neurologist and supported by laboratory tests proving the presence of the poliovirus.

For the above definition, the following are not covered:

i. Poliovirus infections without paralysis
ii. Other enterovirus infections
iii. Guillain-Barré syndrome or transverse myelitis

31. FULMINANT VIRAL HEPATITIS

A definite diagnosis of fulminant viral hepatitis evidenced by all of the following:

i. Typical serological course of acute viral hepatitis
ii. Development of hepatic encephalopathy
iii. Decrease in liver size
iv. Increase in bilirubin levels
v. Coagulopathy with an international normalized ratio (INR) greater than 1.5
vi. Development of liver failure within 7 days of onset of symptoms
vii. No known history of liver disease

The diagnosis must be confirmed by a Consultant Gastroenterologist.

For the above definition, the following are not covered:

i. All other non-viral causes of acute liver failure (including paracetamol or aflatoxin intoxication)

ii. Fulminant viral hepatitis associated with intravenous drug use

32. LOSS OF INDEPENDENT EXISTENCE [BEFORE AGE 65]

A definite diagnosis [before age 65] of a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

i. 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.

ii. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.

iii. Feeding oneself – the ability to feed oneself when food has been prepared and made available.

iv. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

v. Getting between rooms – the ability to get from room to room on a level floor.

vi. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis has to be confirmed by a Specialist.

33. ENCEPHALITIS

A definite diagnosis of acute viral encephalitis resulting in a persistent neurological deficit documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by typical clinical symptoms and cerebrospinal fluid or brain biopsy findings.

For the above definition, the following are not covered:

i. Encephalitis caused by bacterial or protozoal infections

ii. Myalgic or paraneoplastic encephalomyelitis

34. SPORADIC CREUTZFELDT-JAKOB DISEASE (SCJD)

A diagnosis of sporadic Creutzfeldt-Jakob disease, which has to be classified as “probable” by all of the following criteria:

i. Progressive dementia

ii. At least two out of the following four clinical features: myoclonus, visual or cerebellar signs, pyramidal/extrapyramidal signs, akinetic mutism

iii. Electroencephalogram (EEG) showing sharp wave complexes and/or the presence of 14-3-3 protein in the cerebrospinal fluid

iv. No routine investigations indicate an alternative diagnosis

The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

i. Iatrogenic or familial Creutzfeldt-Jakob disease

ii. Variant Creutzfeldt-Jakob disease (vCJD)

35. AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE) - resulting in permanent loss of physical abilities

A definite diagnosis of amyotrophic lateral sclerosis. The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

i. 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.

ii. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.

iii. Feeding oneself – the ability to feed oneself when food has been prepared and made available.

iv. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

v. Getting between rooms – the ability to get from room to room on a level floor.

vi. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by nerve conduction studies (NCS) and electromyography (EMG).

For the above definition, the following are not covered:

i. Other forms of motor neurone disease

ii. Multifocal motor neuropathy (MMN) and inclusion body myositis

iii. Post-polio syndrome

iv. Spinal muscular atrophy

v. Polymyositis and dermatomyositis

36. BACTERIAL MENINGITIS - resulting in persistent symptoms

A definite diagnosis of bacterial meningitis resulting in a persistent neurological deficit documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by growth of pathogenic bacteria from cerebrospinal fluid culture.

For the above definition, the following are not covered:

Aseptic, viral, fungal, parasitic or non-infectious meningitis

37. CHRONIC PANCREATITIS – leading to exocrine and endocrine pancreatic insufficiency

A definite diagnosis of severe chronic pancreatitis evidenced by all of the following:

i. Exocrine pancreatic insufficiency with weight loss and steatorrhoea

ii. Endocrine pancreatic insufficiency with pancreatic diabetes

iii. Need for oral pancreatic enzyme substitution

These conditions have to be present for at least 3 months. The diagnosis must be confirmed by a Consultant Gastroenterologist and supported by imaging and laboratory findings (e.g. faecal elastase).

For the above definition, the following are not covered:

i. Chronic pancreatitis due to alcohol or drug use

ii. Acute pancreatitis

38. CHRONIC ADRENOCORTICAL INSUFFICIENCY (ADDISON'S DISEASE)

Chronic autoimmune adrenal insufficiency is an autoimmune disorder causing gradual destruction of the adrenal gland resulting in inadequate secretion of steroid hormones. A definite diagnosis of chronic autoimmune adrenal insufficiency which must be confirmed by a Consultant Endocrinologist and supported by all of the following diagnostic tests:

i. ACTH stimulation test

ii. ACTH, cortisol, TSH, aldosterone, renin, sodium and potassium blood levels

For the above definition, the following are not covered:

Secondary, tertiary and congenital adrenal insufficiency

Adrenal insufficiency due to non-autoimmune causes (such as bleeding, infections, tumours, granulomatous disease or surgical removal)

39. PRIMARY CARDIOMYOPATHY

A definite diagnosis of one of the following primary cardiomyopathies:

i. Dilated Cardiomyopathy

ii. Hypertrophic Cardiomyopathy (obstructive or non-obstructive)

iii. Restrictive Cardiomyopathy

iv. Arrhythmogenic Right Ventricular Cardiomyopathy

The disease must result in at least one of the following:

i. Left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months.

ii. Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months.

iii. Implantation of an Implantable Cardioverter Defibrillator (ICD) for the prevention of sudden cardiac death

The diagnosis must be confirmed by a Consultant Cardiologist and supported by echocardiogram, cardiac MRI or cardiac CT scan findings.

The implantation of an Implantable Cardioverter Defibrillator (ICD) must be determined to be medically necessary by a Consultant Cardiologist.

For the above definition, the following are not covered:

i. Secondary (ischaemic, valvular, metabolic, toxic or hypertensive) cardiomyopathy
ii. Transient reduction of left ventricular function due to myocarditis
iii. Cardiomyopathy due to systemic diseases
iv. Implantation of an Implantable Cardioverter Defibrillator (ICD) due to primary arrhythmias (e.g. Brugada or Long-QT-Syndrome)

40. SYSTEMIC SCLEROSIS (SCLERODERMA) – with organ involvement

A definite diagnosis of systemic sclerosis evidenced by all of the following:

i. Typical laboratory findings (e.g.anti-Scl-70 antibodies)
ii. Typical clinical signs (e.g. Raynaud's phenomenon, skin sclerosis, erosions)
iii. Continuous treatment with corticosteroids or other immunosuppressants

Additionally, one of the following organ involvements must be diagnosed:

i. Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted
ii. Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterisation
iii. Chronic kidney disease with a glomerular filtration rate of less than 60 ml/min (MDRD-formula)
iv. Echocardiographic signs of significant Grade III left ventricular diastolic dysfunction

The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.

For the above definition, the following are not covered:

i. Localized scleroderma without organ involvement
ii. Eosinophilic fasciitis
iii. CREST - Syndrome

What are the General Policy Provisions?

i Free Look Option:

At Master Policy level:

In case the Master Policyholder does not agree with the terms and conditions of the Master Policy or otherwise and has not made any claim, the Master Policyholder has the option to request for cancellation of the Master Policy by returning the Master Policy Document (if issued physically) along with a written request stating the reasons for non-acceptance to the insurer within 30 days from the receipt of Master Policy Document, whether received electronically or otherwise (Whichever is earlier). Upon the receipt of such a cancellation request, the Company will cancel the Master Policy and refund the premiums received after deducting proportionate risk premium for the period of insurance cover and expenses incurred on medicals, if any and applicable stamp duty. All Insured Members' coverage will cease post the request for free look cancellation by the Master Policyholder.

At Member level:

Where the Insured Member is paying the premium for his/her coverage and the Insured Member does not agree with the terms and conditions of the Insurance Coverage or otherwise and has not made any claim , he/she has the option to request for cancellation of the insurance coverage with a written request stating the reasons for non-acceptance to the insurer within 30 days from the inception of coverage. Upon such cancellation request, the Company will cancel the insurance coverage in respect of the Insured Member and refund the premiums received in respect of Insured Member after deducting proportionate risk premium for the period of insurance cover and expenses incurred on medicals, if any and applicable stamp duty, for that Insured Member. The coverage for the Insured Member will cease post the request for such free look cancellation.

ii. A Member means a person who meets the eligibility criteria for grant of benefits under the Master Policy. A Member does not automatically become an **Insured Member** unless he/she fulfils the eligibility criteria & complies with all the requisite formalities for grant of insurance cover and the Company grants him an insurance cover.

iii. **Grace Period:** Grace period of 30 days for half-yearly and quarterly premium payment modes and 15 days for monthly premium payment mode will be allowed to pay the due premium from the due date of premium. However, grace period is not allowed at the time of renewal of the Policy.

During the grace period, the Insured Member's insurance coverage is considered to be in-force. If the contingent event of death/TI/CI/ADB/ATPD (as applicable) occurs during the grace period, benefit shall be payable as mentioned above after deducting the due unpaid premium in respect of the Insured Member, subject to the exclusions mentioned in General Policy Provisions (GPP) below.

iv. After the expiry of the Grace Period without payment of the premium in full, the Insurance Coverage under the Master Policy for the relevant Insured Member(s) shall be deemed to have automatically lapsed and all liability of the Company shall cease and the Company is not liable to pay any benefit in case of the contingent event of death/TI/CI/ADB/ATPD (as applicable) of the Insured Member(s).

v. Accidental Death Benefit (ADB):

"Accident" is defined as "A sudden, unforeseen and involuntary event, caused by external, visible and violent means which occurs during the lifetime of the Insured Member".

"Bodily Injury" means Injury must be evidenced by external signs such as contusion, bruise and wound except in cases of drowning and internal injury.

"Injury" means accidental physical bodily harm excluding illness or disease, solely and directly caused by an external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

The Accident shall result in Bodily Injury or injuries to the Insured Member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the Accident, directly and independently of any other means cause the death of the Insured Member. Such a death is defined as "Accidental Death".

The date of the Accident should be after the risk commencement date and before the termination/expiry of the Insured Member's insurance coverage.

Exclusions applicable for Accidental Death Benefit

No ADB benefit will be payable on death of the Insured Member occurring directly or indirectly as a result of any of the following:

1. Intentional self-inflicted injury, attempted suicide while sane or insane.
2. Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
3. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes.
4. 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.
5. Participation by the Insured Member in a criminal or unlawful act with criminal intent.
6. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
7. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

vi. Accidental Total & Permanent Disability (ATPD):

"Accident" is defined as "A sudden, unforeseen and involuntary event, caused by external, visible and violent means which occurs during the lifetime of the insured."

"Bodily Injury" means Injury must be evidenced by external signs such as contusion, bruise and wound except in cases of drowning and internal injury.

"Injury" means accidental physical bodily harm excluding illness or disease, solely and directly caused by an external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

"Accidental Total and Permanent Disability (ATPD)" refers to a disability, which:

a. is caused by Bodily Injury resulting from an Accident, and

b. occurs due to the said Bodily Injury solely, directly and independently of any other causes, and

c. occurs within 180 days of the occurrence of such Accident and

d. results in the loss of both arms, or of both legs, or of one arm and one leg, or of both eyes, shall be considered total and permanent disability, without prejudice to other causes of total and permanent disability.

Where, "Loss of an arm or a leg" shall mean physical severance of the arm at or above the wrist or physical severance of the leg at or above the ankle.

"Loss of both eyes" shall mean total and irrevocable loss of sight of both eyes.

The date of the Accident should be after the risk commencement date and before the termination/expiry of the Insured Member's insurance coverage.

Exclusions for Accidental Total and Permanent Disability

No ATPD benefit will be payable in respect of any of the conditions covered, arising directly or indirectly as a result of any of the following:

1. Intentional self-inflicted injury, attempted suicide while sane or insane.
2. Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
3. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes.
4. 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.
5. Participation by the Insured Member in a criminal or unlawful act with criminal intent.
6. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
7. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

vii. Terminal Illness: Terminal Illness is defined as "advanced or rapidly progressing incurable illness in the opinion of appropriate independent Medical Practitioner, life expectancy is no greater than six (6) months from the date of notification of claim. The Terminal Illness must be diagnosed and confirmed by Medical Practitioner. The Medical Practitioner should be a specialist from that field of medicine for which the Terminal Illness is being claimed. The Company reserves the right for an independent assessment by a different Medical Practitioner other than the Medical Practitioner whose diagnosis has been provided by the Insured Member.

viii. Critical Illness Condition: Critical Illness Condition means the first diagnosis of any one of the specified Critical Illnesses or performance of any of the specified medical procedures/surgeries by a specialist Medical Practitioner (as listed in Critical Illnesses covered).

Exclusions for Critical Illness

Notwithstanding anything to the contrary stated herein and in addition to the foregoing exclusions, no Critical Illness benefit will be payable if the Critical Illness Condition occurs from, or is caused by, either directly or indirectly, voluntarily or involuntarily, due to one of the following:

1. Congenital Condition: Any external congenital condition or related illness is not covered. In case any Internal congenital condition or related illness is known and was/is being treated, is disclosed at proposal stage and accepted, claims will be processed as per policy terms and conditions.
2. Drug Abuse: Member is under the influence of Alcohol or solvent abuse or use of drugs except under the direction of a registered Medical Practitioner.
3. Pre-existing disease (PED) means any condition, ailment, injury or disease: a) that is/are diagnosed by a physician not more than 36 months prior to the date of the commencement of the coverage by the insurer; or its reinstatement, whichever is later or b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of the commencement of the coverage, or its reinstatement, whichever is later.
4. Self-inflicted Injury: Intentional self-inflicted injury by the Insured Member.
5. Suicide: If the Critical Illness was contracted due to attempted suicide.
6. Criminal Acts: Insured Member involvement in criminal activities with criminal intent.
7. War and Civil Commotion: Exposure to war, invasion, hostilities, (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.

8. Nuclear Contamination: Exposure to radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
9. Aviation: Insured Member's participation in any flying activity, other than as a passenger in a commercially licensed aircraft.
10. Hazardous sports and pastimes: Taking part or practicing for any hazardous hobby, pursuit or any race not previously declared and accepted by the Company.
11. Failure to seek medical advice or treatment by a medical practitioner leading to occurrence of the insured event.

i**x. Survival Period:** The Survival Period (30 days) is defined as the period of time after the date of first diagnosis of covered Critical Illness Condition that the Insured Member has to survive to be eligible for receiving CI Sum Assured.

x. Waiting Period: Waiting Period is defined as a period of 90 days starting from the date the Members becomes an Insured Member or from the date of reinstatement of Insured Member's insurance coverage. No amount shall be payable in case of occurrence of covered Critical Illness Condition within the Waiting Period. Waiting Period shall not be applicable for the Insured Member(s) whose cover is renewed with the Company, provided who have already completed their Waiting Period fully. In cases where at the time of renewal of Member's insurance coverage, partial Waiting Period is exhausted, only the balance Waiting Period shall be applicable at the time of renewal.

xi. Revival: A lapsed Master Policy/Insured Member's insurance coverage can be revived within 90 days of the first unpaid premium or up to the scheme renewal date, whichever is earlier, subject to following conditions:

- The Master Policy has not been terminated.
- Payment of due premiums along with applicable interest rate, on simple interest basis, as notified by the Company from time to time.
- Revival shall be as per the Board Approved Underwriting Policy of the Company and the Company may require Insured Member(s) to furnish satisfactory evidence of health and other requirements in accordance with the Company's BAUP.
- The Company reserves the right to revive the Master Policy/Insured Member's insurance coverage at the original terms, revive with modified terms or decline the revival of the Policy/Insured Member's insurance coverage, in accordance with the Company's BAUP.
- The Company will not be liable to pay for any relevant benefit while the Master Policy/Insured Member's insurance coverage is in lapsed state.
- The Revival of the Master Policy shall only be effective from the date on which the Company has issued a written endorsement confirming the Revival of the Master Policy Insured Member's insurance coverage.

The basis for determining the interest rate is the average of the daily rates of 10-Year G-Sec rate over the last five calendar years ending 31st December every year rounded to the nearest 50 bps plus a margin of 100 bps, and any change in the basis of this interest rate will be subject to prior approval of the Competent Authority. The Company undertakes the review of the Interest rates for revivals on 31st December every year with any changes resulting from the review being effective from the 1st of April of the following year. The information is sourced from a reliable source. The applicable interest rate for FY 2024-25 is 7.50%

xii. Suicide Clause: In case of death of an Insured Member due to suicide within 12 months:

- from the date of commencement of risk for the Insured Member, the nominee shall be entitled to 80% of the premiums paid in respect of the Insured Member's cover till the date of death or the surrender value (if any) as available on the date of death whichever is higher, provided the cover is in-force or
- from the date of revival of the Master Policy/Member Coverage, the nominee shall be entitled to an amount which is higher of 80% of the premiums paid in respect of the Insured Member's cover till the date of death or the surrender value (if any) as available on the date of death.

Suicide provision will not be applicable to Members who migrate from an existing scheme of another insurance provider to the scheme provided by the Company. Similarly, this provision will not be applicable for Insured Member(s) whose insurance coverage gets renewed upon renewal of the scheme with the Company. Further, Suicide provision shall not apply to EDLI schemes/schemes with compulsory participation.

xiii. Free Cover Limit

There would be respective Free Cover Limits (FCLs) for Base Death/TI/CI/ADB/ATPD Sum Assured (as applicable) under this plan. The risk cover up to the applicable FCL(s) for each member within the group would be provided without any individual evidence of health. The FCL(s) will be determined as per the Company's Board Approved Underwriting Policy (BAUP) of the Company.

xiv. In case Master Policyholder fails to remit the Premiums received/collected from Insured Member, the Company will pay the claim as per terms and conditions of the Policy provided the Insured Member or his/her Claimant is able to prove that he/she had paid the due Premium to the Master Policyholder and secured a proper receipt leading him/her

to believe that the Insured Member was covered under the Master Policy. In any such event, Master Policyholder shall be liable to re-pay the due Premium along with interest at the rate specified by the Company.

xv. Medical Practitioner: means a person who holds a valid registration from the Medical Council of any State of India or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license; but excluding a Medical Practitioner who is:

- Insured Member himself/herself or an agent of the Insured Member or
- Insurance Agent, business partner(s) or employer/employee of the Insured Member or
- a member of the Insured Member's immediate family.

xvi. Nomination: Nomination is effected as per Section 39 of Insurance Act, 1938 as amended from time to time.

xvii. Assignment: Assignment shall be applicable in accordance with provisions of Section 38 of the Insurance Act 1938, as amended from time to time.

xviii. Tax Benefits: Tax Benefits may be available as per extant tax laws and are subject to amendments from time to time. For tax related queries, contact Your independent tax advisor.

xix. Policy Loan: Not available under this plan.

xx. This product is also available online. A rebate of 5% in the rates will be provided if product is sold through the online channel.

Section 41 of the Insurance Act, 1938 as amended from time to time:

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

Section 45 of the Insurance Act, 1938 as amended from time to time: Fraud and Misstatement would be dealt with in accordance with provisions of Section 45 of the Insurance Act, 1938, as amended from time to time. For provisions of this Section, please contact the Insurance Company or refer to the policy contract of this product on our website www.canarahsbclife.com.

PROCEDURE FOR GRIEVANCE REDRESSAL

In case of any concern you may have, kindly visit any of our branches or call our resolution center. You can also write an email to us or reach us through the online form on our website. We will respond to you maximum within two weeks from the date of receiving your complaint.

Complaint Redressal Unit
Canara HSBC Life Insurance Company, 139P, sector 44, Gurugram - 122003, Haryana, India
Toll Free- 1800-103-0003/1800-891-0003
Email: cru@canarahsbclife.in

In case you do not receive a response from us or are not satisfied with the same you may write to our Grievance Redressal Officer at

Grievance Redressal Officer
Canara HSBC Life Insurance Company, 139P, sector 44, Gurugram - 122003, Haryana, India
Toll Free- 1800-103-0003/1800-891-0003
Email: gro@canarahsbclife.in

To locate our branch please visit https://www.canarahsbclife.com/contact-us/locate-a-branch.

In case the complaint is not attended to within two weeks of registration of the complaint or the resolution provided by the Insurer/GRO is not satisfactory, the client may complain to Bima Bharosa by visiting: https://bimabharosa.irdai.gov.in

In case you are still not satisfied with the decision/resolution provided by the Company, you may approach the Insurance Ombudsman of your respective State for redressal of your grievance. For more details kindly refer to our website www.canarahsbclife.in or the GBIC website at https://cioins.co.in/Ombudsman for the list of Ombudsman.

Kindly note that you may approach the Insurance ombudsman, if you do not receive response from us within 30 days from the date of filing the complaint or if your complaint is rejected or if you are not satisfied with our response.

Canara HSBC Life Insurance Company Limited
(IRDAI Regn. No. 136)
Registered Office: 8th Floor, Unit No. 808 - 814, Ambadeep Building, Plot No.14, Kasturba Gandhi Marg, New Delhi - 110001, India

Head Office: 139 P, Sector 44, Gurugram-122003, Haryana, India

Corporate Identity No.: L66010DL2007PLC248825

Website: www.canarahsbclife.com

Call: 1800-103-0003/1800-891-0003

SMS: 7039004411. Missed Call: 8071262709

Email: customerservice@canarahsbclife.in

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IRDAI or its officials do not involve in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint "

This product brochure gives only the salient features of the plan and it is indicative of terms and conditions. This brochure should be read in conjunction with the Terms & Conditions for this plan as provided in sample policy contract available on our website.

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