FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PROSPECTUS
FUTURE HOSPI-CASH

A. **Salient Features of the Policy**

1. You can claim for each day of hospitalization as per your plan.
2. ICU benefit available for maximum period of 10 days for each hospitalization and maximum 20 days during the policy period.
3. The per day benefit will be 2 times when hospitalized in an ICU in the home city i.e. within the city of residence.
4. The per day benefit will be 3 times when hospitalized in an ICU outside the home city i.e. outside the city of residence.
5. Additional convalescence benefit of Rs. 5000 for hospitalization of more than 10 days; payable only once per hospitalization event.
6. The product is offered from 6 months to 65 years and renewable lifelong.

Max Policy Term	1 year
Min Age at entry	6 months
Max age at entry	65 years
Renewal	Lifelong

7. The policy can be on individual sum insured basis or on family floater basis, covering Self, spouse, and two dependent children (up to age 25 years).
8. For Individual as well as Family floater plan only one hospitalization benefit across all members needs to be selected.
9. No medical test required for clean proposal except for Plan C and Plan D where insured is above 55 years of age.
10. Premium paid is exempt under the section 80 D of Income Tax.
11. There will be no loading on premium for adverse claims experience in our Individual Hospicash policy.

B. **DEFINITIONS**

I. Standard Definitions

1. **Accident** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

3. **Conditions precedent** shall mean a policy terms or conditions upon which the insurers liability under the policy is conditional upon.

4. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   i. **Internal Congenital Anomaly -** Congenital Anomaly which is not in the visible and accessible parts of the body.
   ii. **External Congenital Anomaly** - Congenital Anomaly which is in the visible and accessible parts of the body.

5. **Day care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under -
   i. has qualified nursing staff under its employment;
   ii. has qualified medical practitioner/s in charge;
   iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

6. **Day care treatment** refer to medical treatment, and/or surgical procedure which is:
   i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
   ii. which would have otherwise required hospitalization of more than 24 hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition.

7. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

8. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

9. **Disclosure to information norm** – 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.

10. **Grace period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

11. **Hospital -** A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

12. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive '**Inpatient Care'** hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

13. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **Acute condition** - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
    b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
       (i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
       (ii) it needs ongoing or long-term control or relief of symptoms
       (iii) it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
       (iv) it continues indefinitely
       (v) it recurs or is likely to recur

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

15. **Inpatient Care** means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.

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

17. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

18. **Maternity expense/treatment** means**:**
    a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b. expenses towards lawful medical termination of pregnancy during the policy period.

19. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

20. **Medical expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of **Illness** or **Accident** on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

21. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close Family members.

22. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer

23. **Portability** means the right accorded to an individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

24. **Pre-existing Disease** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

25. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

27. **Unproven/ Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India.

II. **Specific Definitions:**

28. **Alternative treatment** are forms of treatment other than treatment “Allopathy” or “modern medicine” and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian content.

29. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/ her independent sources of income.

30. **Family** means and includes You, Your Spouse & Your dependent child/ children (up to the age of 25 years)
    (i) The maximum number of days of Hospitalisation as mentioned in the Schedule would float over all members under the Family Floater Policy.
    (ii) In the event of more than one **Family** member being hospitalised at the same time, the number of days each member has been hospitalised would be added, and the maximum allowable for the whole **Family** would be restricted to the number of days as mentioned in the Schedule (maximum number of days would float over the **Family**) under the Family Floater **Policy**

31. **Home City** means the city of residence.

32. **Other Than Home City** means the city other than the residential city of the insured.

33. **Policy** means the complete documents consisting of the Proposal, Policy wording, Schedule and Endorsements and attachments if any.

34. **Policy Period** means the period between commencement date and the expiry date specified in a schedule and include both commencement date as well as the expiry date.

35. **Proposal** means that portion of the policy which sets out your personal details, they type of insurance cover in force, the period and the sum insured.

36. **Prospect** means any person who is a potential customer of an insurer and likely to enter into an insurance contract either directly with the insurer or through a distribution channel.

37. **Prospectus** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.

38. **Schedule** means that portion of the Policy which sets out Your personal details, the type of insurance cover in force, the period and the sum insured. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule.

39. **You, Your, Yourself** means the Insured Person shown in the Schedule.

40. **We, Our, Us, Insurer** means Future Generali India Insurance Company Limited.

Please note
a) Insect and mosquito bites is not included in the scope of definition of **Accident**.
b) **Medical Expenses** would include both medical treatment and/ or surgical treatment

C. **POLICY BENEFITS:**

In the event of Accidental Bodily Injury or illness first occurring or manifesting itself during the Policy Period and causing the Insured's Hospitalisation for Inpatient Care within the Policy Period, the Company will pay:

I. the Hospital Cash benefit for each continuous and completed period of 24 hours of **Hospitalisation** necessitated solely by reason of the said Accidental **Bodily Injury** or Sickness, for a maximum of 30 days / 60 days /90 days/ 180 days as per the **schedule**.
OR

II. two times the Hospital Cash benefit for each continuous and completed period of 24 hours required to be spent by the Insured in the Intensive Care Unit of a Hospital situated in the Home city of the Insured, during any period of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Sickness for a maximum period of 10 days for each hospitalisation and 20 days during the policy period
OR

III. three times the Hospital Cash benefit for each continuous and completed period of 24 hours required to be spent by the Insured in the Intensive Care Unit of a Hospital situated in a city other than Home city of the Insured, during any period of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Sickness for a maximum period of 10 days for each hospitalisation and 20 days during the policy period.

* *In case of Section II and III the maximum benefit payable in case of ICU whether in Home city/ other than Home city, is limited upto 10 days for each hospitalisation and maximum of 20 days for all hospitalisations put together in the policy period. In case of the same hospitalisation involving ICU stay in both Home city as well as other than Home city , the benefits under the "other than home city" would have precedence over benefits under Home city while adjudication of claim.*

** *In case of Sec I, II and III the maximum benefits would however be restricted to 30/ 60/ 90/ 180 days as per the plan opted for each hospitalisation or all hospitalisations during the policy period.*

****In case the hospitalisation exceeds the maximum stipulated under Sec I as per the selected plan while adjudicating any claim the benefits under ICU would have precedence over non ICU hospitalisation.*

**** *In case the hospitalisation in ICU exceeds the per hospitalisation maximum limit of 10 days or the per policy period limit of 20 days, the remaining period of hospitalisation in ICU will be paid as per non ICU hospitalisation benefits subject to the overall policy maximum of 30/ 60/ 90 or 180 days.*

IV. A Fixed amount towards convalescence for **Hospitalization** beyond 10 consecutive days which is payable only once per **Hospitalization** event. This benefit is payable only if there is an admissible claim under any of the daily benefits.

Plan Benefit Structure

Plans A, B, C, D can be offered for different options 30 days / 60 days / 90 days / 180 days

Benefits	**Plans**			
	A	**B**	**C**	**D**
Daily Hospitalization benefit due to sickness	**500**	**1000**	**2000**	**3000**
ICU benefit in home city of residence (max. 10 days)	**1000**	**2000**	**4000**	**6000**
ICU benefit in other than home city of residence (max. 10 days)	**1500**	**3000**	**6000**	**9000**
Convalescence benefit for hospitalization exceeding consecutive 10 days*	**5000**			

*Home city would mean within the municipal corporation limits of the city of residence.

Other than home city would mean outside the municipal corporation limits of city of residence. For Mumbai home city would include Thane and Panvel, for Delhi Home city would also include National Capital Region (NCR)

*A fixed amount towards convalescence for Hospitalisation beyond 10 consecutive days which is payable only once per hospitalisation event. This benefit is payable only if there is an admissible claim under any of the daily benefits.

D. **EXCLUSIONS**

I. Waiting Periods:

We will not pay for any expenses incurred by **You** in respect of claims arising out of or howsoever related to any of the following:

1. Benefits will not be available for any condition, ailment or **Injury** or related condition(s) for which **You** have been diagnosed, received medical treatment, had signs and/or symptoms, prior to inception of **Your** first **Policy**, until 48 consecutive months have elapsed, after the date of inception of the first **Policy** with **Us**.

   This Exclusion shall cease to apply if **You** have maintained the **Policy** with **Us** for a continuous period of 48 months, without break from the date of **Your** first Hospicash **Policy** with **Us**.

   This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the Policy is a Renewal of a Hospital cash Policy without break in cover

   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

2. Without derogation from the above point no. (1), any Hospitalisation during the first consecutive 24 months during which You have the benefit of a Health Insurance Policy with Us in connection with cataracts, benign prostatic hypertrophy, hernia of all types, hydrocele, all types of sinuses, fistulae, hemorrhoids, fissure in ano, dysfunctional uterine bleeding, fibromyoma, endometriosis, hysterectomy, all internal or external tumors/ cysts/ nodules/ polyps of any kind including breast lumps (except malignant conditions), Surgery for prolapsed inter vertebral disc unless arising from Accident, Surgery of varicose veins and varicose ulcers.

   This exclusion shall apply for a continuous Period of 48 months from the date of **Your** first Hospicash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared such **Illness** at the time of proposing the **Policy** for the first time.

   This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the Policy is a Renewal of a Hospital cash Policy without break in cover

   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

3. Without derogation from the above point No.(1), any **Hospitalisation** during the first 12 months during which You have the benefit of a Health Insurance **Policy** with **Us** in connection with any types of gastric or duodenal ulcers, stones in the urinary and biliary systems, **Surgery** on ears/ tonsils/ adenoids.

   This exclusion period shall apply for a continuous period of 48 months from the date of **Your** first Hospicash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared such **Illness** at the time of proposing the **Policy** for the first time.

   This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the Policy is a Renewal of a Hospital cash Policy without break in cover

   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

4. **Hospitalisation** during the first consecutive 36 months during which You have the benefit of the **Policy** with **Us** in connection with joint replacement **Surgery** due to degenerative condition, Age related osteoarthritis and Osteoporosis unless such joint replacement **Surgery** is necessitated by accidental Bodily **Injury**.

   This exclusion shall apply for a continuous period of 48 months from the date of **Your** first Hospicash **Policy** with **Us** if the above referred **Illness** were present at the time of commencement of the **Policy** and if **You** had declared such **Illness** at the time of proposing the **Policy** for the first time.

   This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the Policy is a Renewal of a Hospital cash Policy without break in cover

   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

5. **Hospitalisation** for any **Illness** diagnosed or diagnosable within 30 days (1 month), of the commencement of the **Policy** Period except those incurred as a result of accidental bodily **Injury**.

   This Exclusion shall apply only to the extent of the amount by which the benefit amount has been increased if the Policy is a Renewal of a Hospital cash Policy without break in cover

   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

II. Standard Exclusions:

We will not pay for any expenses incurred by You in respect of claims arising out of or howsoever related to any of the following:

a) **Investigation & Evaluation- Code- Excl04**

i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

b) **Change-of-Gender treatments: Code- Excl07**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

c) **Cosmetic or Plastic Surgery: Code- Excl08**

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

d) **Hazardous or Adventure sports: Code- Excl09**

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

e) **Code- Excl12**

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

f) **Code- Excl13**

Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or a Hospital where the Hospital has effectively become the Insured Person's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

g) **Refractive Error: Code- Excl15**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

h) **Unproven Treatments: Code- Excl16**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

i) **Birth control, Sterility and Infertility: Code- Excl17**
Expenses related to Birth Control, 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

j) **Maternity : Code Excl 18**
i. Medical treatment expenses traceable to child birth (including complicated deliveries and caesarean section incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during policy period.

III. Specific Exclusions

k) Injury or Disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not).
l) Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an Accident.
m) Vaccination (unless post bite treatment), inoculation
n) Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of accidental bodily Injury.
o) Hospitalisation for General debility, "Run-down'' condition or rest cure, sexually transmitted disease other than HIV/AIDS, intentional self-Injury.
p) The treatment of obesity (including morbid obesity) and other weight control programs , services and supplies.
q) Hospitalisation arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) and its variants or mutants.
r) Congenital internal and/or external Illness/disease/defect anomaly.
s) Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/ materials.
t) Costs incurred on all methods of treatment including Alternative treatments other than Allopathy.
u) Genetic disorders and stem cell implantation/surgery/storage.
v) Hormone replacement therapy.
w) Any treatment including Surgery to remove organs from the donor in case of a transplant surgery.
x) Any Hospitalisation received out of India

E. **Policy Options:** Individual, Family floater and Group

F. **Family Definitions:**
- Family means Self, Spouse & children (up to 25 years)
- The minimum age for covering children is 6 months.
- The maximum age for covering children as dependents is 25 years. Above 25 years can be covered as self-proposers.

G. **Plan Eligibility**

Plan	Income criteria
Plan A and Plan B	Not applicable
Plan C	Monthly income above Rs 50000/-
Plan D	Monthly income above Rs 75000/-
Multiple policies where per day benefit exceeds Rs 3000/- (all policies put together)*	Eligibility - 125 percent of the insured's daily income.

***Maximum benefit available for an individual, is Rs 6000/- per day.**

A person can buy Hospital Cash policies, wherein the benefit will not exceed Rs 6000/- per day under a single or multiple Hospital cash policies. If the per day benefits put together for all these policies exceed Rs 6000/-, he will not be eligible to buy any additional policy.

H. **Age Eligibility**

Max Policy Term	1 year
Min Age at entry	6 months
Max Age at entry	65 years
Renewal	Lifelong

I. **General terms and Clauses**

I. Standard Terms and Clauses

1. **Disclosure to information norm**:
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.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. **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.

3. **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 fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to
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;

4. **Migration**
The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get all the accrued continuity benefits in waiting periods as per the IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
https://general.futuregenerali.in/general-insurance/pdf/Guide_to_Portability_and_Migration_25-Mar-2020.pdf

5. **Complete Discharge**
   Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

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

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

   For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
   a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
   b. the active concealment of a fact by the insured person having knowledge or belief of the fact;
   c. any other act fitted to deceive; and
   d. any such act or omission as the law specially declares to be fraudulent

   The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. **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.

8. **Moratorium Period**

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from 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, deductibles as per the policy contract.

9. **Nomination**

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

10. **Possibility of Revision of Terms of the Policy Including the Premium Rates**

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the

premium rates. The insured person shall be notified three months before the changes are effected

11. **Redressal of Grievance**
In case of any grievance the insured person may contact the company through
Website: https://general.futuregenerali.in/
Toll Free: 1800-220-233 / 1860-500-3333 / 022-67837800
Email: Fgcare@futuregenerali.in
Courier: Grievance Redressal Cell, Future Generali India Insurance Company Ltd.
Lodha I –Think Techno Campus, B Wing –2nd Floor, Pokhran Road –2, Off Eastern Express Highway Behind TCS, Thane West – 400607

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at fggro@futuregenerali.in or call at: 7900197777

For updated details of grievance officer, kindly refer the link https://general.futuregenerali.in/general-insurance/pdf/Grievance_Redressal_Procedures.pdf

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

II. Specific Terms and clauses

1. **Due Care**
Where the Policy requires You to do or not to do something, then the complete satisfaction of that requirement by You or Someone claiming on your behalf is a precondition to any obligation under this Policy. If you or someone claiming on Your behalf fails to completely satisfy that requirement, then We may refuse to consider Your claim. You will cooperate with us at all times.

2. **Insured**
Only those persons named, as the Insured in the schedule shall be covered under this policy. The details of the insured are as provided by You. A person may be added as an Insured during the Policy period after his application has been accepted by Us, an additional premium has been paid and Our agreement to extend cover has been indicated by it, issuing an endorsement confirming the addition of such person as an Insured cover under this Policy shall be withdrawn from any Insured upon that Insured giving 14 days written notice to be recovered by Us.

3. **Pre-Policy Medical Tests**
Medical tests are required only for plan C and D for proposer above age 55 years only. For any positive declaration in the proposal form, medical underwriting would be advised. In case of any pre-policy check-up required as per the company the medical tests would be conducted at our empanelled Network diagnostic centers. Validity of these reports shall be 1 month. 50% cost of medical tests will be reimbursed to you if the Proposal is accepted by us and subject to realization of cheque.

4. **Cost of Pre-insurance Medical examination**
We will reimburse 50% of the cost of any pre-insurance medical examination once the Proposal is accepted and the Policy is issued for that Insured. We shall maintain a list of and the fee chargeable by institutions where such pre insurance medical examination may be conducted, the reports from which will be accepted by us such list shall be furnished to the prospective policy holder at the time of pre insurance medical examination.

5. **Communication**

a) Any communications, meant for Us must be in writing and delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule.
b) All the notifications and declarations for us must be in writing and sent to the address specified in the schedule. Agents are not authorized to receive, notices or declarations on Our behalf.
c) You must notify Us immediately for any change in address.

6. **Claims Procedure**

If You meet with any accidental Bodily Injury or suffer an Illness/ sickness that may result in a claim, then as a condition precedent to Our liability, You must comply with the following:

a) You or someone claiming on your behalf must inform Us in writing immediately, and in any event within 48 hours of the aforesaid Illness or Bodily injury. You must immediately consult a Medical Practitioner and follow the Medical advice and treatment that he recommends.

b) You must take reasonable steps or measure to minimise the quantum of any claim that may be made under this Policy.
c) You shall expeditiously provide the Company with any and all information and documentation in respect of the hospitalization. The claim and/ Our liability hereunder that may be requested. You shall submit Yourself for examination by the Company's medical advisors as often as may be considered necessary by Us. The cost of such medical examination will be borne by Us.
d) You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation (written details of the quantum of any claim along with certified copies of discharge card, hospital bill and receipt) and other information if We ask for, to investigate the claim or Our obligation to make payment for it.
e) In the event of the death of the insured person, nominee claiming on his/ her behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 14 days.

f) Mandatory documents required to process claim are:
   - Completely filled Future Hospicash Claim form (original)
   - Discharge certificate/ card from Hospital (photocopy)
   - Final Hospital bill with receipt (photocopy)

g) The periods for intimation or submission of any documents as stipulated under (d) and (e) will be waived in case of any hardships being faced by the insured or his representative which is supported by some documentation

7. **Settlement of Claims**

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)
v. Our doctors will scrutinize the claims and flag the claims as Settled/Rejected/Pending within the period of 30 days of the receipt of the last `necessary` documents.
vi. Pending claims will be asked for submission of incomplete documents.
vii. Rejected claims will be informed to the insured person in writing with the reason for rejection.

8. **Basis of Claim Payment**

i. If You suffer a relapse within 45 days of the date when You last obtained medical treatment or consulted a Medical Practitioner and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.
ii. If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two Policy period, including the deductibles for each policy period. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of the premium to be received for the Renewal/ due date of premium of health insurance Policy, if not received earlier.
iii. We shall make payment in India in Indian Rupees only.
iv. The Company shall only make payment under this policy to the insured or in the event of death or total incapacitation of the Insured to the Proposer/Nominee. Any payment made in good faith by the Company as aforesaid shall operate as a complete and final discharge of the Company`s liability to make payment under this Policy for such claim.
v. A continuous and completed period of less than 24 hours of Hospitalization or Day care treatment consequent upon an insured event shall be deemed to be a continuous and completed period of 24 hours if such period extends to at least 12 hours.

9. **Renewal**

a) The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
b) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
c) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
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
h) Your Future Hospicash Policy shall be renewable lifelong
i) Any hospitalisation as a result of accident /disease contracted during the break period will not be admissible under the policy.
j) In case of Hospicash policy there will be no loading on premium for adverse claims experience (except for Group policies)

10. **Cancellation**

a) The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

Period on risk	Rate of premium refunded
Up to one month	75% of annual rate
Up to three months	50% of annual rate
Up to six months	25% of annual rate
Exceeding six months	Nil

b) 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.
c) 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.
d) if no claim has been made then, We shall refund a pro rata premium for the unexpired policy period.
e) For Family floater policies, in the event of the death of any of the insured members, the cover ceases to exist for that insured and the remaining members would continue to have the coverage until the end of the policy period.
f) In case of a group policies, the following would apply:
    i. Discount percentage for a favourable claim ratio (bonus): Low claim ratio discount at the following scales will be allowed on the total premium at the renewal only, depending upon the incurred

claim ratio for the entire group insured under the Group Future Hospicash Policy for up to preceding 3 years.

Incurred claim Ratio Under the Group Policy	Discount Percentage (%)
Up to 20%	20
21-35%	15
36-50%	10
51-55%	5

ii. Loading percentage for High claims ratio (MALUS): The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the Group Future Hospicash Policy up to preceding 3 years.

Incurred claim Ratio Under the Group Policy	Loading Percentage (%)
Between 71% and 80%	25
Between 81% and 100%	50
Between 101% and 125%	85
Between 126% and 150%	115
Between 151% and 175%	150
Between 176% and 200%	180
Over 200%	Cover to be reviewed

11. **Dispute Resolution**
   a. Any and all disputes or differences which may arise under or in relation to this Policy, relating to the quantum of any claim/liability otherwise being admitted, shall be referred to arbitration in accordance with Arbitration and Conciliation Act 1996 within a period of 30 days of either the Company or the insured giving notice in this regard.
   b. The applicable law in and of the arbitration shall be Indian law.
   c. The expenses of the arbitrator shall be shared between the parties equally and such expenses along with all reasonable cost in the conduct of the arbitration shall be avoided by the arbitrator to the successful party, or where no party can be said to have been wholly successful to such a party as substantially succeeded.
   d. It is agreed a **condition precedent** to any right of action or suit upon this **policy** that an award by such arbitrator or arbitrators shall be first obtained.
   e. In the event that these arbitration provisions shall be held to be invalid then all such disputes shall be referred to the exclusive jurisdiction of the Indian Courts.

12. **Compliance with Policy Provisions**
   Failure by **You** or the Insured Person to comply with any of the provisions in this Policy may invalidate all claims hereunder.

13. **Territorial Limits and Law**
   a) We cover Hospital cash benefit due to Accidental **Bodily injury** or Sickness sustained by the Insured Person during the **Policy** Period anywhere in India only.
   b) The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian Law.
   c) The **Policy** constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by **Us**, for which approval shall be evidenced by an endorsement on the **Schedule**.

J. **Mandatory Disclosures**

a) Your Hospicash Policy shall be renewable lifelong, if renewed continuously without any break in insurance.
b) The brochure/ prospectus mentions the premium rates as per the age slabs/ Sum Insured. Premium would be applicable as per the completed age of the eldest member in the family at every renewal. Premium for Spouse will be 50% of the Self premium and the Premium for child will be 25% of the Self Premium.
c) The premiums as shown in the prospectus/ brochure are subject to revision as and when approved by the regulator. However such revised premiums would be applicable only from subsequent Renewals and with due notice whenever implemented.

d) Maximum benefit available for an individual is Rs.6000/- per day.
   A person can buy Hospicash Policies, wherein the benefit will not exceed Rs.6000/- per day under a single or multiple Hospital cash policies. If the per day benefits put together for all these policies exceed Rs.6000/- ; he will not be eligible to buy any additional policy.
e) Renewals will not be refused or cancellation will not be invoked by Us except on ground of fraud, moral hazard, misrepresentation. If You prefer to cancel the Policy the cancellation will be on short period basis.
f) In case of individual HospiCash Policy, there will be no loading on premium for adverse claims experience.
g) Terms for enhancing the Sum insured :
   i. No increase in Sum insured during the currency of the policy.
   ii. For the enhanced sum insured, waiting period will apply afresh.
h) Detailed exclusions are given in the Prospectus.

K. **Premiums**
As per Annexure

L. **Claims Administration**
In case of any claims please contact:
Claims Department
Future Generali Health (FGH)
Future Generali India Insurance Co. Ltd. Office No. 3, 3rd Floor, “A” Building, G - O - Square S. No. 249 & 250, Aundh Hinjewadi Link Road, Wakad, Pune - 411 057.

Toll Free Number: 1800 103 8889
Toll Free Fax: 1800 103 9998
Email: fgh@futuregenerali.in

This prospectus shall form part of your proposal form, hence please sign as you have noted the contents of this prospectus

Name	Place
Signature	Date

Future Generali India Insurance Company Limited. IRDAI Regn. No. 132 | CIN: U66030MH2006PLC165287.
Regd. and Corp. Office: 801 and 802, 8th floor, Tower C, Embassy 247 Park, L.B.S. Marg, Vikhroli (W), Mumbai – 400083. Call us at: 1800-220-233 / 1860-500-3333 / 022-67837800| Fax No: 022 4097 6900 | Website: https://general.futuregenerali.in |Email: fgcare@futuregenerali.in.

Annexure

1. Individual Premiums Plan wise exclusive of Goods and Services Tax

30 days										
Benefit (₹/ Day)	6 months - 25 years	26- 35 years	36-45 years	46-55 years	56-60 Years	61-65 years	66-70 years	71-75 years	76-80 years	Above 80 years
₹ 500/ day	261	391	521	717	912	977	1108	1368	1629	1629
₹ 1000/ day	486	728	971	1336	1700	1821	2064	2550	3035	3035
₹ 2000/ day	936	1403	1871	2573	3275	3509	3976	4912	5848	5848
₹ 3000/ day	1386	2078	2771	3810	4850	5196	5889	7274	8660	8660

60 days										
Benefit (₹/ Day)	6 months - 25 years	26- 35 years	36-45 years	46-55 years	56-60 years	61-65 years	66-70 years	71-75 years	76-80 years	Above 80 years
₹ 500/ day	287	430	573	788	1004	1075	1219	1505	1792	1792
₹ 1000/ day	534	801	1068	1469	1870	2003	2270	2805	3339	3339
₹ 2000/ day	1029	1544	2058	2830	3602	3859	4374	5403	6432	6432
₹ 3000/ day	1524	2286	3048	4191	5335	5716	6478	8002	9526	9526

90 days										
Benefit (₹/ Day)	6 months - 25 years	26- 35 years	36-45 years	46-55 years	56-60 years	61-65 years	66-70 years	71-75 years	76-80 years	Above 80 years
₹ 500/ day	301	452	602	828	1054	1129	1279	1581	1882	1882
₹ 1000/ day	561	841	1122	1543	1963	2103	2384	2945	3506	3506
₹ 2000/ day	1081	1621	2161	2972	3782	4052	4593	5673	6754	6754
₹ 3000/ day	1600	2401	3201	4401	5601	6001	6802	8402	10002	10002

180 days										
Benefit (₹/ Day)	6 months - 25 years	26- 35 years	36-45 years	46-55 years	56-60 years	61-65 years	66-70 years	71-75 years	76-80 years	Above 80 years
₹ 500/ day	318	477	636	875	1114	1193	1352	1670	1989	1989
₹ 1000/ day	591	887	1182	1625	2069	2216	2512	3103	3694	3694
₹ 2000/ day	1137	1705	2273	3126	3979	4263	4831	5968	7105	7105
₹ 3000/ day	1682	2524	3365	4627	5889	6309	7150	8833	10515	10515

2. Family Floater

Premium of Self	Premium calculation as per highest age of the family member
Premium of Spouse	50% of Self premium
Premium of Child	25% of Self premium

3. Group Discounts

The group discounts are permissible as per the following scale depending upon total number of insured persons covered under the group policy

Number of insured persons under the group policy	**Group Discounts in %**
101-500	5%
501-1000	10%
Above 1000	12.5%