



Bharti AXA Life Non Linked Group Complete Shield Rider

A Non-Linked, Non-Participating Group Health Insurance Rider

Unfortunate events like Accidents and Illnesses always come suddenly and adversely affect our life and financial situation. Protection for such events is useful in many ways. The insurance benefits offered under Bharti AXA Life Non Linked Group Complete Shield Rider can protect your employees or group members in the event of Accidental Death, Accidental Total and Permanent Disability, Accidental Partial and Permanent Disability, Terminal Illness and Critical Illness. You can choose what your group needs and pay for only those benefits. With these benefits, you can ensure that:

- a. Your employees and their families are not affected financially in the event of Accidental Death or Permanent/Partial Disability due to accident.
- b. Your employees are protected against high medical expenses and loss of earning capacity in the event they suffer a Terminal Illness or Critical Illness.

Highlights of Bharti AXA Life Non Linked Group Complete Shield Rider

Comprehensive Group Protection: Choice of one or more Rider Benefit Options from a list of 4 available covers, including Accidental Death, Total/Partial Disability, Terminal Illness and Critical Illness.

Flexible Critical Illness Packages: Four CI packages — Lite (4 CIs), Core (9 CIs), Plus (21 CIs) and Max (33 CIs) — to suit the protection needs of your workforce.

Additional or Accelerated CI Cover: Option to choose Critical Illness as an Additional benefit (over and above base sum assured) or as an Accelerated benefit (from the base sum assured).

Yearly Renewable Term: One-year renewable term offering flexibility to renew and update group members annually.

Broad Group Eligibility: Available for both employer-employee and non-employer-employee groups.

Tax Benefits may be applicable as per the prevailing tax laws.

What Benefits Can Be Availed Under This Rider?

The Bharti AXA Life Non Linked Group Complete Shield Rider offers coverage against a range of risks. The Master Policyholder may opt for coverage against one or more risks by choosing from the following Rider Benefit Options:

Rider Benefit Option

1. Accidental Death Benefit (ADB)

2. Accidental Disability
 - a. Accidental Total and Permanent Disability (ATPD)
 - b. Accidental Partial and Permanent Disability (APPD)
3. Terminal Illness (TI)
4. Critical Illness
 - a. Additional Critical Illness (CI) – Lite/ Core/ Plus/ Max
 - b. Accelerated Critical Illness (ACI) – Lite/ Core/ Plus/ Max

Important Notes:

- Additional Critical Illness (CI) and Accelerated Critical Illness (ACI) cannot be opted together. Only one of these options can be chosen.
- Terminal Illness (TI) and Critical Illness (CI/ACI) cannot be opted simultaneously as these may contain overlapping benefits.
- More than one benefit option can be opted subject to 100% of base premium and subsequent rider restrictions.

A detail of benefits under each rider event is provided below.

Accidental Death Benefit (ADB)

On the occurrence of death of a Member within the Rider Coverage Term, caused by an accident, provided that the death occurs within 180 days from that accident, the sum assured for ADB shall be paid to the nominee/claimant.

If Accidental Death occurs after the Rider Coverage Term but within 180 days from the date of accident, the claim will be honored by the Company, subject to the accident having occurred within the Rider Coverage Term and the Rider Benefit being in-force on the date of accident.

In the event of an accident on the Date of Termination of Cover resulting in the death of the Member, the ADB sum assured shall not be payable. On Death other than Accidental Death, no benefit shall be payable.

On payment of the ADB to the Claimant, the cover under this benefit will terminate and all rights, benefits and interests under this Rider Benefit will stand extinguished.

On Death due to reasons other than accident, no benefit shall be payable. Upon Surrender, no benefit is payable. There is no Maturity Benefit under this Rider Benefit option

Accidental Disability Benefit: The Master Policyholder, has option to choose from ATPD and APPD under this Rider Benefit.

1. Accidental Total and Permanent Disability (ATPD)

If an accident during the Coverage Term results in Total and Permanent Disability within 180 days, the ATPD Sum Assured will be paid to the member as a single lump sum.

ATPD Benefit is payable if the Member suffers any of the following disabilities due to an Injury or Accident due to which there is total and irrecoverable disability:

- a) Loss of Use of at least two limbs
- b) Loss of Sight of both eye
- c) Loss of hearing and loss of speech
- d) Loss of Use of four fingers and Thumb of both hands
- e) Loss of Use of one limb and sight of one eye
- f) Loss of Use of one limb and hearing
- g) Loss of Use of one limb and speech
- h) Loss of sight of one eye and speech
- i) Loss of sight of one eye and hearing
- j) Loss by severance of two or more limbs at or above wrists or ankles
- k) Loss by severance of four Fingers and Thumb of both hands
- l) Loss by severance of one limb and sight of one eye
- m) Loss by severance of one limb and hearing
- n) Loss by severance of one limb and speech

If ATPD occurs beyond the Rider Coverage Term, this sum assured will be paid provided the disability occurs within 180 days from the date of accident. This is applicable subject to Accident occurring within the Rider Coverage Term and the Rider Benefit Option being in-force on the date of Accident. The disabilities stated above must have continuously lasted, without interruption, for at least 180 days and must, in the opinion of a Medical Practitioner, be deemed permanent. However, for disabilities involving physical severance (sub-points j to n above), the 180-day period is not applicable and the benefit shall commence immediately.

The benefit shall be payable only once during the Rider Term and the cover shall terminate upon payout of the benefit.

On payment of the ATPD sum assured to the Claimant, the cover under this benefit will terminate and all rights, benefits and interests under this Rider Benefit option will stand extinguished.

2. Accidental Partial and Permanent Disability (APPD)

If the Member gets partially and permanently disabled due to an accident within the Coverage Term, such that the disability occurs within 180 days from the date of accident, the APPD Sum Assured will be paid as a lump sum.

If APPD occurs beyond the Rider Coverage Term, this sum assured will be paid provided the disability occurs within 180 days from the date of accident. This is applicable subject to Accident occurring within the Rider Coverage Term and the Rider Benefit Option being in-force on the date of Accident.



The disabilities as stated below must have continuously lasted, without interruption for at least 180 days and must in the opinion of a Medical Practitioner, be deemed permanent. These disabilities as stated below must also be verified by a Medical Practitioner appointed by the Company.

- i. Loss of sight of one eye or the actual loss by physical separation of one entire hand or one entire foot.
- ii. Loss of Use of a hand or a foot without physical separation
- iii. Loss of toes – all
- iv. Loss of hearing - one ear
- v. Loss of four fingers and thumb of one hand
- vi. Loss of four fingers of one hand

The benefit shall be payable only once during the Rider Term and the cover shall terminate upon payout of the benefit.

On Death under Accidental Disability Benefit, no benefit shall be payable. Upon Surrender under Accidental Disability Benefit, no benefit is payable. There is no Maturity Benefit under this Rider Benefit option

Terminal Illness (TI)

Terminal Illness is an incurable, irreversible medical condition, certified by a Medical Practitioner, that is expected to result in death within 6 to 12 months (sometimes up to 24 months).

The TI Benefit is an acceleration of the base benefit. On diagnosis of Terminal Illness, the portion of the base sum assured equal to the Rider Sum Assured shall be payable and the rider cover will terminate. The base sum assured will reduce to the extent of the Rider Sum Assured and the cover for the same shall continue.

On payment of the TI sum assured to the Claimant, the cover under this benefit will terminate and all rights, benefits and interests under this Rider Benefit option will stand extinguished.

On Death, no benefit shall be payable under this benefit. There is no Maturity Benefit under this Rider Benefit option. Upon Surrender, no benefit is payable.

Critical Illness (CI) — (Additional and Accelerated)

Under this Rider Benefit Option, upon confirmatory diagnosis of any of the covered Critical Illnesses, the CI Sum Assured prevailing at the time of diagnosis will be paid to the claimant, provided the Rider is in force.

The Master Policyholder must choose one of the following Options at Rider inception:

Package	Number of Critical Illnesses Covered
Lite	4 CIs
Core	9 CIs
Plus	21 CIs
Max	33 CIs

In addition to the above Rider Benefit options, the Rider Benefit can be taken as an additional rider cover or accelerated rider cover. The accelerated rider cover will be known as Accelerated Critical Illness Benefit and the additional rider cover will know as Additional Critical Illness Benefit.

1. Accelerated Critical Illness (ACI) Benefit

In case of Accelerated CI, the benefit will be paid from the base benefit and is not in addition to the base sum assured. If the Accelerated CI Sum Assured is less than the Base Sum Assured, the Member Base Policy will continue with the Base Sum Assured reduced to the extent of the Accelerated CI Sum Assured already paid out. If the Accelerated CI Sum Assured is equal to the Base Sum Assured, the Member Base Policy as well as this Member Rider will terminate upon payment of this benefit.

2. Additional Critical Illness (CI) Benefit

In case of Additional CI, 100% of the respective Rider Sum Assured shall be payable on confirmatory diagnosis of a covered condition. There may be a survival period applicable from the date of diagnosis of Critical Illness. If the Member is diagnosed with a Critical Illness within the Coverage Term and the Survival Period goes beyond the Coverage Term, the claim shall be honored as per applicable terms and conditions. If the Member dies before the end of the Survival Period, no CI claim will be payable; however, 100% of the premium will be refunded and the Member Rider policy will terminate.

On payment of the CI sum assured to the Claimant, the cover under this benefit will terminate and all rights, benefits and interests under this Rider Benefit option will stand extinguished.

On Death, no benefit shall be payable under this benefit. Upon Surrender, no benefit is payable. There is no Maturity Benefit under this Rider Benefit.

List of Illnesses Covered

On occurrence of the event insured by the respective Rider Benefit, Insured Amount for the respective Rider shall be payable.

Sr. No.	Name of CI/ Surgery	Lite	Core	Plus	Max
1	Cancer of Specified Severity	✓	✓	✓	✓
2	Myocardial Infraction (First Heart Attack of Specific Severity)	✓	✓	✓	✓
3	Open Chest CABG	✓	✓	✓	✓
4	Kidney Failure Requiring Regular Dialysis	✓	✓	✓	✓
5	Stroke Resulting in Permanent Symptoms		✓	✓	✓
6	Major Organ /Bone Marrow Transplant		✓	✓	✓
7	Permanent Paralysis of Limbs		✓	✓	✓
8	End stage liver failure		✓	✓	✓

9	Open Heart Replacement or Repair of Heart Valves		✓	✓	✓
10	Motor Neuron Disease with Permanent Symptoms			✓	✓
11	Multiple Sclerosis with Persisting Symptoms			✓	✓
12	Benign Brain Tumor			✓	✓
13	Blindness			✓	✓
14	Deafness			✓	✓
15	End stage lung failure			✓	✓
16	Coma of Specified Severity			✓	✓
17	Loss of Speech			✓	✓
18	Major Head Trauma			✓	✓
19	Primary (Idiopathic) Pulmonary hypertension			✓	✓
20	Third degree burns			✓	✓
21	Loss of Limbs			✓	✓
22	Aorta Graft Surgery				✓
23	Apallic Syndrome or Persistent Vegetative State (PVS)				✓
24	Alzheimer's Disease				✓
25	Parkinson's Disease				✓
26	Aplastic Anaemia				✓
27	Loss of independent Existence (cover up to Insurance age 74)				✓
28	Brain Surgery				✓
29	Cardiomyopathy				✓
30	Muscular Dystrophy – Resulting in Permanent loss of Physical abilities				✓
31	Poliomyelitis				✓
32	Medullary Cystic Disease				✓
33	SLE with Lupus Nephritis (Systematic lupus Eryth. with Renal Involvement)				✓

The definitions of Critical Illness events are mentioned in Appendix 1 mentioned at the end of this

Upon occurrence of insured event(s), respective insured amount(s) shall be payable subject to maximum 100% of the Rider Sum Assured and the respective insured event(s) shall terminate thereafter. Further, the cover shall continue to remain inforce for other active Insured Event(s), if any.

Maturity Benefit – No maturity benefit is payable under this plan.

Surrender Benefit – In case of surrender of the Policy, no benefit is payable.

The Rider Contract can be surrendered either by the Master Policyholder or the Member.

In case the Member of the Master Policy surrenders the Rider Contract, the policy will terminate and no surrender value will be payable.

In case the Master Policyholder surrenders the Rider Contract, the Members of the Group will be given the option to continue Rider cover till the end of the Coverage Term. The option to continue the cover will be applicable only to those schemes where the premium is paid by the members provided the Member Base Policy is in force.

If the Member chooses to continue the Rider Contract upon Surrender of the Rider Contract by the Master Policyholder, then this needs to be specifically communicated to the Company by the Master Policyholder or the Member and will be effective only upon acceptance of the same by the Company.

Paid-Up - Not Applicable.

Types of groups eligible for insurance under this plan:

- The product intends to cover employer – employee groups where the premium is being borne by employer / Master Policy Holder or Non employer- employee groups.

Eligibility Criteria

Bharti Axa Life Non Linked Group Complete Shield Rider											
Minimum Entry Age	18 years										
Maximum Entry Age	79 years for ADB, ATPD, APPD 65 years – for others										
Maturity Age	Minimum: 19 years Maximum: 80 years										
Minimum Sum Assured	Rs.10,000 per member										
Maximum Sum Assured	No Limit, Subject to Board Approved Underwriting Policy										
Policy Term	1 month - 1 year (annually renewable)										
Premium Payment Term	One Year Renewable Term										
Minimum Group Size	5 members at inception of the policy (across all options)										
Mode (Frequency)	<table border="1"> <thead> <tr> <th>Frequency</th> <th>Modal Factors</th> </tr> </thead> <tbody> <tr> <td>Annual</td> <td>1</td> </tr> <tr> <td>Semi-Annual</td> <td>0.51</td> </tr> <tr> <td>Quarterly</td> <td>0.26</td> </tr> <tr> <td>Monthly</td> <td>0.0867</td> </tr> </tbody> </table>	Frequency	Modal Factors	Annual	1	Semi-Annual	0.51	Quarterly	0.26	Monthly	0.0867
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Monthly	0.0867										

Minimum Premium	The minimum premium shall be Rs.1 for each variant#
Maximum Premium	Maximum premium is subject to maximum Sum Assured.

* All ages mentioned are age last birthday.

The premium shall be subject to Board approved Underwriting policy.

(No new lives beyond 79 years age last birthday will be added to the group.)

A new member can join the group at any point during the policy term subject to the group policy being in force, eligibility criteria as defined above, and underwriting requirements as prescribed by the Company from time to time.

Notes:

- Transgender rates follow male rates. Any additional underwriting criteria for transgender lives shall be as per the Board Approved Underwriting Policy (BAUP).
- The maximum Rider Sum Assured shall comply with the IRDAI Master Circular on Life Insurance Products and any subsequent changes as applicable.
- In case of multiple riders, the cumulative premium should not exceed 100% of the base premium
- The Premium Payment Term of rider shall not exceed the outstanding Premium Payment Term of base plan.
- Similarly, Cover Term of rider cannot exceed the outstanding Policy Term of base plan.

Terms and conditions

Free Look period

i. From the date of receipt of the insurance policy having policy term of one year or more, a Master Policyholder or Member will have 30 days called as “Free Look period” for reviewing the terms and conditions of the policy.

ii. In case the Master Policyholder or Member is not satisfied with policy terms or conditions, he/she has the option to return the policy within these 30 days period to the insurer for cancellation.

iii. Irrespective of the reasons mentioned, insurer must accept the request of the Master Policyholder or Member to exercise the option of free look cancellation.

iv. The Master policyholder or Member shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges. All rights under this Policy shall stand extinguished immediately on the cancellation of the Policy under the free look option.

If the Policy is opted through Insurance Repository (IR), the computation of the said Free Look Period will be as stated below: -



For existing e-Insurance Account: For the purpose of computation of commencement of free look period, the date of delivery of email confirming the credit of the insurance policy by IR shall be reckoned as the starting date.

For New e-Insurance Account: If an application for e-Insurance Account accompanies the proposal for insurance, the date of receipt of the 'welcome kit' from the IR with the credentials to log on to the e-Insurance Account (e IA) or the delivery date of the email confirming the grant of access to the eIA or the delivery date of the email confirming the credit of the Insurance policy by the IR to the eIA, whichever is later shall be reckoned for the purpose of computation of the free look period.

Grace Period

A grace period of 30 days from the premium due date will be allowed for all premium payment modes except monthly mode and in case of monthly mode, a grace period of 15 days from the premium due date will be allowed for payment of premiums.

During the grace period, the policy is considered to be in-force including risk cover under the Rider.

Lapsation

If the Premium/s is/are not paid on the due date/s or during the grace period, the Policy shall lapse (with effect from the date of first unpaid premium). Lapse of the Policy shall extinguish all rights and benefits of the Master Policyholder and the Insured Member(s) under the Policy.

Revival of the Lapsed Policy (Applicable for Non-Annual modes)

The revival shall be as per the Board Approved Underwriting Policy. A Policy, which has lapsed for non-payment of the premiums, may be revived for full benefits under the policy subject to the following conditions:

- The application for revival is made within 90 days of the first unpaid premium or before the next Annual Renewal Date of the Policy, whichever is earlier
- Satisfactory evidence of insurability of the Insured Member(s) is produced
- Payment of an amount equal to all unpaid premiums
- The Company will not be liable to pay for any death claims which occurs due to death of Insured Member(s) while the Master Policy is in lapsed status

The effective date of Revival is the date on which the above conditions are satisfied and the risk is accepted by the Company. We reserve the right to Revive the Master Policy at the original terms, revive with modified terms or decline the Revival of the Master Policy, in accordance with the Our board approved underwriting policy. The Revival will take effect only on it being specifically communicated by the Company.

Termination of Master Policy

The Master Policy shall terminate on the occurrence of the earliest of the following:

- a) On payment of Free Look cancellation
- b) if the lapsed Master Policy has not been revived
- c) at the end of Policy Term
- d) at the Annual Renewal Date if Master Policy is not renewed
- e) You may terminate this Master Policy by giving Us at least 30 days notice
- f) Non -payment of the Premium within the grace period

Termination of coverage

The Coverage of an Insured Member under the Policy shall terminate on the Termination Date which will be on the date of occurrence of the earliest of any of the following events:

- a) On completion of Coverage Term/expiry date
- b) On death of Insured Member / Payment of the rider benefit
- c) On payment of Free Look cancellation
- d) The date Insured Member ceases to be an eligible member of the group
- f) On Annual Renewal Date, if Insured Member Age exceeds at the maximum maturity age as per the Master Policy Document
- e) The date on which Master Policy is terminated or is lapsed
 - f) Exclusions as defined specifically pertaining to rider benefit, if any.
- g)

If the in-force Master Policy is terminated by the Master Policyholder before the Annual Renewal Date, unexpired Premium (excluding taxes) shall be refunded without interest to the Master Policyholder.

Closure of Policy to new members:

The Master Policyholder or the Insurer will be entitled to terminate the Policy by providing prior written notice of atleast 30 days, stating its intent to terminate the policy, in which case the Master Policy will stand terminated and will close to new members.

Any unexpired premium shall be payable to the Master Policyholder or the members in the proportion in which the premium was paid. The cover under the Master Policy shall cease to exist.

Tax Benefit

Tax benefits may be applicable as per prevailing tax laws.

Addition of Member:

The Master Policyholder can choose to add new Members by paying the Premium for such Member. The Master Policyholder should inform or intimate the Company with the list of new joiners preferably within 30 days from the date of new joiners becoming eligible to be admitted under this Master Policy. The Risk Commencement Date for the new joiners shall be the date of joining of the Eligible Member, provided that their details are intimated to the Company within 30 days and due premium in full is paid in advance. If such intimation is not given to the Company within the above-mentioned period of 30 days, the life cover

under this Policy shall not extend to such new employees, unless the same is specifically approved in writing by the Company. The Company shall communicate its decision on addition of Eligible Member based on its then prevailing underwriting policy. In case of inadequate Premium, the Insurance Coverage will begin from the date of receipt of the full Premium. Premium shall be deposited in advance for addition of new Members. The Premium charged shall be proportionate to the unexpired duration of the Policy Year, as applicable. Any applicable levies, taxes, duties or surcharges will also be charged.

Deletion of Member:

In case a Member leaves the scheme during the Member Coverage Term (due to reasons other than death), where Master Policyholder has paid the Premium, the Company will refund the pro- rata Premium to the Master Policyholder. The Master Policyholder should inform the Company of deletions for Members leaving the scheme within 30 days. Such Members' Insurance Coverage will cease from the date of leaving the scheme.

Advance Deposit:

The Master Policyholder can keep adequate advance deposit, to cover the premium requirements of new members expected to join the scheme during the year.

Based on Master Policyholders choice, all mid-year deletion refund can be deposited in the advance deposit or will be refunded back to Master Policyholder.

Where the Master Policyholder decides not to keep such advance deposit, all mid-year additions will be covered only after the premiums for them are received and refunds for mid-year deletions will be refunded back to the Master Policyholder.

Other Terms & Conditions

1. The rider will be customized based on the scheme level underwriting, wherever appropriate.
2. The maximum maturity age, and the maximum and minimum entry ages may vary based on scheme within the limits as mentioned under eligibility criteria above.
3. Insurance cover would commence only after acceptance of risk by Bharti AXA Life & receipt of full premium.

Claims process

The Beneficiary/ (ies) should report the claim to the Master Policyholder on occurrence of unfortunate death of Insured Member and following primary documents along with the written notice for processing the claim should be submitted:

- Copy of Death Certificate
- Copies of medical reports, if any
- Death Claim Form (to be jointly signed by nominee(s)/ beneficiary(ies) and Master Policyholder and submitted by the Master Policyholder in case of lender borrower group);
- Any other documentation that the Company may consider as material and relevant to the claim

Please note the above is not an exhaustive list and additional documents may be required / as may be demanded by the Company depending on the circumstances of death and validity of the claim.

The Company reserves the right to call for any additional information and documents required to satisfy itself as to the validity of the claim.

Suicide Claim Provision

Not applicable under this product

Survival Period

A survival period of 30 days from the diagnosis and fulfillment of the Insured Event(s) is applicable where the member must survive the survival period for the benefit to be paid. The Company may waive off the Survival Period basis the risk assessment of the specified scheme. The Survival Period is only applicable under Critical Illness based Insured Event(s).

Waiting period

A waiting period of 90 days may be applicable under both Accelerated Critical Illness and Additional Critical Illness benefit options. In case the Member is diagnosed with any of the covered Critical Illness during this period, no benefit shall be payable. The Company shall refund the premium applicable and the Member Rider policy will terminate with all rights and benefits thereunder.

No waiting period applies for Critical Illness claims arising solely due to an accident.

Waiting Period will not be applicable on consecutive renewal of the Rider Cover for the Member with the Company. Waiting Period can be waived off to the extent of waiting period already served, in case wherein the Master Policyholder is transferring the covered Members from other policy with CI cover to this Master Rider Policy. In case there is a break in cover on account of any reason, waiting period will be applicable from the date of commencement of cover, post the break in cover. The Company may waive off the Waiting Period basis the risk assessment of the specified scheme.

The definitions applicable for the rider benefit option -

Definitions and Exclusions – Critical Illness Benefits

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 leukaemia 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 SPECIFIED SEVERITY)

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

- 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. 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.

Excluded are:

Angioplasty and/or any other intra-arterial procedures

4. 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.

5. 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 from alcohol or drug abuse is excluded.

6. Kidney Failure Requiring Regular Dialysis

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

7. Stroke resulting in permanent symptoms

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

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

8. Major Organ /Bone Marrow Transplant

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 hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

- i. Other stem-cell transplants
- ii. Where only Islets of Langerhans are transplanted

9. 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.

10. 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.

11. 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 is excluded.

12. Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist:

- 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:

- a. 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.

13. Blindness

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

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.

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

14. 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 90decibels across all frequencies of hearing" in both ears.

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 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 ($\text{PaO}_2 < 55\text{mmHg}$); 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:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

17. **Loss of Speech**

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the Vocal Cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

18. **Major Head Trauma**

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

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

The Activities of Daily Living are:

- 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.

The following are excluded:

- a. Spinal cord injury.

19. Primary (Idiopathic) Pulmonary hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

- 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.

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.

20. 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.

21. 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:

1. Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts)
2. Surgery of the aorta related to hereditary connective tissue disorders (e.g., Marfan syndrome, Ehlers–Danlos syndrome)
3. Surgery following traumatic injury to the aorta.

22. Apallic Syndrome or Persistent Vegetative State (PVS)

A 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:

1. Complete unawareness of the self and the environment
2. Inability to communicate with others.
3. No evidence of sustained or reproducible behavioral responses to external stimuli
4. Preserved brain stem functions.
5. Exclusion of other treatable neurological or psychiatric disorders with appropriate neurophysiological or neuropsychological tests or imaging procedures.
6. 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.

23. **Alzheimer's Disease**

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

1. 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.
2. Personality change
3. Gradual onset and continuing decline of cognitive functions
4. No disturbance of consciousness
5. Typical neuropsychological and neuroimaging findings (e.g., CT scan)

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.

For the above definition, the following are not covered:

- Other forms of dementia due to brain or systemic disorders or psychiatric conditions

24. **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:

1. Muscle rigidity
2. Tremor
3. Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses)

Idiopathic Parkinson's disease must cause neurological deficit resulting [before age 65] in the permanent and irreversible inability of the Life Assured to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 6 months despite adequate drug treatment.

Activities of Daily Living are:

1. 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.
2. 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.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. 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.

For the above definition, the following are not covered:

1. Secondary parkinsonism (including drug- or toxin-induced parkinsonism)
2. Essential tremor
3. Parkinsonism related to other neurodegenerative disorders.

25. **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:

1. Bone marrow stimulating agents.
2. Immunosuppressant
3. Bone marrow transplantation

The diagnosis must be confirmed by a Consultant Haematologist and evidenced by bone marrow histology. Temporary or reversible aplastic anemia is excluded and not covered in this Policy.

26. Loss of independent Existence (cover up to Insurance age 74)

Inability to perform at least three (3) of the “Activities of Daily Living” as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word “permanent” shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor.

Only Life assured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

Activities of daily living:

- i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
- 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 lying position in a bed to a sitting position in an upright chair or wheelchair and vice versa; The ability to move from a bed to an upright chair or wheelchair and vice versa;
- iv. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
- vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

27. Brain Surgery

The actual undergoing of surgery to the brain under general anesthesia during which a Craniotomy with removal of bone flap to access the brain is performed.

The following are excluded:

- a. Burr hole procedures, trans-phenoidal procedures and other minimally invasive procedures such as irradiation by gamma knife or endovascular embolisations, thrombolysis and stereotactic biopsy, and,
- b. brain surgery as a result of an accident.

The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

28. **Cardiomyopathy**

A definite diagnosis of one of the following primary cardiomyopathies:

1. Dilated Cardiomyopathy
2. Hypertrophic Cardiomyopathy (obstructive or non-obstructive)
3. Restrictive Cardiomyopathy
4. Arrhythmogenic Right Ventricular Cardiomyopathy

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

1. Left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months.
2. 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.
3. 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 or cardiac MRI. The implantation of an Implantable Cardioverter Defibrillator (ICD) must be determined by a Consultant Cardiologist.

For the above definition, the following are not covered:

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

29. **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.

30. **Muscular Dystrophy – Resulting in Permanent loss of Physical abilities**

A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle without involvement of the nervous system.

The diagnosis must be confirmed by a company appointed Registered Medical Practitioner who is a neurologist based on all the following conditions:

1. Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction.
2. Characteristic Electromyogram; or
3. Clinical suspicion confirmed by muscle biopsy.

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:

1. 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.
2. 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.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. 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.

31. **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:

- Poliovirus infections without paralysis
- Other enterovirus infections
- Guillain-Barré syndrome or transverse myelitis

32. **Medullary Cystic Disease**

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

1. Ultrasound, MRI or CT scan showing multiple cysts in the medulla and corticomedullary region of both kidneys.
2. Typical histological findings with tubular atrophy, basement membrane thickening and cyst formation in the corticomedullary junction.
3. Glomerular filtration rate (GFR) of less than 40 ml/min (MDRD formula)
4. The diagnosis must be confirmed by a Consultant Nephrologists.

For the above definition, the following are not covered:

1. Polycystic kidney disease
2. Multisystem renal dysplasia and medullary sponge kidney
3. Any other cystic kidney disease

33. **SLE with Lupus Nephritis (Systematic lupus Eryth. with Renal Involvement)**

The Systemic Lupus Erythematosus (SLE) is a systemic autoimmune disease. It can affect any part of the body. The immune system erroneously attacks the body's cells and tissue resulting in inflammation and damage. It can be diagnosed by typical laboratory findings and associated symptoms, the so-called

butterfly rash being the most known, and has to be treated with corticosteroids or other immunosuppressants.

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

1. Typical laboratory findings, such as presence of antinuclear antibodies (ANA) or anti-dsDNA antibodies
2. Symptoms associated with lupus erythematosus (butterfly rash, photosensitivity, serositis)
3. Continuous treatment with corticosteroids or other immunosuppressants

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

1. Lupus nephritis with proteinuria of at least 0.5 g/day and a Glomerular filtration rate of less than 60 ml/min (MDRD formula)
2. Libman-Sacks endocarditis or myocarditis
3. Neurological deficits or seizures over a period of at least 3 months and supported by cerebrospinal fluid or EEG findings. Headaches, cognitive and psychiatric abnormalities are specifically excluded.

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

The other form of lupus erythematosus the Discoid lupus erythematosus or subacute cutaneous lupus erythematosus or a lupus erythematosus that is drug-induced are not covered.

The following will be the exclusions under respective riders

Permanent Exclusions

The company shall not be liable to make any payment under this Policy towards the insured event, caused by, based on, arising out of or howsoever attributable to any of the following:

1. Pre-existing conditions during waiting period.
2. Self-inflicted injuries, substance abuse, war, nuclear risks.
3. Non-disclosure or misrepresentation

Any other restrictions shall be as per Board Approved Underwriting Policy.

Grievance Redressal

1. Customer Service

You can seek clarification or assistance on the Policy from the following:

- The Advisor through whom the Policy was bought
- The Customer Service Representative of the Company at toll free no. 1800 102 4444
- WhatsApp us 'Hi' at 02248815768
- SMS "SERVICE" to 56677
- Email: service@bharti-axa.com
- Mail to: Customer Service

Bharti AXA Life Insurance Company Ltd.

Spectrum tower, 3rd Floor,

Malad link road, Malad (west),

Mumbai 400064. Maharashtra

2. Grievance Redressal Procedure

Step 1: Inform us about your grievance



In case you have any grievance, you may approach our Grievance Redressal Cell at any of the below-mentioned helplines:

Lodge your complaint online at www.bharti.axa.com

Call us at our toll free no. 1800 102 4444

Email us at complaints.unit@bharti.axa.com

Write to us at:

Registered Office:

Bharti AXA Life Insurance Company Ltd.
Unit No. 1902, 19th Floor, Parinee Crescenzo
'G' Block, Bandra Kurla Complex, BKC Road,
Behind MCA Ground, Bandra East,
Mumbai -400051, Maharashtra

Grievance Redressal Cell

Bharti AXA Life Insurance Company Ltd.
Spectrum tower, 3rd Floor,
Malad link road, Malad (west),
Mumbai 400064. Maharashtra'

- Visit our nearest branch and meet our Grievance Officer who will assist you to redress your grievance/ lodge your complaint.

Step 2: Tell us if you are not satisfied

In case you are not satisfied with the decision provided or if you have not received any response post completion of 14 days, you may write to Head - Customer Service for resolution at the above mentioned address or email at: head.customerservice@bharti.axa.com:

You are requested to inform us about your concern (if any) within 8 weeks of receipt of resolution as stated above, failing which it will be construed that the complaint is satisfactorily resolved.

If you are not satisfied with the response or do not receive a response from us within 14 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority (IRDA of India) of India on the following contact details:

IRDA of India Grievance Call Centre (IGCC) TOLL FREE NO:155255 or 18004254732

Email ID: complaints@irda.gov.in

You can also register your complaint online at <https://bimabharosa.irdai.gov.in/>

Address for communication for complaints by paper:

General Manager

Insurance Regulatory and Development Authority of India(IRDAI)

Policyholder's protection & Grievance Redressal Department – Grievance Redressal Cell.

Sy.No.115/1, Financial District, Nanakramguda,

Gachibowli, Hyderabad – 500 032.

Step 3: If you are not satisfied with the resolution provided by the Company

Where the redressal provided by the Company is not satisfactory despite the escalation above, the customer may represent the case to the Ombudsman for Redressal of the grievance.

For preferring a complaint before the Insurance Ombudsman, you may prefer to Insurance Ombudsman Rule, 2017(as may be amended from time to time).

To locate the nearest Ombudsman office, please visit <https://www.cioins.co.in/Ombudsman> or you may also locate the list our website - <https://www.bharti.axa.com>

Assignment and Nomination

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

Nomination: Nomination shall be in accordance with the provisions of sec 39 of the Insurance Act 1938 as amended from time to time.

SECTION 41 OF 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 prospectus 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 INSURANCE ACT 1938 as amended from time to time

Fraud, Misstatement or suppression of material fact, would be dealt with in accordance with provisions of Sec 45 of the Insurance Act 1938 as amended from time to time. ***[A Leaflet containing the simplified version of the provisions of Section 45 is enclosed in appendix – I for reference]***

About Us

Bharti AXA Life Insurance Company Limited is a wholly owned subsidiary of Bharti Life Ventures Private Limited (Bharti Group Company), a business group in India with interests in telecom, agri business and retail.

As we further expand our presence across the country with a large network of distributors, we continue to provide innovative products and service offerings to cater to specific insurance and wealth management needs of customers. Whatever your plans in life, you can be confident that Bharti AXA Life will offer the right financial solutions to help you achieve them.

Disclaimers

- Riders are not mandatory and are available for a nominal extra cost
- Bharti AXA Life Insurance is the name of the Company and Bharti AXA Life Non Linked Group Complete Shield Rider is only the name of the non-linked non-participating group health insurance rider and does not in any way represent or indicate the quality of the policy or its future prospects.
- This rider brochure is indicative of the terms, conditions, warranties and exceptions contained in the insurance policy bond
- Tax benefits are as per the Income Tax Act, 1961, and are subject to any amendments made thereto from time to time



Bharti AXA Life Insurance Company Limited, IRDAI Registration No.: 130

Bharti AXA Life Insurance Company Limited, IRDAI Registration No.: 130 dated 14/07/2006 [Life Insurance Business]

Registered Office: Unit No. 1902, 19th Floor, Parinee Crescenzo, 'G' Block, Bandra Kurla Complex, BKC Road, Behind MCA Ground, Bandra East, Mumbai -400051, Maharashtra



UIN: 130B035V01

CIN - U66010MH2005PLC157108

ADVT No.: II-Mar-2026-5945

BEWARE OF SPURIOUS/ FRAUD PHONE CALLS

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

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

Provisions regarding Policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

01. No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 yrs from

- a. the date of issuance of Policy or
- b. the date of commencement of risk or
- c. the date of reinstatement of Policy or
- d. the date of rider to the Policy

whichever is later.

02. On the ground of fraud, a Policy of Life Insurance may be called in question within 3 years from

- a. the date of issuance of Policy or
- b. the date of commencement of risk or
- c. the date of reinstatement of Policy or
- d. the date of rider to the Policy

whichever is later.

For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

03. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance Policy:

- a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
- b. The active concealment of a fact by the insured having knowledge or belief of the fact;

- c. Any other act fitted to deceive; and
 - d. Any such act or omission as the law specifically declares to be fraudulent.
04. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
05. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Policyholder, if alive, or beneficiaries.
06. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which Policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the Policy of life insurance is based.
07. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on Policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.
08. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance Policy would have been issued to the insured.
09. The insurer can call for proof of age at any time if he is entitled to do so and no Policy shall be deemed to be called in question merely because the terms of the Policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Ordinance, 2014 and only a simplified version prepared for general information. Policy Holders are advised to refer to Original Ordinance Gazette Notification dated December 26, 2014 for complete and accurate details.]