A Non-Linked, Non-Participating Individual Rider (attachable to Unit Linked products)

1. Part A

Forwarding Letter

As per Base Policy

1.1. Rider Policy Preamble

Rider Policy Terms & Conditions and Privileges within referred to

This Rider Policy Document is the evidence of the contract between Reliance Nippon Life Insurance Company Limited (hereinafter called "Company") and the Policyholder referred to below. The terms listed in Part B (Definitions) of this Rider Policy Document and which have been used elsewhere in the Policy Document in Initial Capital letters shall have the meaning set out against them in Part B, wherever they appear in the Rider Policy Document.

The Company agrees to pay the Benefits, as stipulated in the Base Policy Schedule to the Claimant on the basis of the statements, Proposal, declarations and Premium along with taxes as applicable from the Policyholder on the assurance that the Policyholder has agreed to all the Policy Terms & Conditions referred to in this Rider Policy Document. The Benefits shall be paid as stipulated in the Rider Policy Document. The Claimant needs to submit applicable documents to the Company for claiming the Benefit.

It is hereby further agreed that this Rider Policy shall be subject to the terms, conditions and Exclusions in this Rider Policy Document and that the Base Policy Schedule and every endorsement placed on Base Policy by the Company shall be deemed to be a part of this Rider Policy Document.

This Rider is not a stand-alone insurance product and is available only with Base insurance products. This Rider Policy Document should be read in conjunction with the Base Policy Document.

Policy Schedule – Reliance Nippon Life Critical Illness Plus Rider

As per Base Policy

Key Feature Document

This is an optional critical illness rider benefit that can be opted along with the Base Policy either at the time of purchase of the Base Policy or on any subsequent policy anniversary subject to meeting the minimum policy conditions applicable for this rider. The rider benefit provides for financial compensation, in the event of life insured being diagnosed with any of the covered 25 critical illnesses. The Policyholder will have to pay additional premium in addition to Base Policy premium if the rider benefit has been opted.

Critical Illness Benefit	The rider provides a lumpsum amount equal to Rider Sum Assured, which is payable, if the life assured survives for a period of 30 days following Diagnosis of any one of the covered 25 critical illnesses with fulfilment of covered critical illness definition, subject to the rider benefit being In-force i.e. all due premiums under the rider benefit have been paid. The benefit under this rider will cease after a claim under this rider is paid. If the Base Policy to which the rider is attached is surrendered or terminated, the rider benefit will also be terminated and the exit value, if any, shall be paid in respect of the rider benefit. If the policyholder voluntarily opts to discontinue the rider benefit and terminate it prior to completion of Rider Policy Term, the exit value, if any, shall be paid and the rider benefit shall be terminated.
Waiting Period	A Waiting Period of 90 days is applicable from the date of commencement of rider risk and from the date of revival for every subsequent revival during the Rider Policy Term. No Benefits shall be payable on Diagnosis of the critical illnesses during this Waiting Period.

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2. Part B

2.1. Definitions

"**Annualised Premium**" means the premium payable in a year chosen by the Policyholder, excluding the taxes, any underwriting extra premiums and loadings for modal premiums, if any

"Assignment" is the process of transferring the rights and benefits to an Assignee. Assignment should be in accordance with the provisions of Section 38 of Insurance Act, 1938 as amended from time to time.

"**Benefits**" means the critical illness benefit, as per the Rider Terms and Conditions

"Diagnosis" means a process of determining by examination of the causes of illnesses. It is an investigative analysis made by a physician based upon various medical tests including but not limited to radiological, clinical, and histological or laboratory tests acceptable to the Company. In the event of any doubt regarding the appropriateness or correctness of the Diagnosis, We will have the right to call for the Life Insured's examination and/or the evidence used in arriving at such Diagnosis, by a Medical Practitioner or an independent expert selected by Us. The opinion of such an expert as to such Diagnosis shall be binding on both You and Us.

*"***Free look/Free look cancellation of the Policy***"* means where the Policyholder disagrees to any of the Policy Terms and conditions stipulated in this Policy Document within the specified time period, he/she may cancel the Policy by returning it to the Company stating the reasons for his/her objections

"**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

"**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:
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

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

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

"**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 member of the family.

"**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 or
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

"**Rider Premium Payment Term"** means the period or the term during which the Policyholder is required the pay the premium for this Rider to the Company.

"**Rider Sum Assured"** means the Sum Assured opted by the Policyholder for this Rider as specified in the Policy Schedule for the Base Policy.

"Rider Term/Rider Policy Term" means entire term opted for this rider as specified in the Policy Schedule for the Base Policy.

"**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.

"**Total Rider Premiums Paid**" means total of all premiums received excluding any extra premium and taxes

"**Waiting Period**" means the time period within which no Policy claims are admissible. Waiting period of 90 days from the date of commencement of rider risk and from the date of revival for every subsequent revival during the Rider Policy Term is applicable under the Policy.

The Terms not defined here, shall have the same meaning, as defined in the Base Policy.

3. Part C

3.1. Key Benefits

3.1.1. Critical Illness Benefit

The rider provides a lumpsum benefit, which is payable, if the life assured survives for a period of 30 days following Diagnosis of any one of the covered 25 critical illnesses with fulfilment of covered critical illness definition, subject to the rider benefit being In-force i.e. all due premiums under the rider benefit have been paid. A Waiting Period of 90 days from the date of commencement of rider risk and from the date of revival for every subsequent revival during the Rider Policy Term, will be applicable. No Benefits shall be payable on Diagnosis of the covered critical illnesses during this Waiting Period.

If the Diagnosis is made within the Rider Policy Term and however the survival period crosses the end point of Rider Policy Term, a valid claim arising as a result of such a Diagnosis shall not be denied.

The benefit under this rider will cease after a claim under this rider is paid or at the end of the Rider Term, whichever is earlier. If the Base Policy to which the rider is attached is surrendered or terminated, the rider benefit will also be terminated and the exit value, if any, shall be paid in respect of the rider benefit. If the policyholder voluntarily opts to discontinue the rider benefit and terminate it prior to completion of Rider Policy Term, the exit value, if any, shall be paid and the rider benefit shall be terminated.

The list of critical illnesses covered under the rider are as below:-

1.	Cancer of specified severity	14.	Benign Brain Tumour
2.	Open chest CABG	15.	Motor Neuron disease with permanent symptoms
3.	Myocardial Infarction (first heart attack of specific severity)	16.	End Stage Lung Failure
4.	Stroke resulting in permanent symptoms	17.	End Stage Liver Failure
5.	Kidney failure requiring regular dialysis	18.	Aplastic Anaemia
6.	Major Surgery of Aorta	19.	Systemic Lupus Erythematosus with Lupus Nephritis
7.	Open heart replacement or repair of heart valves	20.	Alzheimer's disease (before age 61)
8.	Major organ /bone marrow transplant	21.	Parkinson's disease (before age 61)
9.	Permanent paralysis of limbs	22.	Major head trauma
10.	Blindness	23.	Loss of speech
11.	Coma of specified severity	24.	Primary (idiopathic) Pulmonary Hypertension
12.	Third degree burns	25.	Apallic syndrome
13.	Multiple sclerosis with persisting symptoms		

A comprehensive list of definitions of each of the above critical illness and the relevant exclusions are covered in Appendix A.

3.1.2. Death Benefit

There is no death benefit under this rider.

3.1.3. Maturity Benefit

There is no maturity benefit under this rider.

3.2. Premium Details

3.2.1. Payment of Premium

- Rider premium is payable over and above the premium under the Base Policy and shall be paid along with the premium under the Base Policy
- Rider can be attached on commencement of the Base Policy or on any subsequent policy anniversary subject to 5 years as minimum outstanding Policy Term of the Base Policy
- Addition of the rider will be subject to underwriting, the outstanding Policy Term and Premium Payment Term of the Base Policy
- Premium payment frequency and mode of the Rider shall be same as Premium payment frequency and mode of the Base Policy.
- There is no frequency loading applicable on rider premium
- Rider Term can be less than or equal to the Policy Term of the Base Policy, subject to maximum maturity age of 75 and the maximum term allowed under the rider. If the entry age plus Base Policy Term is beyond age 75, the rider would be of term 75 less entry age, subject to the maximum policy term allowed under the rider. The rider shall not be offered if the outstanding Policy Term under the Base Policy is less than 5 years.
- Rider Premium Payment Term can be less than or equal to the Premium Payment Term of the Base Policy.
- The rider premium shall not exceed 100% of the premium under the Base Policy in compliance with the IRDAI (Protection of Policyholders Interest) Regulations, 2017.
- Taxes (along with cess) at the rate as declared by the Government from time to time shall be collected along with the rider premium.
- The Rider Sum Assured shall not exceed the sum assured on death under the Base Policy
- The premium rates under the rider are guaranteed for an initial period of fifteen years from commencement of the rider policy and are reviewable thereafter subject to IRDAI approval. Any revision in the premium rates shall be notified to the Policyholder at least three months prior to date of such revision. The review in premium rates shall be in compliance with regulation 6 of IRDA (Health Insurance) Regulations, 2016.

3.2.2. Grace Period

The grace period will be same as applicable for the Base Policy.
In case of a claim arising during the grace period, the eligible benefit amount will be paid to the claimant after deducting the due unpaid premium for that policy year.

4. Part D

4.1. Free Look

In the event, You are in disagreement with the terms and conditions stipulated in the Policy Document, You may opt out of this Policy, by stating the reasons of Your disagreement in writing and return the Policy to the Company within 15 days (30 days of receipt, where the if Policy has been obtained through Distance Marketing* channel) of its receipt, for cancellation. You are requested to take appropriate acknowledgement of Your request letter and return of Policy. In which event, the Company will refund the premium paid subject to a deduction of a proportionate risk premium for a period of cover less expenses incurred by the Company on Your medical examination, if any, and stamp duty charges.

Please note that if the Policy is opted through Insurance Repository ('IR'), the computation of the said Free Look Period will be from the date of the email informing Policy credit in IR.

Any request received for Free Look cancellation of the Policy shall be processed and premium refunded within 15 days of receipt of the request.

*Distance Marketing includes every activity of solicitation (including lead generation) and sale of insurance products through the following modes:

(i) Voice mode, which includes telephone-calling:
(ii) Short Messaging services (SMS):
(iii) Electronic mode which includes e-mail, internet and interactive television (DTH):
(iv) Physical mode which includes direct postal mail and newspaper & magazine inserts; and
(v) Solicitation through any means of communication other than in person.

4.2. Premium Discontinuance

If the Policyholder discontinues the payment of premiums, the plan provides non-forfeiture Benefits as described below:

4.2.1. Lapse

The rider benefit shall lapse if due premiums are not received before expiry of grace period.

No rider benefit shall be payable in lapse status. In case rider benefit is not revived within the revival period, the rider benefit shall be terminated. and the exit value (in respect of the rider benefit), if any, shall be payable.

4.2.2. Exit Value

If the Base Policy to which this rider is attached is lapsed or surrendered, the rider benefit will be lapsed and the exit value, if any, shall be payable as per the table below. The rider benefit will be terminated once the exit value is paid. If the Policyholder voluntarily opts to discontinue the rider Benefit and terminate it prior to completion Rider Policy Term, the exit value, if any, shall be paid and the rider Benefit shall be terminated.

Premium Payment type	When is it payable	Exit Value
Regular Premium Payment	No benefit payable	No benefit payable

Limited Premium Payment	Exit value shall be payable if at least 3 full year's rider premium have been paid	75% multiplied by Total Rider Premiums Paid multiplied by (1 minus Rider Premium Paying Term divided by Rider Policy Term) multiplied by (outstanding Rider Term divided by Rider Term)

4.2.3. Policy Revival

Rider benefit can be revived during the revival period as applicable to the Base Policy by paying the arrears of premiums along with interest at prevailing rate of interest, subject to satisfactory evidence of continued insurability based on Company's Board Approved Underwriting Policy. Prevailing interest rate applicable on revival shall be equal to 10 year benchmark G-sec interest rate as on last working day of previous financial year, rounded up to the nearest multiple of 25 basis points. The prevailing rate of interest on revival for FY20-21 is 6.25% p.a.

The Company reserves the right to revise the applicable interest rate less frequent than annual subject to IRDAI approval. Revival will be based on the Board Approved Underwriting Policy of the Company. All terms and conditions applicable under the Base Policy shall be applicable to this rider. The revival of this rider shall take effect only if the Base Policy is in full force or it has been revived.

5. Part E

Not Applicable

6. Part F

6.1. General Terms and Conditions

Please refer Base Policy Document for common Terms & Conditions applicable on this Rider. Such general/common Terms & Conditions shall be deemed part of Rider Policy Document also and shall have effect accordingly. Terms & Conditions contained under Part F of the Base Policy Document shall apply to this Rider Policy Document.

6.2. Claims

On Diagnosis of any one the covered 25 critical illnesses of the Life Insured, the Claimant should intimate the Company in writing within 60 days, from the date of Diagnosis. The claim shall be payable on survival of the life insured for 30 days after diagnosis of any of the covered critical illness with fulfilment of covered critical illness definition, subject to the rider benefit being In-force i.e. all due premiums under the rider benefit have been paid.

We shall be provided the following necessary information and documents of all claims of such Diagnosis or Surgery or treatment, as applicable:

List of documents required in the event of a claim for Critical Illness Benefit

a. Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
    i. Name of the Life Insured;
    ii. Name, date of occurrence and medical details confirming the event giving rise to the Claim.
    iii. Written confirmation from the treating Medical Practitioner that the event giving rise to the claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed by physician within 48 months prior to the effective date of the rider policy issued by the insurer or its reinstatement or for which Medical Advice or treatment was recommended by, or received from, a Physician within 48 months Prior to the effective date of the rider policy issued by the insurer or its reinstatement
b. Original and copy of Policy Document;
c. Duly completed claim form;
d. Original Discharge Certificate/Death Summary/Discharge Card from the Hospital/Medical Practitioner/Indoor case papers;
    i. Hospital Discharge Card photocopy
    ii. Hospital Bills photocopy
    iii. Pharmacy/Investigations Bills
    iv. Investigations Reports
    v. Details of the treatment received by the Insured Person from the inception of the ailment
    vi. Letter from treating consultant stating presenting complaints with duration and past medical history
    vii. Histopathology / Cytology / FNAC / Biopsy /Immuno- histochemistry reports
    viii. X-Ray / CT scan / MRI scan / USG /Radioisotope / Bone scan Reports
    ix. Blood Tests
    x. Any other specific investigation done to support the Diagnosis like the PAP Smear / Mammography, etc.
e. Photo ID Proof of Insured/ Nominee;
f. Address Proof of Insured / Nominee;
g. KYC documents and 2 recent coloured passport size photographs of Insured/ Nominee as per the Anti Money Laundering (AML) Guidelines of the Company
h. Signed NEFT mandate along cancelled cheque copy of Insured/Nominee

i. Any other documents as may be required by Us

In case of Diagnosis of any one the covered 25 critical illness in a jurisdiction outside India, We will honour the claim subject to providing satisfactory evidence of Diagnosis and treatment (if required) and submission of necessary information and documents of all claims of such Diagnosis or Surgery or treatment as applicable.
Company reserves the right to call for any additional / other document which may be relevant, including documents/ information concerning the title of the person claiming Benefits under this Policy, as may be required by the Company.
If the Claim is not notified to Us within the time period specified above, then We shall be provided the reasons for the delay in writing. We shall condone such delay on merits where the delay has been proved to be for reasons beyond the Claimant's control.
In the event of assignment under this Policy, the assignee would be entitled to the Benefits under the Policy, subject to Section 38 of Insurance Act, 1938 as amended from time to time or any further amendments affected by the IRDAI or other appropriate governmental authorities from time to time.
The Company shall settle the claim within 30 days (45 days in case of claim warranting an investigation) from the date of receipt of last necessary document in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016. In the case of delay in the payment of a claim, the Company shall pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

6.3. Nomination

Nomination for this Rider shall be as per the Nomination Schedule under the Base Policy as per Section 39 of the Insurance Act, 1938 as amended from time to time.

[A Leaflet containing the simplified version of the provisions of Section 39 is enclosed in Appendix – C for reference]

6.4. Assignment

Assignment should be in accordance with provisions of section 38 of the Insurance Act 1938 as amended from time to time.

[A Leaflet containing the simplified version of the provisions of Section 38 is enclosed in Appendix – D for reference]

Assignment will not be permitted if the Policy is issued under Married Women's Property Act, 1874.

6.5. Limitation of Liability

The maximum liability of the Company under this rider shall not, in any circumstances, exceed the aggregate amount of the relevant Benefits payable hereunder.

6.6. Exclusion

We shall not be liable to make any payment under this Policy towards a covered Critical resulting from or in respect of any of the following:

1. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy;
2. 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
   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 or its reinstatement.
3. Any Critical Illness caused due to treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

4. Any condition caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis.
5. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner,
6. Any Critical Illness caused due to intentional self-injury, suicide or attempted suicide
7. Any Critical Illness, caused by foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
8. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
9. Working in underground mines, tunneling or involving electrical installations with high tension supply, or as jockeys or circus personnel.
10. Congenital External Anomalies or any complications or conditions therefrom including any developmental conditions of the Insured.
11. Any Critical Illness caused by any treatment necessitated due to participation as a professional in hazardous or adventure sport, 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.
12. Participation by the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.
13. Any Critical Illness, caused by Medical treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Any Critical Illness due to miscarriages (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
14. Any Critical Illness, caused by any unproven treatment, service 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.
15. Any Critical Illness based on certification/diagnosis/treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for.
16. Any Critical Illness, caused due to any treatment, including surgical management, to change characteristics of the body to those of opposite sex.
17. Any Critical Illness, caused due to cosmetic or plastic surgery or any treatment to change the 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 considered a medical necessity, it must be certified by the attending Medical Practitioner.
18. Any Critical Illness, caused due to surgical treatment of obesity that does not fulfil all the below conditions:
    a) Surgery to be conducted is upon the advice of the Doctor
    b) The Surgery / Procedure conducted should be supported by clinical protocols
    c) The member has to be 18 years of age or older and
    d) Body Mass Index (BMI);
        1) greater than or equal to 40 or
        2) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
            i) Obesity related cardiomyopathy
            ii) Coronary heart disease
            iii) Severe Sleep Apnea
            iv) Uncontrolled Type 2 Diabetes
19. Any Critical Illness, caused due to treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reason.

20. Any Critical Illness, caused by treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
21. In the event of the death of the Insured Person within the stipulated survival period as set out above.
22. Any Critical Illness, caused by Birth Control, sterility and infertility. This includes:
    a) Any type of contraception, sterilization
    b) Assisted Reproductive services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c) Gestational Surrogacy
    d) Reversal of sterilization

6.7. Fraud Misstatement of a Material Fact and Forfeiture

In the event of a fraud, the Policy shall be cancelled immediately and all the premiums paid till date shall be forfeited, subject to fraud being established as per Section 45 of the Insurance Act, 1938, as amended from time to time. In the event of a misstatement or suppression of a material fact, not amounting to fraud, by the insured, the Policy shall be declared "Null and Void" and premiums paid shall be refunded, subject to misstatement or suppression of fact being established, in accordance with Section 45 of the Insurance Act, 1938, as amended from time to time. (Please refer to the simplified version of the provisions of Section 45 as mentioned in Appendix E for reference).

7. Part G

7.1. Grievance Redressal

Please refer Base Policy Document, for the Grievance Redressal procedure.

7.2. General Terms and Conditions

Please refer Base Policy Document for common Terms & Conditions applicable on this Rider. Such general/common Terms & Conditions shall be deemed part of Rider Policy Document also and shall have effect accordingly. Terms & Conditions contained under Part G of the Base Policy Document shall apply to this Rider Policy Document.

About Reliance Nippon Life Insurance Company Limited

Reliance Nippon Life Insurance Company Limited, is a licensed life insurance company registered with the Insurance Regulatory & Development Authority of India (IRDAI) Registration No. 121. Reliance Nippon Life Insurance Company Limited offers You products that fulfill Your savings and protection needs. Our aim is to emerge as a transnational Life Insurer of global scale and standard.

CIN: U66010MH2001PLC167089

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For more information or any grievance,

1. Call Us between 9 am to 6 pm, Monday to Saturday on our Toll Free Call Centre Number 1800 102 1010
2. Fax Number +91-22-30002222
3. Visit us at www.reliancenipponlife.com or
4. Email us at rnlife.customerservice@relianceada.com

BEWARE OF SUSPECIOUS PHONE CALLS AND FICTICIOUS/FRAUDULENT OFFERS

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.

Appendix A: Definitions & Exclusions of covered critical illnesses

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;
ix. All tumors in the presence of HIV infection.

2. **Open chest CABG**

The actual undergoing of heart Surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The Diagnosis must be supported by a coronary angiography and the realization of Surgery has to be confirmed by a cardiologist.

The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

3. **Myocardial Infarction (first heart attack of specific severity)**

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

i. A history of typical clinical symptoms consistent with the Diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

4. **Stroke resulting in permanent symptoms**

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner

and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

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

5. Kidney failure requiring regular dialysis

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

6. Major Surgery of Aorta

The actual undergoing of major Surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

7. Open heart replacement or repair of heart valves

The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The Diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

8. 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 haematopoietic 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. 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.

11. Coma of specified severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This Diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

12. 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.

13. 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 and HIV are excluded.

14. 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:

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.

15. 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.

16. End Stage Lung Failure

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

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
iv. Dyspnea at rest

17. End Stage Liver Failure

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

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

18. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

i. Blood product transfusion;
ii. Marrow stimulating agents;
iii. Immunosuppressive agents; or
iv. Bone marrow transplantation.

The Diagnosis must be confirmed by a haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

i. Absolute neutrophil count of less than 500/mm³ or less
ii. Platelets count less than 20,000/mm³ or less
iii. Reticulocyte count of less than 20,000/mm³ or less

Temporary or reversible Aplastic Anaemia is excluded.

19. Systemic Lupus Erythematosus with Lupus Nephritis

A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final Diagnosis must be confirmed by a Registered Doctor specialising in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis:
Class I Minimal Change Lupus Glomerulonephritis
Class II Messangial Lupus Glomerulonephritis
Class III Focal Segmental Proliferative Lupus Glomerulonephritis
Class IV Diffuse Proliferative Lupus Glomerulonephritis
Class V Membranous Lupus Glomerulonephritis

20. Alzheimer's Disease (before age 61)

Clinically established Diagnosis of Alzheimer's Disease (presenile dementia) resulting in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months.

21. Parkinson's Disease (before age 61)

The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in Permanent Inability to perform independently at least three of the activities of daily living as defined below.

i. Transfer: Getting in and out of bed without requiring external physical assistance
ii. Mobility: The ability to move from one room to another without requiring any external physical assistance
iii. Dressing: Putting on and taking of all necessary items of clothing without requiring any external physical assistance
iv. Bathing/Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means

v. Eating: All tasks of getting food into the body once it has been prepared

Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

22. 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:

i. Spinal cord Injury;

23. Loss of speech

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

All psychiatric related causes are excluded

24. 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 Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

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.

25. Apallic syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact. The Diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

Appendix B: Insurance Ombudsman

Refer Base Policy Document for the detailed list of the Insurance Ombudsman. For updated list, please refer, http://www.gbic.co.in/ombudsman.html

Appendix C: Section 39, Nomination by Policyholder

Please refer to Base Policy Document

Appendix D: Section 38, Assignment and Transfer of Insurance Policies

Please refer to the Base Policy Document

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

Please refer to Base Policy Document