Kotak Group Assure
A Non-Linked Non- Participating Group Life Insurance Plan
(UIN: 107N051V04)

Part B

DEFINITIONS

a) "Act" means Insurance Act, 1938, as amended from time to time.

b) "Age" refers to the age on last birthday of the Member and Beneficiary, as the case may be (as per the English calendar).

c) "Beneficiary" Means, the Member; or the nominee; or the legal heir of the Member or the nominee, as the case may be.

d) **"Board":** Means the board of directors of the Insurer.

e) "Certificate of Insurance" or "COI" means the certificate issued to the Member to confirm his/her coverage under the Policy.

f) "Cover Schedule" means is a schedule decided between the Insurer and the Policyholder, giving the details of the cover amount amortised at the specified rate of interest in the period between the cover commencement date and cover termination date as mentioned in the Certificate of Insurance, including coverage for moratorium (with or without accrued interest for moratorium period, as applicable), if any.

g) "Date of Commencement of Policy": means the date mentioned in the Schedule as Date of Commencement of Policy.

h) **"Date of Commencement of Risk/Cover":** means the date mentioned as Date of Commencement of Risk/Cover in the Certificate of Insurance issued to the concerned Member:
   1) For Existing Member: It will be same as Date of Commencement of Policy.
   2) For New entrants: The date of receipt of Member data and date of realization of premium, whichever is later.

i) "Membership Form cum Declaration of Good Health" or "DOGH" means declaration provided by the individual Member regarding his medical condition at the time of the entry into the scheme in the format prescribed

Kotak Mahindra Life Insurance Company Limited
CIN: U66030MH2000PLC128503, IRDAI Registration No. 107, Regd. Office: 8th Floor, Plot # C-12, G- Block, BKC, Bandra (E), Mumbai- 400 051, Website: www.kotaklife.com, Email: kli.groupoperations@kotak.com, Toll Free No.: 18001207856.

by the Insurer commonly known as Membership Form- cum-Declaration of Good Health.

j) "Grace Period" means a period of 30 days from the due date for the payment of Premium for yearly, half-yearly and quarterly mode and 15 days for monthly mode without levy of any interest or penalty during which time the cover is considered to be in-force without any interruption as per the terms of the Policy. Grace Period is not applicable to Single Premium cover

k) "Group" means a group of Members who assemble together with a purpose of engaging in a common economic activity and not formed with the main purpose of availing insurance cover. Such members are accepted by the Insurer as constituting a Group for the purposes of this Policy.

l) "IRDAI" means the Insurance Regulatory and Development Authority of India;

m) "Lapsed Cover" Means a suspension of insurance cover for a Member for non-payment of Premiums where Premium is not paid within Grace Period. Such suspension shall be deemed effective from the date of the first unpaid.

n) "Life Insured" includes the Member as defined below.

o) "Member/s" means a person/s:
- Who is/are resident(s) in India or a citizen of India;
- who has/have opted for insurance under this policy and for whom the premiums as herein specified have been paid to the Insurer, and
- who is/are in good health and wherever required as per the understanding has/have duly completed and submitted the Membership Form cum Declaration of Good Health (Evidence of Good Health), in the Insurer's format to the Policyholder or has undergone medical examination, as per **Annexure 2**, and the Insurer has agreed to provide cover to him/her on the basis results of medical examination and such other evaluation as the Insurer, may deem fit, and
- who has/have availed a loan from with the Policyholder on or after the date of commencement of this Policy towards <Personal Loan/Housing Loan > and such loan is outstanding as on the date of commencement of his/her cover; and
- who is borrower or co-borrower of the Loan and

- in respect of whom Member data is provided to the Insurer by the Policyholder as mentioned herein, and
- who falls within the age range indicated by the Insurer for this Policy

p) "Moratorium Period" means the period commencing from the date of disbursement of loan, during which the sum assured equals the initial cover amount and, in case the interest is not being paid during the moratorium period, the additional interest accumulated thereon. The cover after Moratorium period shall reduce in line with the cover schedule.

q) "Non-Medical Limit" means the amount of the Sum Assured granted on the life of the Member on submission of declaration of good health and without undergoing any medical examination/underwriting as per the underwriting rules of the Insurer.

r) "Nominee" shall mean the person nominated by the Member to receive the Benefits under the Policy in the event of his /her death.

s) "Policy" shall mean the contract of insurance entered into between the Policyholder and the insurer as evidenced by the Policy Document.

t) "Policy Document" Shall mean this agreement, any supplementary contracts or endorsements therein, whenever executed, any amendments thereto agreed to and signed by the Insurer and the individual enrollment forms, if any, of the insured Members, which together constitute the entire contract between the parties

u) "Policyholder" refers to the Master Policyholder.

v) "Revival" Means reinstatement of the lapsed benefits of the Cover in accordance with the provisions of the COI. Revival may be of the following two types and the same may be made by a Member within the timelines indicated below:
   a. 'Minor Revival': means revival made within six months from the due date of the first unpaid Premium causing the insurance cover to Lapse; and
   b. 'Major Revival': means revival made after six months but within five years from the due date of the first unpaid Premium causing the insurance cover to Lapse, subject to expiry of Cover Term.

w) "Sum Assured" means the loan amount outstanding at the beginning of the policy month during which the death occurs, as specified in the Certificate

of Insurance/Cover Schedule issued to each Member on his/ her admission to the scheme.

x) "Section 64 VB" – As defined under the Act.

y) Words importing the masculine gender shall include the feminine gender and vice versa.

z) Words in the singular shall include the plural and vice versa.

Part C

1. BENEFITS PAYABLE

The Sum Assured, as defined in the definition section, is based on the Member Data (as per the Annexure 1 –MD, provided to the Insurer (and updated from time to time) and shall be subject, inter alia to the limits mentioned in the table herein below and all the terms and conditions appearing herein:

For Single Premium

Option no.	Option	Min. Sum Assured (Rs.)	Max. Sum Assured (Rs.)	Min. Entry Age	Max. Entry Age	Max Maturity Age
1	Easy Group Assure	5,000	No limit	15	73	75
2	Group Assure	25,000	No limit	15	73	75
3	Group Assure plus Critical Illness Benefit	100,000	No limit	18	63	65
4	Group Assure plus Disability Benefit	25,000	No limit	18	63	65

For Regular Premium

Option no.	Option	Min. Sum Assured (Rs.)	Max. Sum Assured (Rs.)	Min. Entry Age	Max. Entry Age	Max Maturity Age
1	Easy Group Assure	5,000	No limit	15	70	75
2	Group Assure	25,000	No limit	15	70	75
3	Group Assure plus Critical Illness Benefit	100,000	No limit	18	60	65
4	Group Assure plus Disability Benefit	25,000	No limit	18	60	65

The Cover cannot be increased for any member unless prior written approval of the Insurer is taken.

Sum Assured under this plan:

- For Loans: A loan repayment schedule will define the sum assured during each month. It may include a moratorium period, with or without interest, to reflect the loan repayment schedule. Sum Assured, subject to a maximum of the outstanding amount in borrower's loan account as at the end of the month of death, would be paid. Claims payments will be made to the Beneficiary unless it is payable to the Policyholder as mentioned under clause 3 of Part F.

  This Cover under the Policy Contract is restricted to the Expected Principal Loan Amount (loan repayment schedule agreed between the Policyholder and the Insurer) only and the balance outstanding, if any, due under the Loan Agreement would be governed by the Loan Agreement between the Policyholder and the Member.

  The event of Death should be intimated to the Insurer preferably within 3 months and in case of failure to intimate within the said period the Insurer reserves its right to seek any relevant/additional documents for processing the claim. The Insurer at its sole discretion may calculate the benefit payable on the death of the Member after verifying the actual date of death.

Benefit on Survival:

No survival benefit will be paid under any of the options.

<<Benefits payable in case of Joint Life Cover:

Joint Life cover shall be offered only in cases where the insurable interest between two lives to be insured is clearly established. The benefits payable in case of Joint Life cover shall depend upon the contingent events and the corresponding options as mentioned in the table hereunder:

Contingent Events	Options for Calculation of Benefits Payable
In the event of first Death of any of the two lives insured	Easy Group Assure

In the event of Death or Terminal Illness (whichever is earlier) of any of the two lives insured	Group Assure
In the event of Death or Terminal Illness or Accidental Permanent Disability (whichever is earlier) of any of the two lives insured	Group Assure plus Disability Benefit
In the event of Death or Terminal Illness or Critical Illness (whichever is earlier) of any of the two lives insured	Group Assure plus Critical Illness Benefit

Note: Once the Benefits (payable on the first occurrence of any of the events as mentioned in the table above) are paid, the life cover stands terminated and no further benefits are paid under this contract>>

Benefits available under various plan options:-

Following are the various benefit options available under the Policy, however amongst the following only the option chosen by the Policyholder will be applicable.

Option 1:- Easy Group Assure

On Death:
Sum Assured will be paid.

Option 2:- Group Assure

On Death:
Sum Assured will be paid provided no Sum Assured is paid under Terminal Illness to the Member/Beneficiary earlier.

On Terminal Illness:

Terminal Illness is a non-correctable/non-curable medical condition or a non-response to specific disease therapy (which is likely to culminate in death within a year).

Terminal Illness Benefit provides for immediate payment of the Sum Assured, as a result of the diagnosis of Terminal Illness, and consequently the cover under the group policy will cease for the Member.

Terminal Illness should be established and confirmed in writing and with reasonable certainty; in the opinion of both the Member's attending physician (based on consultation with relevant medical specialists) as well as Chief Medical Officer of the Insurer. The decision of the Chief Medical Officer of the Insurer would be final in this regard.

The Member will be entitled to make a Terminal Illness claim on fulfillment of following conditions:

1. The medical illness should have been exhaustively investigated, diagnosed and treated by specialists in that faculty, and at the end of the treatment, the attending medical experts must have opined that the disease is incurable, and only supportive / empirical therapy can be offered. A certificate from the treating specialist confirming this condition should be produced.
2. Where the Member is an employee of a company, the employer (company) is required to certify that the Member (employee) has not been able to fulfill the daily requirements of his/her job continuously during the last two months in view of his terminal illness, immediately prior to the date of intimation of Terminal Illness to the Insurer. Where the Member is self-employed, he/she should provide suitable supporting evidence of inability to work as defined above to the Insurer.

Exclusions:

No benefits will be payable under following circumstances:

1. Self-inflicted injuries or attempted suicide within one year from the commencement of member cover/ date of revival of member cover;

Note: Apart from the coverages mentioned above, no other benefits are available to the Member.

Option 3:- Group Assure plus Critical Illness Benefit

On Death:

Sum Assured will be paid provided no Sum Assured is paid under Terminal Illness or Critical Illness to the Member/beneficiary earlier.

On Terminal Illness:

Terminal Illness is a non-correctable/non-curable medical condition or a non-response to specific disease therapy (which is likely to culminate in death within a year).

Terminal Illness Benefit provides for immediate payment of the Sum Assured, as a result of the diagnosis of Terminal Illness, provided no Sum Assured has been paid earlier; Critical Illness Benefit to the Member/beneficiary and consequently the cover under the Policy will cease for the Member.

Terminal Illness should be established and confirmed in writing and with reasonable certainty; in the opinion of both the Member's attending physician (based on consultation with relevant medical specialists) as well as Chief Medical Officer of the of the Insurer. The decision of Chief Medical Officer of the Insurer would be final in this regard.

The Member will be entitled to make a Terminal Illness claim on fulfillment of following conditions:

1. The medical illness should have been exhaustively investigated, diagnosed and treated by specialists in that faculty, and at the end of the treatment, the attending medical experts must have opined that the disease is incurable, and only supportive / empirical therapy can be offered. A certificate from the treating specialist confirming this condition should be produced.

2. Where the Member is an employee of a company, the employer (company) is required to certify that the Member (employee) has not been able to fulfill the daily requirements of his/her job continuously during the last two months in view of his terminal illness, immediately prior to the date of intimation of Terminal Illness to the Insurer. Where the Member is self-employed, he/she should provide suitable supporting evidence of inability to work as defined above to the Insurer.

Exclusions for Terminal Illness:

The exclusions under this option consist of the "Exclusions under Group Assure" already mentioned above.

On Critical Illness:

If the Member is diagnosed with a critical illness or undergoes surgery covered as per the terms and conditions specified herein, the sum assured available under this option will be paid, subject to the following conditions, and consequently the cover under the Group Policy will cease for the said Member.

Conditions:

No benefits will be payable:

1. If the condition is diagnosed within the lien period of 45 days after the risk commencement date or the date of any reinstatement.)
2. For any pre-existing diseases unless specifically mentioned in the Proposal Form and accepted by the Insurer and endorsed thereon.

General Conditions:

1) The benefit is payable in full on the first ever occurrence of any one of the critical illnesses defined below and only if the policy is in force at the time of diagnosis of the critical illness.

2) The Member/Policyholder should notify the Insurer within 30 days from the date of diagnosis of critical illness; giving the following details such as date of diagnosis of critical illness, nature and extent of critical illness and details thereof, including medical reports and investigations; the Member's address etc.

3) The Member is willing to be examined by a Medical Examiner nominated by the Insurer.

4) The decision of the Chief Medical Officer of the Insurer would be final in all regards.

For the payment of benefits under this option a critical illness means the following:

MYOCARDIAL INFARCTION (FIRST HEART ATTACK – OF SPECIFIED SEVERITY)
The first occurrence of heart attack 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:

a) a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
b) new characteristic electrocardiogram changes
c) elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

1) Other acute Coronary Syndromes
2) Any type of angina pectoris
3) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease or following an intra-arterial cardiac procedure

CANCER OF SPECIFIED SEVERITY
A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & 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 –

1. All tumours 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 & CIN-3.
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond
3. Malignant melanoma that has not caused invasion beyond the epidermis
4. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below
6. Chronic lymphocyctic leukaemia less than RAI stage 3

7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification
8. 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

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

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:
1. Angioplasty and/or any other intra-arterial procedures

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.

MAJOR ORGAN / BONE MARROW TRANSPLANT
The actual undergoing of a transplant of:

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1. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
2. 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:
1. Other stem-cell transplants
2. Where only islets of langerhans are transplanted

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.

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.

SURGERY OF AORTA
The actual undergoing of surgery via thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or a traumatic rupture of the aorta. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. There must have been excision and replacement of a portion of diseased aorta with a graft. Stent-grafting is not covered.

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.
OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES
The actual undergoing of open-heart valve surgery 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.

BLINDNESS

I. Total permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
II. The blindness is evidenced by:
    a. corrected visual acuity being 3/60 or less in both eyes or ;
    b. the field of vision being less than 10 degrees in both eyes
III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure

Exclusions for Critical Illness:

No benefits will be payable under following circumstances:

1. No payment will be made by the Company for any claim directly or indirectly caused by, based on, arising out of, or howsoever, to any Critical Illness for which care, treatment, or advice was recommended by or received from a Physician, or which first manifested itself or was contracted up to 48 months prior the date of commencement/revival of the cover, or for which a claim has or could have been made under any earlier policy
2. No benefits will be payable under this Policy if a claim or event suffered by the Life Insured is directly or indirectly attributed to or exacerbated as a result of any of the following :
    a) War or hostilities (whether war be declared or not), civil war, rebellion, revolution, civil unrest or riot, participation in any armed force or peace keeping activities.
    b) If a person acts on his/her own or on behalf of or in connection with any group or organization to influence by force any group, corporation or government by terrorism, kidnapping or attempted kidnapping, attack, assault, or any other violent means with criminal intent.
    c) Self inflicted injuries, attempted suicide, and immorality, and deliberate participation of the life insured in an illegal or criminal intent.

d) Drug-taking other than under the direction of a qualified medical practitioner, abuse of alcohol or the taking of poison.
e) Nuclear fusion, nuclear fission, nuclear waste or any radioactive or ionizing radiation.
f) Injuries or diseases arising from professional sports, racing of any kind, scuba-diving, aerial flights (including bungee-jumping, hang-gliding, ballooning, parachuting and skydiving) other than as a crew member or as a fare-paying passenger on a licensed carrying commercial aircraft operating in a regular scheduled route or any hazardous activities or sports unless agreed by special endorsement.
g) Unreasonable failure to seek medical advice.

Note: Apart from the coverages mentioned above, no other benefits are available to the Member.

Option 4:- Group Assure plus Disability Benefit

On Death:

Sum assured will be paid provided no Sum Assured is paid under Terminal Illness or Permanent Accidental Disability to the Member/beneficiary earlier.

On Terminal Illness:

Terminal Illness is a non-correctable/non-curable medical condition or a non-response to specific disease therapy (which is likely to culminate in death within a year).

Terminal Illness Benefit provides for immediate payment of the Sum Assured, as a result of the diagnosis of Terminal Illness, provided no Sum Assured has been paid earlier; either on Death or Permanent Accidental Disability Benefit to the Member/beneficiary and consequently the cover under the group policy will cease for the Member.

Terminal Illness should be established and confirmed in writing and with reasonable certainty; in the opinion of both the Member's attending physician (based on consultation with relevant medical specialists) as well as the Chief Medical Officer of the Insurer. The decision of the Chief Medical Officer of the Insurer would be final in this regard.

The Member will be entitled to make a Terminal Illness claim on fulfillment of following conditions:

1. The medical illness should have been exhaustively investigated, diagnosed and treated by specialists in that faculty, and at the end of the treatment, the attending medical experts must have opined that the disease is incurable, and only supportive / empirical therapy can be offered. A certificate from the treating specialist confirming this condition should be produced.
2. Where the Member is an employee of a company, the employer (company) is required to certify that the Member (employee) has not been able to fulfill the daily requirements of his/her job continuously during the last two months in view of his terminal illness, immediately prior to the date of intimation of Terminal Illness to the Insurer. Where the Member is self-employed, he/she should provide suitable supporting evidence of inability to work as defined above to the Insurer.

Exclusions for Terminal Illness:

The exclusions under this option consist of the "Exclusions under Group Assure" already mentioned above.

On Permanent Accidental Disability:

If the Member becomes permanently disabled due to an accident then the Sum Assured as at the date of accident would be payable on fulfilment of following conditions provided no Sum Assured has been paid earlier; either on Death or Terminal Illness Benefit to the Member/beneficiary and consequently the cover under the group policy will cease for the insured Member. The benefits will be payable immediately after the end of waiting period.

Accident: For the purpose of this definition, an accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Waiting Period:

The waiting period of 180 days from the date of accident is applicable to this option and the Member must remain continuously disabled during the 180 days waiting period.

Permanent Accidental Disability Conditions:

- **General Conditions:**

1. This benefit is payable on Occupational Disability conditions or Physical Impairment conditions arising specifically from an accident. Such "accidental disability" should arise directly from bodily injury caused solely, directly and independently of all other causes and disease, ageing or degenerative conditions effected through external, violent and sudden means of which there is evidence of a visible contusion or wound on the exterior of the body. The insured condition must occur within 30 days of the accident that was the sole cause of the condition.

2. The Member/Policyholder must report the claim to the Insurer within 30 days of accident, giving required details such as date of the accident, nature and extent of the accidental disability, including medical reports and investigations; the Member's address etc.

3. There will be a waiting period of 180 days applicable to this option from the date of accident and disability should be continuous during the waiting period of 180 days from the date of accident. During the waiting period, the scheduled premiums are due from the Policyholder.

4. Disability assessment will be carried out by the Insurer's Chief Medical Officer (CMO) during or at the end of waiting period.

5. The decision of the Insurer's Chief Medical Officer (CMO) would be final in all regards.

- **Occupational Disability benefit conditions:**

1. Provides benefits in the event of the Member becoming "accidentally disabled" such that he is permanently unable to carry out a reasonable occupation.

2. The reasonability of an occupation will be influenced by the Member's education, training, experience and employment history.

3. The Member unemployed at the accident date is not eligible to claim under the Occupational Disability condition (Temporary unemployment due to switching of jobs etc, up to 90 days will be covered. Offer letter from the new employer should be submitted as a proof of temporary unemployment). Therefore, a Member unemployed at the accident date

needs to meet one of the 'Physical Impairment Benefit Conditions' mentioned below to make a claim.

4. The Member must inform the Insurer if he is no longer engaged in his occupation; in addition to all changes in the Member's job activities and/or environment which are not of an occasional or isolated nature.

5. The Occupational Disability Benefit will not be payable where the Member has already retired (i.e. ceased being engaged in his occupation due to retirement prior to being disabled and has not become re-engaged in any occupation).

- **Physical Impairment Benefit Conditions arising from accidental disability:**

  - Permanent loss of speech.

  - Permanent loss of use of a combination of any two of the following: hand, foot, eye.

  - Permanent confinement to bed or wheelchair.

Exclusions:

No benefits will be payable under following circumstances:

1. No benefits will be payable under this Policy if a claim or event suffered by the Member is directly or indirectly caused by or exacerbated as a result of any of the following:
   a. Activities like Extreme climbing (soloing), Ice climbing, Extreme altitude climbing – above 6000 m, Cave diving, Internal exploration of wrecks, Diving at depths greater than 30 m, Motorized racing (speed contests) , Boxing (including kick boxing), Base jumping, Sky surfing, Aerobatic flying, Parasailing , Employment as a mine-blaster
   b. Undisclosed recurrent participation in the following risky activities like Piloting any aircraft, Ballooning, Parachuting without a static line, Hang gliding, Paragliding and Rock climbing
   c. War or hostilities (whether war be declared or not), civil war, rebellion, revolution, civil unrest or riot, participation in any armed force or peace keeping activities, an act of any person acting on their own or on behalf of or in connection with any group or organization to influence by force any group, corporation or

government by terrorism, kidnapping or attempted kidnapping, attack, assault, or any other violent means.

d. If a person acts on his/her own or on behalf of or in connection with any group or organization to influence by force any group, corporation or government by terrorism, kidnapping or attempted kidnapping, attack, assault, or any other violent means with criminal intent.
e. Self inflicted injuries, attempted suicide, and immorality, and deliberate participation of the Member in an illegal or criminal intent.
f. Nuclear fusion, nuclear fission, nuclear waste or any radioactive or ionizing radiation.

Note: Apart from the coverages mentioned above, no other benefits are available to the Member.

Beneficiary

Subject to the applicable laws, the benefits/claim payment will be made to the Beneficiary. The said benefits shall be payable in India.

The benefits shall be limited at all times to the monies payable under this policy.

2. PREMIUMS PAYABLE

Mode of Premium Payment: << Single/Monthly/Half yearly/Quarterly/Annual Premium>>.

Accepted Premium Rates * (Rate per ` 1000/- of cover)

As per the Annexure 4- Premium Rate Table

*The Policyholder is liable to pay Goods and Services tax, cess and other statutory levies (as applicable from time to time) on the premiums payable. The Premiums payable are calculated based on the aforesaid premium rates, and are subject to Goods and Services cess and other levies as may be applicable from time to time. The Insurer reserves the right to review the Premium rates periodically and change the premium rates (from the pre-approved set of premium rates) applicable under the Policy in respect of new entrants at any time, by giving the Policyholder two months' notice in writing.

Payment of Premiums

The Policyholder/Member shall pay premiums for each Member/themselves according to the mode specified in the agreement. The premium for each individual Member would vary depending on the benefit for which they are covered.

A Grace Period will be allowed for payment of premiums. The grace period is 15 days from the due date of payment where the agreed premium mode is monthly, and 30 days otherwise. If the premium is not paid on or before the expiry of the grace period, the cover under the Policy will automatically lapse.

If any death occurs within the grace period and before the payment of the premium then due, and the death claim is admitted, the claim will be settled by recovering the due premium.

The Insurer is liable for any claim if the Premiums in respect of the concerned Member is received by the Insurer/Policyholder, subject to the Member proving that he has paid the Premium and has secured a proper receipt that he was duly insured

Special Conditions, if any:

< as applicable>

1. As per the Insurance regulations, no cover shall be extended to any person(s) unless the premium due for such cover has been received in advance by the insurance Insurer.
   < To comply with this regulation, Policyholder will need to keep a deposit as per Section 64VB, equivalent of approx premium amount due in next month with Insurer.> OR < Therefore all covers shall commence from the valued credit date in Insurer's account with Policyholder.>
2. Rates will be reviewed after 12 months after the commencement of Policy unless revised earlier as envisaged aforesaid under clause Premium payable. This will be applicable for new Members only and will be based on preapproved premium tables by IRDAI.
3. It has been mutually agreed between the Policyholder and the Insurer that participation mode is voluntary for all existing and future new members.

Signed for and on behalf of Kotak Mahindra Life Insurance Company Ltd. at Mumbai on

_____.

Authorised Signatory

Part D

1. Lapse

The cover for Member will cease if the Premiums are not received by the Insurer/Policyholder within the Grace Period.

The Member cover can be revived by making an application within five years from the date of the first unpaid premium and before the cease date of the Member cover as per the clause on 'Revival' mentioned below.

In case the Member cover is not revived as per the Revival provisions, the same shall stand terminated.

Cover for Members with single premium option shall not lapse.

2. Revival

The Member cover can be revived by making an application within five years from the date of the first unpaid premium and before the cease date of the Member cover as per the following conditions:

i. **Minor Revival:**

The Member may revive the cover within 6 months, from the due date of the first unpaid premium without proof of good health and payment of outstanding premiums together with interest charges (currently calculated @ 9% p.a. on the due premium). The said interest rate may be revised from time to time with prior approval from IRDAI.

ii. **Major Revival**

The Member may revive the cover after 6 months, from the due date of the first unpaid premium by furnishing satisfactory evidence of health as required.

The arrears of premiums together with interest charges (currently calculated @9% p.a. on the due premium may be charged. The said interest rate may be revised from time to time with prior approval from IRDAI.

The revival of the Member cover may be on terms different from those applicable when the Member cover lapsed based on Board Approved Underwriting Policy (BAUP).

The revival will take effect only after the Insurer communicates its decision to the Policyholder.

Revival is not applicable for single premium policy.

3. Surrender:

The Surrender value would become payable on happening of any of the following circumstances:

- Loan cancelled from inception (where the loan granted is not availed by the customer due to change in circumstances that makes the loan no longer required, or where the client was pressurized into buying insurance and chooses to cancel it)
- Voluntary surrender of insurance cover by the Insured Member.

Surrender Value in case of surrender after the free look period* would be:

In case of Single premiums:

Surrender Value = 75% × Single premium
× (Outstanding Cover Term^/Cover Term^)
× (Outstanding Cover Amount^/Total Cover Amount^)

In case of Regular premiums,

No Surrender value is available.

Amount received in case of cancellation within the free look period* would be:

In case of Single premiums:

Free look cancellation Amount= Single premium × (Outstanding Cover Term^/Cover Term^) × (Outstanding Cover Amount^/Total Cover Amount^) - Stamp duty and Medical expenses, if any

In case of Regular premiums,

Free look cancellation Amount = Regular premium× (Term to next Premium Payment/Term between Premium Payments) × (Outstanding Cover Amount^/Total Cover Amount^)- Stamp duty and Medical expenses, if any

Where “Term to next premium payment” means the number of days until the Member is due to pay another premium; and “Term between premium payments” means the number of days between scheduled premium payments.

^As per the Cover Schedule issued by the Insurer.

These policies acquire no paid-up values or loan values.

* The free look period allows for the member to cancel the cover from inception. This must be notified to the Policyholder/Insurer within 15 days of the member receiving the COI.

NOTE:

3. The outstanding and total amounts above are as per the original Cover schedule at the time of surrender or repayment, and not the actual Loan amounts.
4. In case of Surrender of the Policy by the Policyholder or foreclosure of loan by the Member or transfer of loan to another company by the Members, the cover shall continue till the end of the contracted term, unless expressly surrendered by the Member.

4. Cover

The Cover for each member is subject to the following:

- Cover shall commence from the date of receipt of premium or fulfilment of underwriting requirements whichever is later.
- Cover shall commence from the contract date of loan by the Member (date of loan agreement), as stated in the Member data submitted by the Policyholder, for non-medical cases.
- For underwritten cases, cover will commence on the acceptance of risk by the Insurer post completion of Medical requirements.
- On the basis of the disclosures made by the Member in the underwriting requirements, the Insurer may at its discretion can call for additional information, decline cover or accept with/without health loadings on premiums or any other terms and conditions.
- Cover shall be restricted to the amount described under the Section of this Policy Contract, titled Benefits Payable;
- Cover shall be declined as a result of failure to provide satisfactory Evidence of Good Health as required under this policy.

5. Loans

Loans are not available under the policy.

6. Policyholder Covenants

The Policyholder agrees to apply its prescribed norms and procedures for assessing the cover applications and apply its stipulated credit recovery procedures thereon, regardless of whether or not cover is sought on the lives of its borrowers. The Insurer reserves with it the right to call for the guidelines of the Policyholder's credit criteria at any time, and the Policyholder shall supply the same to the Insurer within the time limits if any specified therein. The Policyholder (or any of its affiliated organization / entity) in its capacity as Group Organizer / Group Manager, with whatsoever nomenclature may be, is prohibited from collecting any amount other than the insurance premium payable to the Insurers with regard to the underlying Group Insurance..

The Policyholder shall collect the duly valid and complete Membership Form cum Declaration of Good Health (Evidence of Good Health) along with such other documents as it may require for the purpose of the insurance cover given to the member. The Policyholder shall preserve and maintain it as an integral part of such documentation. The Policyholder shall allow the officers of the Insurer (including representatives authorized in writing by the Insurer), to inspect and make copies of all/any relevant records for the purposes of this Policy, at reasonable hours on any day.

In accordance to the IRDAI circular ref 015/IRDA/Life/Circular/GI Guidelines/2005 dated July 14, 2005, the Policyholder shall obtain a Certificate of compliance from the Auditor of the group or the Manager of the group on every anniversary date of the Policy and submit the same to the Insurer at its request. Renewal of such Policy / cover will be subject to such submission of Certificate of compliance by the Policyholder to the Insurer. OR Alternatively, The Insurer shall conduct the inspection of the books and records of the Policyholder to assess whether they are complying with the relevant IRDAI guidelines.

Further, where a part of death benefit is paid to the Policyholder towards settlement of loan outstanding, the Policyholder agrees that the Insurer shall have the right to audit or to cause an audit into the accuracy of the Credit Account Statement, in accordance with the Guidelines/ Circulars/ Instructions issued by IRDAI from time-to-time. For the purpose of this clause, Credit Account Statement shall contain the following details:

a) Name of the Policyholder
b) Policy No.

c) Name of the Member
d) Date of Commencement of Risk
e) Sum Assured for the Member
f) Original Amount of Loan
g) Recoveries made by the Policyholder towards the loan
h) Outstanding Loan Balance as on the date of contingent event.
i) Balance Claim Amount

In terms of **Regulation 19 (3) of (Protection of Policyholders' Interests) Regulations, 2017,** the Policyholder shall assist the Insurer, if the Insurer so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the Insurer has against the third parties.

It shall be the duty of the Policyholder to intimate the Insurer with necessary details on the exclusion of the member and it shall indemnify the Insurer for all charges and damages incurred due to payment made to ineligible member.

The Insurer may initiate suitable action against the Policyholder for wrong or incorrect data submitted by them without prejudices to the rights of the Members.

If the Policyholder fails to remit the premiums to the insurer in a timely manner then suitable action will be initiated.

7. Discontinuance

This policy contract may be discontinued by the Policyholder or the Insurer for new entrants by giving the other party at least one month's prior notice in writing. However, in case of single premium payment mode the cover for the existing members will continue even after the discontinuance of the policy. In case of regular premium payment mode the cover for the existing members will continue only for the period for which the premiums have been paid. Thereafter, the cover will continue subject to the payment of future premiums as per the premium rate table for the balance remaining term subject to all the policy terms and conditions.

8. Member Data

The Policyholder must provide the soft copy of the up-to-date Member Data to the Insurer on or before the < > to enable the Insurer to update its records and calculate premium. Hard copies of the Member Data will not be accepted if the same are not accompanied along with the soft copy of the data. A grace period of 7 days will be allowed for providing the Member data to the Insurer. The Insurer

shall not be liable for any claim except as provided for in this Policy document and for only those members whose member data has been provided by the Policyholder to the Insurer. If there is a discrepancy between the soft copy and hard copy of the member data submitted by the Policyholder then in such circumstance the soft copy will be final and will prevail over the hard copy of the member data.

As mentioned above, the Policyholder shall submit the Member Data by the < >, however, claim in respect of a member for whom the Member Data is in the process of so being submitted, shall be submitted by the Policyholder to the Insurer and such a claim shall be considered and settled subject to terms and conditions as provided herein. The Policyholder shall arrange to furnish such documents/information as may be required by the Insurer in this regard.

9. Free look Provision

In case the Policyholder is not agreeable to any of the provisions stated in the Policy, then there is an option of returning the Policy, stating the reasons thereof within 15 days (30 days for electronic policies and policies obtained through Distance Marketing* mode) from the date of the receipt of the Policy. The cancellation request should be submitted to nearest Branch of the Insurer or sent directly to the Insurer's Head Office. On receipt of letter along with the original policy document, the Insurer shall refund the Premium paid after deducting the proportionate risk premium, medical charges (if any) and stamp duty. A Policy once returned shall not be revived, reinstated or restored at any point of time and a new proposal will have to be made for a new policy.

The free look period applicable to this Policy is <15/30> days.

For the Policy, the free look period shall be available to the Policyholder and, for the COI, it shall be available to the concerned Member.

*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 service (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.

Part E

Not applicable.

Part F

1. Suicide Exclusion:

In case of death due to suicide within 12 months from the date of commencement of risk under the policy or from the date of revival of the policy, as applicable, the nominee or beneficiary of the life assured shall be paid 80% of the total premiums paid* till the date of death or the surrender value available as on the date of death whichever is higher, provided the policy is in force.

However if the policy is revived within the 6 months from the date of first unpaid premium, the suicide exclusion shall not be applicable provided the death is after 1 year from date of commencement of cover

*Total Premiums Paid is total of all the premiums paid, excluding any extra premium, any rider premium and taxes

2. Proof of Age

The Policyholder shall submit a declaration in writing of the Age(s) of the Members covered and persons to be covered under this Policy, at inception and along with every monthly statement of Member Data (for Members added from time to time).

The Insurer shall not be liable for payment of any benefits in respect of a Member for whom such a declaration has not been given.

If at a future date, the Age is found to be different from the Age declared, without prejudice to the Insurer's other rights and remedies including those under the Insurance Act, 1938, and any other laws then prevailing, the Insurer will have the right to recover balance premium without interest for the concerned Member/Life Insured before settling his/her claim. In case of excess Premium, the Insurer shall refund the same without interest, after deducting expenses (if any).

The Insurer may call for proof of age from the Policyholder or the concerned Member/Life Insured and the Policyholder or Member must provide the same when required.

3. Payment of Benefit to Policyholder:

If the Policyholder is 1) Reserve Bank of India (RBI) regulated Scheduled Banks (including Cooperative Banks) 2) NBFCs having Certificate of Registration from RBI or 3) National Housing Bank (NHB) Regulated Housing Finance Company 4)

National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies 5) Small Finance Banks (SFB) regulated by RBI 6) Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies 7) Microfinance companies registered under section 8 of the Companies Act, 2013 8) any other category as approved by IRDAI and the Member has authorized the Insurer to pay the benefits under the Policy to the Policyholder, the payment of Insured Benefit may be made to the Policyholder, to the extent of loan outstanding as on the date of contingent event, and subject to the conditions laid down by IRDAI under the Circular IRDAI Circular IRDA/LIFE/CIR/MISC/172/09/2019, dated 26.9.2019 and various other applicable Regulations/ Guidelines/ Circulars or instructions issued from time-to-time.

In other cases, the Insured Benefit shall be payable to the Beneficiary.

4. Nomination and Assignment

i. Nomination is allowed as per Section 39 of the Act, as amended from time-to-time. [A Leaflet containing the simplified version of the provisions of Section 39 is enclosed in Annexure – 5 for reference].

ii. It is mandatory for the Policyholder to have appropriate nomination data and appropriate nomination procedures in place so as to ensure timely and complete discharge to the nominee.

iii. The Policyholder shall ensure that nomination details for all the Members covered under the Policy are obtained, and that the requisite nominations are available/ updated in their records at any point in time. The said details shall be maintained by the Policyholder and will be updated on a regular basis in case of any revisions. The Policyholder shall provide the necessary information and documents to Insurer on demand or as and when required. Further, the nominees' details and records shall be provided by the Policyholder to the Insurer for verification and audit purpose. The Policyholder shall certify the correctness and accuracy of the nomination made by the Member.

iv. In the event of a death claim, the Policy number and the letter from the Policyholder along with the certified information of the nominee details in the Insurer's format shall be provided along with the claim intimation form, proof of address & photo identity of the nominee.

v. Assignment is not allowed under the Policy.

vi. In case of force majeure event, company may at its sole discretion, waive any or all of the above mentioned documents and settle the claim in favour of the Member's nominee or legal heir provided the Insurer is satisfied after its own investigation.

vii. In case of claims due to exit from the Policy other than death (i.e. termination, surrender etc.), individual details to be submitted to the Policyholder in the prescribed from, for onward transmission to the Insurer.

viii. The benefits shall be limited at all times to the monies payable under this Policy.

5. Issuance of Duplicate Policy Document

The Policyholder may request for issuance of duplicate Policy Document by making a request to the Company in writing or in the prescribed form as the case may be. Issuance of duplicate Policy Document shall be made subject to the following conditions:

i. The Policyholder pays the applicable fee.
ii. The Policyholder submits an affidavit cum indemnity in the format, if any, prescribed by the Company
iii. Free Look clause shall not be applicable with respect to such duplicate Policy Document.

6. Claims:

All death claims must be notified to the Insurer in writing within 3 months from the date of the death along with the original death certificate and the primary documents as herein stated. The Insurer reserves its rights to condone the delay on merit for delayed claims, where the delay is genuine and proved to be for reasons beyond the control of the Beneficiary

The primary documents normally required for processing a death claim are:

- Intimation of the claim event (i.e. death) vide duly filled in claim form in the Insurer's format stamped and signed by the authorised representative of the Policyholder
- Original death certificate issued by the Municipal Authority,
- Proof of age of the Life Insured (for example attested copy of birth certificate/ school leaving certificate etc.)
- Proof of membership under the policy

- Last attending Doctor's Certificate stating the exact cause of death and all the associated medical documents
- If the death is due to an accident or any other unnatural cause, the following shall be required:
  - A certified copy of the FIR filed with the Police authorities
  - A certified copy of the Post Mortem Report/Autopsy Report
- Proof of identity of the Nominee, duly certified by the Policyholder
- Member Authorization Form as per prescribed format.
- Original Cancelled cheque showing name of Bank, location of Bank Branch, Name of Account Holder and Account No. In absence of the same the client can even submitted Photocopy of Bank Pass Book/Bank Statement of beneficiary bearing the afore referred details duly attested by the Concerned Bank.
- Guardian details for minor Nominee

All claims shall be subject to the provisions of this Policy document, such other requirements as stipulated by the Insurer and the legal title of the claimant, satisfactory to the Insurer. The Insurer reserves the right to call for any additional information and documents required to satisfy itself as to the validity of a claim.

All amounts due under this Policy are payable in Indian Currency at the office of the Insurer situated at Mumbai, but the Insurer at its absolute discretion may fix an alternative place of payment for the claim at any time before or after the claim arises. A discharge or receipt by the Nominee shall be a good, valid and sufficient discharge to the Insurer in respect of any payment to be made by the Insurer hereunder.

7. Notice

Any notice, information or instruction to the Insurer must be in writing and delivered to the address intimated by the Insurer to the Policyholder which is currently:

Group Operations
Kotak Mahindra Life Insurance Company Limited
7th Floor, Building No.21,
Infinity Park, Off Western Express Highway,
General A.K. Vaidya Marg,
Malad (E), Mumbai,
Maharashtra -400097, India

The Insurer may change the address stated above and intimate the Policyholder of such change by suitable means.

Any notice, information or instruction from the Insurer to the Policyholder shall be mailed to the following address:

<<....>>

……

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or to the changed address as intimated to the Insurer in writing. The Policyholder is also advised to promptly notify the Company of any change in his/her address and/or that of his/her nominee to ensure timely and effective communication of policy related information to the Policyholder

8. Electronic Transactions

All remote transactions effected through the internet, world wide web, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by the Insurer or on behalf of the Insurer, for and in respect of this Policy, shall be legally binding on either party and shall be considered as valid transactions as per extant laws applicable and which are done in adherence to and in compliance with the terms and conditions of such facilities, as may be prescribed by the Insurer from time to time.

9. Fraud / Misstatement:

The provisions of Section 45 of the Insurance Act 1938, as amended from time-to-time, will be applicable to this contract and each life cover provided therein. [A Leaflet containing the Simplified Version of Section 45 is enclosed in Annexure 6 for reference]

10. Force Majeure

If the Insurer's performance or any of the Insurer's obligations are in any way prevented or hindered as a consequence of any act of God or State, strike, lock out, legislation or restriction by any government or any other authority or any other circumstances beyond the Insurer's anticipation or control, the performance of this Policy shall be wholly or partially suspended during the continuance of such force majeure. The Insurer will resume its obligations towards this Policy immediately after the Force Majeure event ceases. The Insurer will keep the IRDAI informed about the suspension of operations during

Force Majeure event and also the resumption of its obligations and undertake to seek IRDAI's permission before effecting any of these changes.

11. Governing Laws

1. Anti Money Laundering Provisions:

   The Prevention of Money Laundering Act, 2002, also applies to insurance transactions. As such the Insurer shall enforce the said legislation to the extent it may be applicable to this Policy.

2. Miscellaneous

   This Policy is subject to the Insurance Act 1938, as amended by the Insurance Regulatory and Development Authority Act, 1999, such amendments, modifications as may be made from time to time and such other relevant regulations including Protection of Policyholder's Interest, as may be introduced there under from time to time by that Authority.

3. Entire Agreement:

   This Policy Document along with the documents and agreements referred to herein, supersedes all prior discussions and agreements (whether oral or written, including all correspondence) with respect to the subject matter of this Policy, and this Policy Document (together with any written and mutually agreed amendments or modifications thereof) contain the sole and entire agreement between the Company and the Policyholder with respect to the subject matter hereof.

4. Jurisdiction:

   Without prejudice to the generality of the aforesaid provisions, this Policy shall be governed by the laws of India. The Courts in India shall have the exclusive jurisdiction to settle any disputes arising under this Policy.

12. General

a. The cover for a Member will cease on the earliest of:

   a. The date on which any one of the option benefits are paid.
   b. The date on which the Policyholder/Member discontinues payment of regular due premiums.
   c. he/she ceases to be member of the group

d. The Member attaining the Maximum Age at maturity as mentioned in the synopsis provided by the Insurer.

b. Any information needed to administer the Policy must be furnished by the Policyholder. Any information pertaining to the Policy shall be accepted by the Company only if it is received from the authorized signatory /e-mail ID of the Policyholder.

c. The Insurer can check/inspect, at any time, if the Benefits are being paid to the correct person as and when due.

Part G

Grievance Redressal System

1. In case you have any query or complaint/ grievance, you may approach any of our nearest branches or you may contact our customer service department at the following address:

   Group Operations,
   Kotak Mahindra Life Insurance Company Ltd.,
   Kotak Towers, 7th Floor, Zone IV,
   Building No. 21, Infinity Park, Off Western Express Highway,
   General A.K. Vaidya Marg, Malad East, Mumbai 400097.
   Toll Free: 1800 120 7856
   Email ID: kli.groupoperations@kotak.com

2. In case you are not satisfied with the decision of the above office, or have not received any response within 10 days, you may contact the following official for resolution:

   The Grievance Redressal Officer,
   Kotak Mahindra Life Insurance Company Ltd.,
   Kotak Towers, 7th Floor, Zone IV,
   Building No. 21, Infinity Park, Off Western Express Highway,
   General A.K. Vaidya Marg, Malad East, Mumbai 400097
   Toll Free: 1800 209 8800
   Email ID: kli.grievance@kotak.com

3. If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

   IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255 or 1800 4254 732
   Email ID: complaints@irdai.gov.in

   You can also register your complaint online at http://www.igms.irda.gov.in/

   Address for communication for complaints:
   Consumer Affairs Department,
   Insurance Regulatory and Development Authority of India,
   Sy. No. 115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad-500032.

4. In case you are not satisfied with the decision/ resolution of the Company, you may approach the Insurance Ombudsman at the address given below if your grievance pertains to:

   (a) delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
   (b) any partial or total repudiation of claims by the Insurer;
   (c) disputes over premium paid or payable in terms of insurance policy;
   (d) misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
   (e) legal construction of insurance policies in so far as the dispute relates to claim;
   (f) policy servicing related grievances against Insurer and their agents and intermediaries;
   (g) issuance of life insurance policy, including health insurance policy which is not in conformity with the proposal form submitted by the proposer;
   (h) non-issuance of insurance policy after receipt of premium in life insurance including health insurance; and
   (i) any other matter resulting from the violation of provisions of the Insurance Act, 1938 as amended from time to time or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned at clauses (a) to (f).

5. The complaint should be made in writing duly signed by the complainant or by his legal heirs with full details of the complaint and the contact information of complainant.

6. As per Insurance Ombudsman Rules, 2017, notification no. GSR 413(E) [F.NO.14019/22/2010-INS.II], dated 25-4-2017 no complaint to the Ombudsman can be made unless:

   - the grievance has been rejected by the Grievance Redressal Machinery of the Insurer;
   - the complainant had not received a reply within a period of one month after the Insurer received the complaint.
   - the complainant is not satisfied with the reply given to him or her by the Insurer.
   - the complaint is made within a period of one year from the date of rejection of the complaint by the Insurer or after receipt of the decision of the Insurer

which is not to the satisfaction of the complainant or after expiry of one month from the date of sending the written representation to the Insurer, if the Insurer named fails to furnish reply to the complainant.

- the complaint on the same subject matter is not simultaneously pending or disposed off by any court or consumer forum or arbitrator.

As per the Ombudsman Rules 2017, the Insurance Ombudsman is not entitled to award compensation exceeding Rs. Thirty lakhs (including relevant expenses if any).

The above information is not exhaustive and is subject to change basis amendments in the relevant laws applicable.

List of Insurance Ombudsman:

Ahmedabad: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in Jurisdiction: Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Bengaluru: Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in Jurisdiction: Karnataka.
Bhopal: Office of the Insurance Ombudsman, 1st Floor of LIC Zonal Office Building, Jeevan Shikha, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal - 462011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in Jurisdiction: Madhya Pradesh, Chhattisgarh.

Bhubaneswar: Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in Jurisdiction: Odisha.
Chandigarh: Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in Jurisdiction: Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in Jurisdiction: Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in Jurisdiction: Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road,

Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in Jurisdiction: Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in Jurisdiction: Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in Jurisdiction: Rajasthan
Ernakulam: Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in Jurisdiction: Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
Kolkata: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in Jurisdiction: West Bengal, Sikkim, Andaman & Nicobar Islands.

Lucknow: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in Jurisdiction: Districts of Uttar Pradesh- Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in Jurisdiction: Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in Jurisdiction: State of Uttarakhand and the following Districts of Uttar Pradesh- Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001.

Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in Jurisdiction: Bihar, Jharkhand.
Pune: Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in Jurisdiction: Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Annexure 1: (MD): Member Data

Field Description
Customer Full Name :
Customer ID:
Certificate No. :
Location:
Plan Option:
Issuance Status of COI:
Branch Name:
Branch Code:
Agreement Date:
Customer Type (industry):
Gender:
Date Of Birth:
Risk Commencement Date:
Cover Amt
Premium Payment Term
Premium Payment Mode
Tenure in Years
Premium amount (excluding Goods and Services Tax and cess)
Goods and Services Tax and
Premium with Goods and Services Tax and cess
Confirmation for underwriting status (MQ/DOGH)
Remarks
Address of the customer (to be provided as Address 1, Address 2….. in excel file)
Pincode

All the above member details are mandatory. The Insurer shall not accept data received from the Policyholder without the above details

The above format may be altered by the Insurer from time to time with prior written notice to the Policyholder.

Annexure 2: (MU): -

Medical Underwriting Limits:

DOGH: Membership Form cum Declaration of Good Health
MQ: Medical Questionnaire

Note: Every proposed entrant must complete underwriting requirement as per above. On the basis of the disclosures made herewith, the Insurer may either call for additional information, decline cover or accept with/without health loadings on premiums or any other terms.

Annexure 3: (Age Proof) for Valid Age Proof:

List of valid age proofs:

- Birth Certificate/
- School / College Leaving Certificate, provided – it specifies Date of Birth, States that Date of Birth is extracted from School / College Records, Stamped and signed by College / School
- Passport
- Driving license
- PAN Card
- Ration Card, which specifies the Date of Issue of the Ration Card and the Date of Birth or Age of the Life to be Insured
- Election ID card (also called voters ID) issued by the Election Commission of India can be accepted as valid age proof provided it was issued at least 2 years before the date of the insurance proposal.
- Extract from service register in case of:
    - Government and semi-government employees
- In case of defense/central government/ state government personnel, identity card issued respectively by the defense department /central government/ state government to their personnel showing, inter alias, the date of birth or age
- Marriage certificate in the case of Roman Catholics issued by Roman Catholic Church
- Domicile certificate in which the date of birth stated was proved on the strength of the
- school certificate or birth certificates

NOTE: Any of the abovementioned Age Proof document submitted should have been issued at least 1 year prior to the date of the cover. In other words, any age proof document which has been issued by the respective issuing authority within a span of 1 year before the risk commencement date, then the same shall not be acceptable.

Annexure 4: Premium Rate Table

Annexure 5: Simplified Version of Section 39

Section 39 - Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

01. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.
02. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
03. Nomination can be made at any time before the maturity of the policy.
04. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.
05. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.
06. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.
07. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
08. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.
09. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.

11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.
12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).
13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them

    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.
14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act, 2015.
16. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.
17. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act, 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policyholders are advised to refer to the Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.]

Annexure 6: Simplified Version of Section 45

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 by Insurance Laws (Amendment) Act, 2015 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 revival 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 revival 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

Kotak Mahindra Life Insurance Company Limited
CIN: U66030MH2000PLC128503, IRDAI Registration No. 107, Regd. Office: 8th Floor, Plot # C-12, G- Block, BKC, Bandra (E), Mumbai- 400 051, Website: www.kotaklife.com, Email: kli.groupoperations@kotak.com, Toll Free No.: 18001207856.

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) Act, 2015 and only a simplified version prepared for general information. Policyholders are advised to refer to the Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.]