HDFC CRITICAL CARE PLAN

STANDARD POLICY PROVISIONS

Unique Identification Number: 101N035V01

1. General

Your Policy will provide a guaranteed amount on diagnosis of any of the critical illnesses described below, during the term of the Policy. The amount payable is specified in the Policy schedule. Your Policy is non-participating and no bonuses will be added to the benefits.

2. Definitions

Accident - means unexpected, unforeseen event not under the control of the insured and resulting in a loss.

Activities of Daily Living are –

- 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
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa
- Mobility: the ability to move indoors from room to room on level surfaces
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene
- Feeding: the ability to feed oneself once food has been prepared and made available.

Company, Insurer, Us, We – means HDFC Standard Life Insurance Company Limited.

Diagnosis - means the act or process of identifying or determining the nature and cause of a disease or injury through evaluation of patient history, examination, and review of laboratory data.

Due dates – means the dates at which Regular Premiums are due to be paid by you.

Expiry/Maturity Date – means the date on which the term of the Policy ends and is the date when the Critical Illness Benefit cover ceases.

Illness – means poor health resulting from disease of body or mind; sickness.

Injury – means damage or harm done to or suffered by a person.

Life Assured – means the person on whose life the contingent events has to occur for the benefits to be payable. The Life Assured must be the policyholder.

Policyholder, You - means the Policyholder stated in the Policy Schedule.

Pre-existing medical condition – means a condition (illness or bodily injury) for which, prior to the receipt of proposal for this policy or prior to the date of reinstatement of this policy:

- The life assured had signs or symptoms which would have caused any ordinary prudent person to seek treatment, diagnosis or care, or
- Medical advice or treatment was recommended by or received from a physician, or
- The life assured had undergone medical tests or investigations.

Any congenital disorder, or related illness or complication arising out of or in connection with a pre-existing medical condition, shall be considered part of that pre-existing medical condition.

Sum Assured– means the sum assured as stated in the Policy Schedule.

3. Benefits

If you pay the premiums that are due, we will pay the following benefits to you or to any other person who is entitled to receive them:

On Maturity

There is no benefit payable on maturity of the policy.

On Death

There is no benefit payable on the death of the life assured.

On Surrender

There is no benefit payable on the surrender of the policy.

On Paid-Up

There is no paid up benefit under this policy.

On Diagnosis of Critical Illness

This plan provides cover against 30 critical illnesses. Any benefit payment will be made only on survival of 30 days post the diagnosis of a critical illness. The diagnosis of Critical Illness must be confirmed by a medical practitioner acceptable to the company.

The benefit will be payable as per one of the situation described below :

Situation 1: If the diagnosed critical illness is covered under Group A (for instance, Cancer), then 100% of the Sum Assured is payable on a valid claim and the policy terminates upon this payment.

Situation 2: If the diagnosed critical illness is covered under Group B (for instance, Coma), then 50% of the Sum Assured is payable on a valid claim and all future premiums payable under this policy are waived. If the Life Assured thereafter does not get diagnosed for any other critical illnesses covered under either group A or group B during the term of the policy, the policy expires at the end of the policy term.

Situation 3: If the diagnosed critical illness is covered under Group B, then 50% of the Sum Assured is payable on a valid claim and all future premiums payable under this policy are waived. If the Life Assured is thereafter diagnosed for another critical illness covered under either Group A or Group B during the term of the policy, then the balance Sum Assured is payable on a valid claim and the policy terminates upon this payment.

The critical illnesses covered under the plan are:

Group A: Critical Illnesses where 100% of the sum assured is paid and the policy is terminated. In case 50% of the sum assured has already been paid on an earlier claim only the balance 50% of the sum assured will be payable.

(1) Cancer

A malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis must be histologically confirmed. The term cancer includes leukaemia but the following cancers are excluded:

- All tumours which are histologically described as pre-malignant, non-invasive or carcinoma in situ;
- All forms of lymphoma in the presence of any Human Immunodeficiency Virus;
- Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus;
- Any skin cancer other than invasive malignant melanoma;
- 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; and
- T1N0M0 Papillary micro-carcinoma of the thyroid less than 1cm in diameter.

(2) Coronary Artery Bypass Graft Surgery (CABGS)

The undergoing of open heart surgery on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

Angiographic evidence to support the necessity of the surgery will be required. Balloon angioplasty, laser or any catheter-based procedures are not covered.

(3) Heart Attack

The first occurrence of heart attack or myocardial infarction which means death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- Typical clinical symptoms (for example, characteristic chest pain);
- New characteristic electrocardiographic changes;
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:
  - o Troponin T > 1.0 ng/ml
  - o AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods; and
- the evidence must show a definite acute myocardial infarction.

The following are not covered:

- Angina; and
- Other acute coronary syndromes, for example myocyte necrosis.

Diagnosis must be confirmed by a consultant cardiologist acceptable to the Company.

(4) Kidney Failure

End stage renal failure presenting as chronic irreversible failure of both the kidneys to function, as a result of which either regular renal dialysis or renal transplant is undertaken. Evidence of end stage of kidney disease must be provided and the medical necessity of the dialysis or transplantation must be confirmed by a consulting physician acceptable to the Company.

(5) Major Organ Transplant (as recipient)

The receipt of a transplant of:

- Human bone marrow using haematopoietic stem cells, preceded by total bone marrow ablation; or
- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ.

Other stem-cell transplants are excluded.

(6) Stroke

A cerebrovascular accident or incident producing neurological sequelae of a permanent nature, having lasted not less than six months. Infarction of brain tissue, hemorrhage and embolisation from an extra cranial source are included. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist acceptable to the Company.

Specifically excluded are cerebral symptoms due to transient ischaemic attacks, any reversible ischaemic neurological deficit, vertebrobasilar ischaemia, cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve or vestibular functions.

Group B: Critical Illnesses where 50% of the sum assured is paid and the policy is continued unless 50% of the sum assured is paid earlier.

(7) Alzheimer's Disease

Alzheimer's disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the life assured. The diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by the Company's appointed doctor.

The following are excluded:

- Non-organic diseases such as neurosis and psychiatric illnesses;
- Alcohol related brain damage; and
- Any other type of irreversible organic disorder / dementia.

(8) Apallic Syndrome

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

(9) Aplastic Anaemia

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

- Regular blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents;
- Bone marrow transplantation.

The diagnosis and suggested line of treatment must be confirmed by a haematologist acceptable to the Company using relevant laboratory investigations, including bone-marrow biopsy. Two out of the following three values should be present:

- Absolute neutrophil count of 500 per cubic millimetre or less;
- Absolute reticulocyte count of 20 000 per cubic millimetre or less; and
- Platelet count of 20 000 per cubic millimetre or less.

(10) Benign Brain Tumour

A benign tumour in the brain where all of the following conditions are met:

- It is life threatening;
- It has caused damage to the brain;
- It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit such as (but not restricted to) characteristic symptoms of increased intracranial pressure such as papilloedema, mental seizures and sensory impairment; and
- Its presence must be confirmed by a neurologist or neurosurgeon acceptable to the Company and supported by findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging technique.

The following are excluded:

- Cysts;
- Granulomas;
- Vascular malformations;
- Haematomas;
- Tumours of the pituitary gland or spinal cord; and
- Tumours of acoustic nerve (acoustic neuroma).

(11) Cardiomyopathy

The unequivocal diagnosis by a consultant cardiologist acceptable to the Company of Cardiomyopathy causing impaired ventricular function, suspected by ECG abnormalities and confirmed by cardiac echo of variable aetiology and resulting in permanent physical impairments to the degree of at least Class IV of the New York Heart Association (NYHA) classification of cardiac impairment.

The NYHA classification of cardiac impairment (Source: "Current Medical Diagnosis and Treatment – 39th Edition"):

- Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnoea, or anginal pain.
- Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.
- Class III:Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV:Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Cardiomyopathy related to alcohol abuse is excluded.

(12) Coma

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:

- No response to external stimuli continuously for at least 96 hours;
- Life support measures are necessary to sustain life; and
- Brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. Confirmation by a neurologist acceptable to the Company must be present.

Coma resulting directly from self-inflicted injury, alcohol or drug abuse is excluded.

(13) End Stage Liver Disease

End-stage liver disease of cirrhosis means chronic end-stage liver faillure that causes all the following :

- Uncontrollable ascites;
- Permanent jaundice;
- Oesophageal or gastric varices; or
- Hepatic encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

(14) End Stage Lung Disease

Final or end-stage of lung disease, causing chronic respiratory failure, as demonstrated by all of the following:

- FEV test results consistently less than 1 litre;
- Requiring permanent supplementary oxygen therapy for hypoxemia;
- Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2 < 55mmHg); and
- Dyspnea at rest.

The diagnosis must be confirmed by qualified pulmonologist acceptable to the Company.

(15) Heart Valve Surgery

The actual undergoing of open-heart surgery to replace or repair heart valve abnormalities. The diagnosis of heart valve abnormality must be evidenced by echocardiogram and supported by cardiac catheterization, if done, and the procedure must be considered medically necessary by a consultant cardiologist acceptable to the Company. Balloon procedures are not covered.

(16) Loss of Hearing

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by audiometric and sound-threshold tests provided and certified by an Ear, Nose, and Throat (ENT) specialist acceptable to the Company.

Total means "the loss of at least 80 decibels in all frequencies of hearing" in both ears.

(17) Loss of Independent Existence

Confirmation by a consultant physician acceptable to the Company of the loss of independent existence due to illness or trauma, which has lasted for a minimum period of 6 months and results in a permanent inability to perform at least three (3) of the 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 hope of recovery with current medical knowledge and technology.

(18) Loss of Limbs

The loss by severance of two or more limbs at or above the wrist or ankle.

Loss of limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

(19) Loss of Sight

Total and irreversible loss of sight in both eyes as a result of illness or accident. The blindness must be confirmed by an ophthalmologist acceptable to the Company.
The blindness must not be able to be corrected by medical procedure.

(20) Loss of Speech

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

All psychiatric related causes are excluded.

(21) Major Burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the life assured's body. The condition should be confirmed by a consultant physician/specialist acceptable to the Company.

(22) Major Head Trauma

Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than 6 weeks from the date of the accident. This diagnosis must be confirmed by a consultant neurologist acceptable to the Company and be supported by unequivocal findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, independently of all other causes.

The accidental head injury must result in a permanent inability to perform at least three (3) of the 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 hope of recovery with current medical knowledge and technology.

The following are excluded:

- Spinal cord injury; and
- Head injury due to any other cause.

(23) Motor Neurone Disease

Motor neurone disease characterised by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateralsclerosis and primary lateral sclerosis. This diagnosis must be confirmed by a neurologist acceptable to the Company as progressive and resulting in permanent clinical impairment of motor functions.

The condition must result in the inability of the life assured to perform at least 3 of the 6 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 a continuous period of at least 6 months.

(24) Multiple Sclerosis

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

- Investigations which unequivocally confirm the diagnosis to be multiple sclerosis;
- There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
- There must be a well documented history of exacerbations and remissions of said symptoms or neurological deficits.

Other causes of neurological damage, such as SLE and HIV, are excluded.

(25) Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist acceptable to the Company, with confirmation of the combination of 3 out of 4 following conditions:

- Family history of other affected individuals;
- Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
- Characteristic electromyogram; and
- Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the life assured to perform at least 3 of the 6 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 a continuous period of at least 6 months.

(26) Paralysis / paraplegia

Complete and permanent loss of the use of two or more limbs, as a result of injury, or disease of the brain or spinal cord. To establish permanence, the paralysis must normally have persisted for at least 6 months from the date of trauma or illness resulting in the life assured being unable to perform his / her usual occupation.

The condition must be confirmed by a consultant neurologist acceptable to the Company.

(27) Parkinson's Disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a consultant neurologist acceptable to the Company.

This diagnosis must be supported by all of the following conditions:

- The disease cannot be controlled with medication;
- Signs of progressive impairment; and
- Inability of the life assured to perform at least 3 of the 6 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 a continuous period of at least 6 months.

Drug-Induced ot toxic causes of Parkinsonism are excluded.

(28) Primary Pulmonary Hypertension

Primary pulmonary hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterisation, resulting in permanent irreversible physical impairment of at least Class IV of the New York Heart Association (NYHA) classification of cardiac impairment and resulting in the life assured being unable to perform his / her usual occupation.

The NYHA classification of cardiac impairment (Source: "Current Medical Diagnosis and Treatment – 39th Edition"):

- Class I:No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnoea, or anginal pain.
- Class II:Slight limitation of physical activity. Ordinary physical activity results in symptoms.
- Class III:Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV:Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

(29) Surgery of Aorta

The actual undergoing of surgery (including key-hole type) for a disease or injury of the aorta needing excision and surgical replacement of the diseased part of the aorta with a graft.

The term "aorta" means the thoracic and abdominal aorta but not its branches.

Stent-grafting is not covered.

(30) Systemic Lupus Erythematosus

A multi-system, multifactorial, autoimmune disorder characterised by the development of auto-antibodies directed against various self-antigens. In respect of this contract, 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 certified doctor acceptable to the Company, specialising in Rheumatology and Immunology.

Other forms, discoid lupus, and those forms with only haematological and joint involvement will be specifically excluded.

WHO lupus classification:

- Class I: Minimal change – Negative, normal urine
- Class II: Mesangial – Moderate proteinuria, active sediment
- Class III: Focal Segmental – Proteinuria, active sediment
- Class IV: Diffuse – Acute nephritis with active sediment and / or nephritic syndrome
- Class V:Membranous – Nephrotic Syndrome or severe proteinuria.

Prerequisite for Payment of Benefits:

Before we pay the benefits under your Policy we will require to be satisfied that:

- the claim is for a critical illness covered under the policy
- the claim fulfills the eligibility criteria of critical illnesses covered under the policy
- the Policy has not been lapsed, surrendered, terminated or cancelled;
- the answers which were given in the application are correct;
- all Policy provisions including any endorsement to your Policy have been met;
- the person to whom the benefits are to be paid is entitled to receive them;

and in addition:

- we must be notified in writing of the diagnosis immediately and in no case later than 60 days from the date of diagnosis; and all relevant documents in support of your claim have been provided to our satisfaction. These would normally include the fully completed claim form; and original Policy document; and originals of any medical reports by the family physician on the critical illness and its treatment; and any medical report the doctor may have on the Life Assured that we consider relevant to the critical illness; and originals of any medical reports from hospitals, specialists and other doctors that we consider relevant to the critical illness. Depending on the circumstances of the illness, disability, operation or other circumstance giving rise to the claim, further documents may have to be provided as we might reasonably require.

Conditions under which claims will not be payable

- Any more than one claim in respect of any single Critical Illness.
- A second partial claim arising out of or consequent to such medical conditions prevailing at the time of the first partial claim, as confirmed by a medical practitioner acceptable to the company.

1 Maximum benefit amount for these diseases is capped at Rs. 10,00,000 per life across all policies held with HDFC Standard Life Insurance Company Limited

4. Payment and Cessation of Premiums

I. The first premium must be paid along with the submission of your completed application. Subsequent premiums are due in full on the date (s) (called here the "Due Dates") and at the frequency set out in your Policy schedule. We will not accept part payment of the premium.

II. If any premium remains unpaid after the fifteen days grace period after the Due Date, we may lapse your Policy with effect from the Due Date of the first unpaid premium.

5. Non-SI/ECS Charge

10% extra of the premium will be charged for non-SI/ECS premium payments.

6. Large Sum Assured Discount

Contracts with Sum Assured greater than Rs. 10,00,000 will be entitled to a premium discount of 15% on the excess of the (undiscounted) premium over the premium corresponding to a Sum Assured of Rs. 10,00,000 (all other parameters – age, gender, term, payment method and payment frequency – being the same). Policies that are rated up are not eligible for the large Sum Assured discount.

7. Premium Review and Guarantee

The premium rate is guaranteed for a period of three years from the date of purchase of the plan. We will review the premium rates at the end of three years, and every three years thereafter, and the rate can increase or decrease based on our experience.

Post review, in case there is any change in the premium rates, the same will be made applicable to the policy from the next policy anniversary immediately following the date of review.

In case there is any change in premium post review, the same will be guaranteed for a period of three years from the date of review.

Any change in the premium rate will be subject to IRDA approval and a notice of at least 15 days will be given to all concerned.

8. Free Look in Period

You will have the option to cancel the contract within fifteen days of receiving the policy documents.

HDFC Standard Life will refund the below mentioned amount:

- premium amount received
- less stamp duty paid
- less cost of cover for the period under cover
- less medical costs incurred.

9. Revival

The policy can be revived within two years from the date of lapsation, either by submitting a personal health statement or by undergoing a full medical underwriting, if required by us, and by paying the applicable premium arrears along with the revival charges.

No more than one revival will be permitted over the life time of the plan.

The cost of medicals for underwriting will be borne by you and we will charge a policy revival fee at the time of revival.

10.Waiting Period

This plan has a waiting period of 180 days from the date of inception or issue of policy or revival whichever is later. No claim will be paid during this waiting period unless the claim arises due to accidental causes.

11.Loans

There is no facility of loans from us against this contract.

12.Assignments and Nominations

Any notice of assignment or change in nomination must be notified in writing to us at our Correspondence Address noted in your Policy schedule.

13.Exclusions:

We shall not be liable to pay any benefit indicated in the policy schedule if the critical illness is caused directly or indirectly by the following:

- Any of the listed dread disease conditions where death occurs within 30 days of the diagnosis
- Any sickness related condition manifesting itself within 180 days of the commencement of the policy/date of acceptance of risk or reinstatement, whichever is later.
- Intentionally self-inflicted injury or attempted suicide, irrespective of mental condition.
- Alcohol or solvent abuse, or the taking of drugs except under the direction of a registered medical practitioner.
- War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
- Service in any military, police, paramilitary or similar organisation.
- Taking part in any act of a criminal nature.
- Any Pre-existing medical condition.
- HIV or AIDS
- Unreasonable failure to seek medical advice
- Radioactive contamination due to nuclear accident
- Diagnosis or treatment outside India except in case of emergency

1 The Policyholder has delayed medical treatment in order to evade the waiting period or other conditions and restrictions pertaining to the policy.

14.Incorrect Information and Non-disclosure

Your Policy is based on the application and declaration which you have made to us and other information provided by you/on your behalf. However, if any of the information provided is incomplete or incorrect, we reserve the right to vary the benefits, which may be payable and, further, if there has been non-disclosure of a material fact then we may treat your Policy as void from inception.

For your benefit, Section 45 of the Insurance Act, 1938 is reproduced below:

No policy of life insurance effected before the commencement of this Act shall after the expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this Act shall, after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy-holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose:

Provided that nothing in this section shall prevent the insurer from calling 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 that the age of the life insured was incorrectly stated in the proposal.

15.Insurance Legislation

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 as may be introduced there under from time to time by that Authority.

It is required to obtain prior approval from the Insurance Regulatory and Development Authority or any successor body before making any material changes to these Provisions.