AVIVA Health Secure

AVIVA Life Insurance

Aviva Health Secure – Get paid a lump sum in case of critical illness

Aviva Health Secure is a health insurance plan that pays you a lump sum amount in case you are diagnosed with any critical illness and procedures as listed ahead.

The kind of lifestyle and stress under which we work on a day to day basis has made us more prone to a lot of critical illnesses, sometimes even at a very early age. More often than not, the cost of treatment or procedure of these diseases are very expensive and can make a serious dent in our savings. Covering the lump sum cost of these critical illnesses is a definitive way to cover your medical expenses. This would not only ensure that you utilise your savings as planned, but would also help you cope up with any lifestyle changes post the critical illness.

Aviva Health Secure
Unique Attractions

Critical Illness Benefit: You get a lump sum amount in case you are diagnosed with any of the 12 major critical illnesses as listed later.

Convenience: You can buy this plan online to save the time and effort that would have been otherwise required.

Tax Benefit: Premiums paid towards this Policy may be eligible for tax benefits as per Section 80D of Income Tax Act 1961. Tax laws are subject to change.

Eligibility Conditions

Entry Age	Minimum: 18 years (last birthday) Maximum: 55 years (last birthday)	
Maturity Age	Maximum: 65 years (last birthday)	
Premium Payment Frequency	Yearly/Half-yearly	
Policy Term	Minimum: 10 years Maximum: 30 years	
Sum Assured	Minimum: ₹ 5,00,000 Maximum: ₹ 50,00,000 (including Critical Illness cover taken under other policies)	
Annual Premium	Minimum: ₹ 2,000	
Premium Payment Term	Equal to the Policy Term	
Payment Frequency	Yearly/Half-yearly (Half-yearly Premium = Yearly Premium X 0.5108)	
Rebate on Large Sum Assured	There is a rebate if you opt for a Sum Assured (SA) of ₹ 10 Lacs and above:	
	Sum Assured (₹)	Rebate per 1000 SA (₹)
	>=10 Lacs and <25 Lacs	₹ 0.90
	>=25 Lacs	₹ 1.50
	Please refer to the Premium quotation to calculate the instalment Premium for your Proposal.	

What are the benefits payable:

Critical Illness

This product provides protection against 12 major critical illnesses by providing a lump sum amount equal to the Sum Assured. The Premium rates will not change for the first five years. However, the Premium rates are reviewable at every five Policy years at the Policy anniversary after approval from the IRDA of India. Such review of Premium rates will be performed by the Company at the beginning of the calendar year and Premium rates after review would only be applicable for the contracts for which the review falls due in that year.

Death, Surrender or Maturity Benefit:

This is a pure health insurance product and hence nothing is payable in case of death, surrender or maturity under this product.

How do I claim in the event of a Critical Illness (CI):

You can claim at the first diagnosis of any Critical Illness provided the Critical Illness has been diagnosed after 90 days of the Policy commencement date or the date of reinstatement.

You would be eligible for the lump sum amount (Sum Assured) provided you have survived at least 30 days after the diagnosis of the Critical Illness.

You need to ensure that Critical Illness is confirmed by a registered medical practitioner, including a relevant specialist acceptable to the Company (the cost of which shall be borne by the Policyholder).

A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license, Medical practitioner shall not include:

a) the Policyholder's close relative; or
b) a person who resides with the Policyholder; or
c) a person covered under this Policy.

"Specialist" means a person who holds a recognised post graduate qualification in any specialised stream of allopathic medicine, is registered by the Indian Medical Council and is practicing within the scope of such license, and shall not include:

a) any relative of the Policyholder/Insured; or
b) any person who resides with the Policyholder/Insured; or
c) any person covered under the Base Plan or this Rider

You are required to file a claim with all the required documents within 90 days from the date of diagnosis of Critical Illness. However, this condition will not prevent the Company from settlement of genuine claims, particularly when the delay in intimation or in submission of required claim documents is due to unavoidable circumstances.

What diseases are covered as Critical Illnesses?

1. First heart attack – of specified severity

I. The first occurrence of 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 this will be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers

II. The following are excluded:

i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
ii. Other acute Coronary Syndromes
iii. Any type of angina pectoris

2. Stroke resulting in permanent symptoms

I. 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.

II. The following are excluded:

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

3. Cancer of specified severity

I. A malignant tumour characterised by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. The diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. Tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 & CIN-3
ii. Any skin cancer other than invasive malignant melanoma
iii. 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
iv. Papillary micro – carcinoma of the thyroid less than 1 cm in diameter
v. Chronic lymphocyctic leukaemia less than RAI stage 3
vi. Microcarcinoma of the bladder
vii. All tumours in the presence of HIV infection

4. Kidney failure requiring regular dialysis

I. 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.

5. Major Organ/Bone Marrow Transplant

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i. Other stem cell transplants

ii. Where only islets of langerhans are transplanted

6. Open Chest CABG

I. The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realisation of surgery has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

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

ii. Any key-hole or laser surgery

7. Benign Brain Tumour

A benign brain tumour means a tumour that is in the brain or meninges excluding the skull, spinal cord. Cysts, abscesses, malformations in the arteries or veins of the brain, haematomas are excluded. Pituitary microadenomas less than 10 mm in diameter are also excluded.

The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of these investigations and acceptable to us.

8. Open Heart Replacement or Repair of Heart Valves

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realisation of surgery has to be confirmed by a specialist medical practitioner. Catheter bases techniques including by not limited to ballon valvotomy/valvuloplasty are excluded.

9. Motor Neurone Disease with Permanent Symptoms

I. Motor Neurone Disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

10. Multiple Sclerosis with Persisting Symptoms

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

i. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

iii. Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least 1 month apart

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

11. Coma of Specified Severity

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

i. No response to external stimuli continuously for at least 96 hours;

ii. Life support measures are necessary to sustain life; and

iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

12. Permanent Paralysis of Limbs

I. Total 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.

What are the exclusions under this plan?

No benefit amount will be payable if the Insured suffers from any of Critical Illnesses as listed above caused directly or indirectly by attempting suicide within one year from the date of commencement of risk or date of reinstatement of the Policy, whichever is later.

Apart from the disease specific exclusions given along with definitions of diseases, no benefit will be payable if the Critical Illness is caused or aggravated directly or indirectly by any of the following acts of the life insured unless those are beyond his/her control:

- Alcohol or drug abuse including taking drugs other than those prescribed by a registered and qualified medical practitioner, any actual or alleged crime committed by the Insured, willful self inflicted injury and attempted suicide
- Failure to seek or follow medical advice
- Engaging in racing of any kind, other than athletics or swimming
- Any form of war, invasion, hostilities (whether war be declared or not), civil war, rebellion, riots, social disorder, insurrection, military or usurped power, or willful participation in acts of violence
- Radioactive contamination due to a nuclear accident
- Any mental or functional disorder, where the definitions are:
  - Functional disorder is a disorder of physiological function having no known organic basis
  - Mental disorder is any clinically significant behavioural or psychological syndrome characterised by the presence of distressing symptoms, impairment of functioning, or significantly increased risk of suffering death, pain, or other disability
- Participation in sports or pastimes of a hazardous nature including (but not limited to) parachuting, potholing, mountaineering and hot air ballooning
- Any condition, ailment or injury or related condition(s) for which Insured had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months to prior to the commencement or reinstatement of the Policy

What Happens if I am Unable to Pay Premiums on Time?

You get a grace period of 30 days from due date to pay the Premium without any interest. If the Premium is not received within the grace period, your Policy will lapse and the cover will cease immediately. The Policy does not acquire any Surrender Value or Paid up Value.

Can I reinstate Lapsed Policy?

A lapsed Policy may be revived during the Policy Term within a revival period of 1 year from the date of first unpaid Premium by submitting the proof of continued insurability to the satisfaction of the Company and making the payment of all due Premiums.

Policyholder will be subject to the then underwriting requirements at the time of reinstatement, basis which the Company may either accept or decline the reinstatement. Further the Company reserves the right to impose any extra Premium as a results of underwriting. The revival of a Lapsed Policy is also subject to payment of revival fee of ₹ 250/-. At the time of revival, the cost of medical examination and special tests, if any, will be borne by the Policyholder.

If at the end of the revival period, the Policy is not revived, the Policy shall terminate and no benefit shall be payable thereafter.

Miscellaneous

Freelook Period

The Policy Terms and Conditions can be reviewed within 30 days from the date of receipt of the Policy document. If the Policy is cancelled during this Freelook Period, the Company will refund the Premium paid after deducting proportionate risk Premium and expenses incurred on medicals and stamp duty.

Cost of Medical Examination

At the time of purchase of the Policy, the cost of medical examination and special tests, if any, will be borne by the Company. At the time of revival of a Lapsed Policy, the cost of medical examination and special tests, if any, will be borne by you.

Nomination & Assignment

Assignment and Nomination is allowed as per the provisions under Section 38 and 39 of Insurance Act 1938, as amended from time to time.

Loan

Loan will not be allowed under this plan.

Section 41

In accordance with Section 41 of the Insurance Act 1938, (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the Premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

Provided that acceptance by an insurance agent of commission in connection with a Policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of Premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Section 45

Policy not to be called in question on ground of misstatement after three years as per Section 45 of the Insurance Act 1938, as amended from time to time.

About Aviva

Aviva Life Insurance Company India Limited is a joint venture between Dabur Invest Corp and Aviva International Holdings Limited - a UK based insurance group, whose association with India dates back to 1834. Aviva group is one of the oldest insurance groups in the world. Currently, it serves 31 million customers across 16 countries (March, 2015).

The Dabur Group, founded in 1884, is one of India's leading producers of traditional healthcare products.

Queries and Complaints

If you would like additional information or if you have any queries or complaints, please contact us at the numbers given below:

For more details, call us at 1800-103-8000
(Toll free for BSNL/MTNL users) or 0124-2709046 or SMS 'Aviva' to 5676737 Website: www.avivaindia.com

AVIVA
Life Insurance

A joint venture between Dabur Invest Corp. and Aviva International Holdings Limited.

Aviva Life Insurance Company India Limited
Aviva Tower, Sector Road, Opposite Golf Course, DLF Phase-V, Sector 43, Gurgaon-122 003, Haryana, India
Website: www.avivaindia.com

Registered Office: 2nd Floor, Prakashdeep Building, 7, Tolstoy Marg, New Delhi-110 001

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Aviva Health Secure is a traditional non-participating product.