BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED

Annexure H

UL MAHILA GAIN

UL MAHILA GAIN II

This Rider option will provide cover against

Critical Illness + Reconstructive breast surgery

The Rider is offered only to female Life Assured. The Rider can be chosen at Policy inception only. The coverage for the above Rider can only be chosen where the issue Age of the Life Assured is not less than 18 (eighteen) and not more than 45 (forty five) years. Coverage shall be provided until the maturity Age or 55 (fifty five) whichever is earlier. The minimum Sum Assured that can be opted for the Rider is Rs. 50,000 with the maximum Sum Assured being Rs.10 lacs.

The Rider charges will be applied on the Sum Assured chosen and would depend on the attained Age of the Life Assured in any particular Policy year. The Rider charges will be deducted at the start of each monthly anniversary by cancellation of units from the unit account.

At each Policy anniversary the Life Assured has the option to exclude the Rider coverage. In case of exclusion, no surrender value is paid.
Rider cover expires if

- If the Policyholder opts out of this Rider option once.
- On the Policy anniversary in which the attained Age is 55
- Policy term under the base Policy is completed.

The charges for the UL Mahila Gain II rider are guaranteed for five years only from the Date of Commencement of the Policy. The Company reserves the right to carry out a general review of the experience from time to time and change the charges as a result of such review on approval from the IRDA. The Company will give notice in writing about the change in charges and the Policyholder will have the option not to pay an increased charge. In such case the UL Mahila Gain II rider cover would expire.

I. CRITICAL ILLNESS

In case the Life Assured is diagnosed with any of the critical illnesses mentioned below and the Policy is in full force, the Company shall pay a sum equal to the critical illness benefit which is equal to a maximum of 100% of Sum Assured for this cover and the Policy will continue with all other benefits.

There is a waiting period of 180 (one hundred and eighty) days, i.e. the critical illness benefit can only be claimed if the illness is diagnosed at least one hundred and eighty days after the date of commencement or reinstatement of risk. If the Life Assured has been diagnosed with any of the condition mentioned under critical illness, the Company should be intimated of the same within 30 days from the date of diagnosis.

No benefit shall be payable until the insured person has provided satisfactory proof to the Company of the occurrence of the relevant critical illness. This includes a diagnosis confirmed by a registered Medical Practitioner with relevant specialization supported by acceptable clinical, radiological, histological and laboratory evidence acceptable to the Company.

The critical illness cover terminates on payment of the first critical illness benefit but the Policy continues with all the other benefits.
However, where the Life Assured dies within 60 (sixty) days of such diagnosis for which critical illness benefit has become payable, death benefit will be payable after the deduction of critical illness benefit. This deduction will not be applicable when the Life Assured dies after 60 (sixty) days from the date of diagnosis of the illness for which critical illness benefit becomes payable.

Critical illnesses to be covered

(1)Cancer
A disease manifested by the presence of a malignant tumour characterised by the uncontrolled growth and spread of malignant cells, and the invasion of tissue. The diagnosis must be evidenced by definite histology. The term cancer also includes leukaemia and malignant disease of the lymphatic system such as Hodgkin's Disease.

Excluded are: any CIN stage (cervical intraepithelial neoplasia); any pre-malignant tu mour; any noninvasive cancer (cancer in situ); prostate cancer stage 1 (T1a, 1b, 1c); all skin cancers including malignant melanoma stage IA (T1a N0 M0); any malignant tumour in the presence of any Human Immunodeficiency Virus.

(2)Heart Attack (Myocardial Infarction)

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:
a) a history of typical chest pain
b) new characteristic electrocardiogram changes
c) elevation of infarction specific enzymes, Troponins or other biochemical markers

Excluded are: Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T; other acute Coronary Syndromes.

(3)Stroke
Any cerebrovascular incident producing neurological sequelae lasting more than 24 hours and including infarction of brain tissue, haemorrhage and embolisation from an extracranial source. Evidence of neurological deficit for at least 3 months has to be produced.

Excluded are: Transient ischemic attacks (TIA); neurological symptoms due to migraine.

(4)Coronary Artery (Bypass) Surgery
The actual undergoing of open chest surgery for the correction of two or more coronary arteries, which are narrowed or blocked, by coronary artery bypass graft (CABG). The surgery must have been proven to be necessary by means of coronary angiography.

Excluded are: Angioplasty and/or any other intra-arterial procedures; key-hole surgery.

(5)Kidney Failure (End Stage Renal Disease)
End stage renal disease presented 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.

(6)Major Organ Transplantation
The actual undergoing of a transplantation as the recipient of a heart, lung, liver, pancreas, small bowel, kidney or bone marrow.

(7)Paralysis
Total and irreversible loss of use of two or more limbs through paralysis due to accident or sickness of the spinal cord. These conditions have to be medically documented for at least 3 months.

Excluded is: Paralysis due to Guillain-Barré-Syndrome.

(8)Aorta (Surgery of Aorta)
The actual undergoing of surgery for a chronic disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

(9)Multiple Sclerosis
Unequivocal diagnosis of Multiple Sclerosis by a consultant neurologist holding such an appointment at an approved hospital. The Insured must exhibit neurological abnormalities that have existed for a continuous period of at least 6 months or must have had at least two clinically documented episodes (each lasting at least 24 hours and occurring at least one month apart in different areas of the central nervous system). This must be evidenced by the typical symptoms of demyelination and impairment of motor and sensory functions as well as by typical MRI findings.

(10)Alzheimer's Disease before Age 60
Clinically established diagnosis of Alzheimer's Disease (presenile dementia) before Age 60 resulting in a permanent inability to perform independently three or more Activities of Daily Living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and the permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months.

(11)Primary Pulmonary Arterial Hypertension
An increase in the blood pressure in the pulmonary arteries, caused by either an increase in pulmonary capillary pressure, increased pulmonary blood flow or increased pulmonary vascular resistance. The diagnosis has to be proved by cardiac catheteriziation showing a mean pulmonary artery pressure of at least 20 mmHg. Right ventricular hypertrophy, dilatation and signs of right heart failure have to be documented for at least 3 months.

Exclusions

In the following cases the critical illness benefit shall not be paid:

(a) Critical illness occurs as a result of the insured person committing any breach of law;

(b) Critical illness existed at the date of commencement or reinstatement of risk;

(c) Critical illness is diagnosed within 6 month of the date of commencement or reinstatement;
(d) Critical illness as a result of AIDS, any AIDS related illness or HIV infection;
(e) Critical illness as a result of self-inflicted injuries whilst sane or insane;
(f) Critical illness as a result of war, invasion, civil war, rebellion or riot;
(g) Critical illness as a consequence of the insured person being under the influence of alcohol or drugs other than in accordance with the directions of a registered medical practitioner;
(h) Critical illness occurs as a result of the insured person taking part in any naval, military or air force operation;
(i) Critical illness occurs as a result of the insured person participating in or training for any dangerous or hazardous sport or competition or riding or driving in any form of race or competition;
(j) Critical illness occurs as a result of aviation, gliding or any form of aerial flight other than as a fare paying passenger of a recognised airline on regular routes and on a scheduled timetable;
(k) Critical illness as a result of failure to seek or follow medical advice.

II. RECONSTRUCTIVE BREAST SURGERY

In case the Policyholder is diagnosed as suffering from breast cancer and therefore undergoes reconstructive breast surgery and the Policy is in full force, the Company shall pay Reconstructive breast surgery benefit equal to 30% of the Sum Assured for this cover (subject to a maximum of Rs. 30,000) for one breast, and 40% of the Sum Assured for this cover (subject to a maximum of Rs. 40,000) for two breasts.

There is a waiting period of 180 (one hundred and eighty) days, i.e. the Reconstructive breast surgery benefit can only be claimed if breast cancer is diagnosed at least 180 days after the date of commencement of risk or reinstatement of risk. The Company should be intimated of the same within 30 days from the date of diagnosis.

Breast reconstruction will mean, for the purpose of this Policy, the surgical procedure to rebuild the contour of breast(s) after removal (mastectomy) due to breast cancer. Reconstruction can either be done by using a breast implant (prothesis) or by using the woman's own tissue (tissue flap techniques). Breast cancer as the underlying disease must have been evidenced by definite

histology and a surgical report must confirm the actual undergoing of reconstructive breast surgery.

No benefit is payable until the insured person has provided satisfactory proof to the Company of the relevant Reconstructive breast surgery. This includes authentic evidence of actual undergoing of reconstructive breast surgery due to breast cancer diagnosed by an oncologist supported by surgical, clinical, radiological, histological and laboratory evidence acceptable to the Company.

The Reconstructive breast surgery cover terminates on payment of the Reconstructive breast surgery benefit, but the Policy continues with all the other benefits.

Exclusions

a) Reduction or augmentation mammaplasty of the unaffected breasts

CHANGE OF OCCUPATION (applicable to all the benefits)

The insured must notify the Company in writing as soon as possible and in any case within 10 (ten) days upon a change of occupation.
The new occupation shall be classified according to the underwriting rules of the Company at the time of change and:

- The new occupation is in the class of risk which the Company declines for such Benefits, the Benefits shall cease as from the date of change of occupation with no surrender value payable.

- If, in the Company's opinion, the new occupation is in a class of lower risk then the reduced Rider charges shall be applicable from the Policy year following the Policy year when the change of occupation is intimated.

- The new occupation is in a class which the Company accepts but is a higher risk, then the revised higher charge for increased risk shall be applicable from the date of commencement of Policy year in which the change of occupation occurs irrespective of the time when the Company is informed of such change.

- Where there is failure in notifying the Company about change in occupation and Rider charges are paid based on the former occupation class and the new occupation is in a class of higher risk, then, in case of claim the Company shall pay the benefit according to the ratio which the charges paid bears to the charges which would have been paid if the higher risk class had been charged.