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POLICY DATE_____POLICY NUMBER_____

POLICY HOLDER_____

POLICY ANIVERSARIES_____

PREMIUM DUE DATES_____

INSURANCE BENEFITS_____

American Life Insurance Company (herein called the Insurance Company) in consideration of the Application for this Policy and of the Payment of premiums as provided in the Policy, hereby

AGREES TO PAY

benefits in accordance with and subject to the terms of the Policy

- The Policy takes effect on the Policy Date shown above.
- Premiums are payable by the Policyholder in amounts determined as hereinafter provided. The first premium is due on the Policy Date, and subsequent premiums are due on the Premium Due Dates shown above.
- The Sections set forth on the following pages of the Policy and attached Riders are part of the Policy.

IN WITNESS WHERE OF, American Life Insurance Company has caused the Policy to be executed as of the Policy Date.

Registrar

Date Prepared:_____

APPLICATION AND ACCEPTANCE

Application is hereby made to the Insurance Company by the Policyholder for this Policy under which insurance is provided, the terms of which are approved and accepted by the Policyholder to take effect on the Policy Date following signature by the applicant. It is agreed that this Application supersedes any previous Application for this Policy.

Signed at: _____ _____
(Name of Policyholder)

Signed on: _____ _____ by: _____
(Company Seal) (Signature & Title)

THE POLICY-GENERAL PROVISIONS

Clause 1 THE CONTRACT, ITS PROVISIONS AND LIMITATIONS

The Policy, the Application of the Policyholder and the individual applications, if any, of the persons insured, the Policy Specifications, constitute the entire contract between the parties hereto. All statements made by the policyholder or by the persons insured shall, in the absence of fraud, be deemed representations and not warranties and no statement shall void the insurance, or be used in defense of a claim under it, unless it is contained in a written application.

The validity of the Policy shall not be contested, except for non-payment of premium, after it has been in force for two years from its Policy Date. No statement made by any person insured under the Policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by such person.

The Policy may be amended at any time, without the consent of the insured hereunder or any other person having a beneficial interest therein, upon written request made by the Policyholder and agreed to by the Insurance Company, but any amendment shall be without prejudice to any claim arising prior to the date of the change. The Policy may be amended to terminate the coverage provided for Insured in any area because of any war, or act of war, such amendment to take effect on the date communicated to the Policyholder by the Insurance Company.

No Agent is authorized to alter or amend this Policy, to waive any conditions or restrictions contained herein, to extend the time of paying a premium or to bind the Insurance Company by making any promise or representation. No change in this Policy shall be valid unless evidenced by an endorsement hereon signed by the Chairman of the Board, President, Vice President, Regional Senior Vice-President, Actuary, Assistant Actuary, Secretary, Regional Secretary, Assistant Secretary or Registrar of the Insurance Company, or by an amendment hereto signed by the Policyholder and by one of the aforesaid officers of the insurance Company.

Wherever in this Policy a personal pronoun in the masculine gender is used or appears, it shall be taken to include the feminine gender also, unless the context clearly indicates the contrary.

It is agreed that this policy shall be interpreted in accordance with the Insurance Act 2049. It is also agreed that 12:01 a.m. standard time in Nepal shall be deemed to be the effective time with respect to any date referred to in the Policy.

Clause 2 CERTIFICATES

The Insurance Company may, upon specific request from the Policyholder, issue to the Policyholder, for delivery to insured hereunder an individual certificate setting forth a statement as to the insurance protection to which the insured person is entitled.

Clause 3 RECORDS AND REPORTS

The Policyholder shall keep a record of the persons insured under the Policy containing, for each person, the essential particulars of the insurance. The Policyholder shall periodically forward to the Insurance Company, such information concerning the persons eligible for the insurance under the Policy as may reasonably be considered to have a bearing on the administration of the insurance under the Policy and on the determination of the premium rates. Such records of the policyholder as have a bearing of the insurance shall be open for inspection by the insurance Company at any reasonable time.

Clerical error in keeping the records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated, but upon discovery of such error an equitable adjustment of premium shall be made.

Clause 4 PREMIUMS

Premiums under the Policy are payable by the Policyholder at such office or offices of the Insurance Company as the Insurance Company may designate in writing to the Policyholder from time to time. Such premiums are due and payable as specified in the policy. The premium due under the Policy on each premium due date shall be the sum of the periodic premium charges for the Insured persons enrolled during the said period for the insurance. The premium charges shall be based upon the rates set forth in the Comprehensive Group Medical Insurance Policy Specifications (hereinafter referred to as "Policy Specifications"), provided that (a) on any Policy Anniversay date, by amendment to the Policy, the Insurance Company may, by providing thirty-one (31) days notice to the Policyholder and by mutual agreement with the Policyholder, change the rates at which further premium charges for the insurance provided by the policy, including any then due, shall be computed, and (b) on any date the extent of coverage under the Policy is changed by amendment to the Policy, the Insurance Company may, by notifying the Policyholder, change the rates at which further premium charges for the insurance provided by the Policy , including any then due, shall be computed.

Clause 5 GRACE IN PAYMENT OF PREMIUMS / TERMINATION OF POLICY

A grace period of thirty-one days, without interest charge, will be allowed for the payment of the premium due under the Policy on any due date except the first. If any premium is not paid before the expiration of the grace period the Policy shall terminate at the end of such grace period, except that if the Policyholder makes written request in advance for termination of the Policy to take effect at any time from the end of the period for which premiums have been paid to the end of the grace period, the Policy shall terminate on the date requested.

This policy could be cancelled by either party on any Policy Anniversary subject to thirty-one (31) days Notice of Cancellation.

Clause 6 CURRENCY

All Payments by the Insurance Company under the Policy shall be made in the same currency as that in which premiums were received by the Insurance Company with respect to the insurance hereunder of the insured, unless otherwise arranged by mutual agreement between the Policyholder and the Insurance Company.

Clause 7 NON-PARTICIPATION

The policy shall not participate in the surplus earnings of the Insurance Company.

Clause 8 ELIGIBILITY

A person eligible for insurance hereunder shall be deemed to refer to any person related to the Policyholder who has answered favourably to questions contained in the G-42 Health Questionnaire of the Insurance Company and is deemed to be acceptable by the Insurance Company to be covered and as defined in Clause 2 – Definitins of “Insured” Comprehensive Group Medical Insurance provisions.

Clause 9 CHANGES IN INSURANCE COVERAGE

If the insurance coverage shown in (c) Insurance coverage-Policy Specifications is subject to change due to changes in Insured’s classification, the following provisions shall apply:

The policyholder shall determine from time to time without discrimination among persons in like circumstances, the classification of each individual Insured, and such determination shall be final and conclusive.

If an insured or employee’s classification changes, the Insured’s insurance shall be adjusted automatically in accordance with the new coverage to conform to the new classification on the date set forth in (d) Changes in Insurance Coverage-Policy Specifications. However, if thirty-one days elapse after change to a classification for which a larger amount of insurance is provided and the Insured fails to make any required premium to the new amount of insurance no increase shall be allowed as a result of such change or any subsequent change unless the Insured furnishes evidence of insurability satisfactory to the Insurance Company.

Should any insured’s insurance be continued during disability, the insurance coverage shall be the same as that for which he was insured immediately prior to such disability.

Clause 10 TERMINATION OF INDIVIDUAL INSURED’S INSURANCE

An Insured’s insurance under this Policy shall automatically terminate : (i) if his employment or relationship with the Policyholder terminates, (ii) if he ceases to be a member of the class or classes of persons eligible for the insurance under the Policy, (iii) if the Policy terminates; (iv) if the Policyholder fails to make payment of , any required premium when due on behalf of the Insured; or, (v) on the date set forth in (e) Termination of Individual Insured’s Insurance - Policy Specifications.

Termination of employment or relationship with Policyholder shall, for all purposes of this policy, be deemed to occur when an Insured ceases to be a person eligible for Insurance coverage under this Policy with the Policyholder. The Policyholder, acting on a basis precluding individual selection, may terminate the Insured’s Insurance by notifying the Insurance Company to that effect or by discontinuing premium payments for his insurance.

Clause 11 BENEFICIARY

The benefits under this Policy shall be payable to the Insured himself or a person designated by him.

Clause 12 AGE CORRECTION

If the age of an insured under this Policy is misstated, there shall be an adjustment in records provided that the corrected age falls within the Eligible Age Groups as shown in (b) Eligibility – Policy Specifications. . The insurance hereunder shall remain unchanged if the insurance coverages applicable to the individual Insured under this Policy do not depend upon age; but if the change in age affects the individual's insurance coverages, they shall be corrected accordingly and the premium adjustment shall take such correction into account.

Clause 13 PARTICIPATION REQUIREMENTS

The insured under this Policy must be no less than 5 in number and one-hundred percent (100%) of the selected sub-group of persons who fulfil the eligibility requirement for insurance under this Policy barring only those who cannot be covered on grounds of health or physical conditions.

Clause 14 TERMINATION OF POLICY

If on the first Policy Anniversary of this Policy or on any premium due date thereafter when the requirements under Clause 13 of The Policy-General Provisions, are not complied with, the Insurance Company may thereupon terminate insurance under this Policy provided written notice of the Insurance Company's intention to effect such termination has been given to the Policyholder at least thirty-one (31) days in advance. It is further provided that the Policyholder, or the Insurance Company may terminate this Policy at any time after the first Policy Anniversary by mailing to the other party written notice of such intention at least thirty-one (31) days in advance of the termination date.

Clause 15 CLAIMS

Notice of Claim: Written notice of an occurrence upon which a claim under this Policy may be based must be given to the Insurance Company within thirty (30) days of such occurrence. Notice given by or on behalf of the claimant to the Insurance Company with particulars sufficient to identify the insured, shall be deemed to be notice to the Insurance Company.
Proof of Loss: The Insurance Company, upon receipt of above notice, will furnish forms for filling proof of loss. The forms must be completed and returned to the Insurance Company within ninety (90) days after the date of the loss for which claim is made. Failure to furnish notice of happening or proof of loss within the time limits required above shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible, to give such notice or proof and that notice and proof were given as soon as was reasonably possible.
Examinations: The Insurance Company shall have the right and opportunity through its medical representative to examine the insured when and so often as it may reasonably require during the pendency of a claim hereunder.
Payment of Claim: Any claim under this Policy is payable in accordance with Clause 11 – The Policy – General Provisions.
Legal Proceeding : Legal action in relation to this Policy shall be taken in accordance with the Insurance Act 2049 of Nepal and its amendments.

Clause 16 : "ACQUIRED IMMUNE DEFICIENCY SYNDROME – AIDS"

No benefits shall be paid under this Policy, in the event of an Insured's loss of a covered event by an opportunistic infection, a malignant neoplasm or suicide, if at the time of such occurrence, there is present in the subject Insured an Acquired Immune Deficiency Syndrome (AIDS).

1. For the purpose of this Clause, the terms "Acquired Immune Deficiency Syndrome" shall have the meanings assigned to it by the World Health Organization. A copy of the definition is maintained in the Company's Head Office in the country of issue of the Policy.
2. Opportunistic infection includes but is not limited to pneumocystis carinii pneumonia, organism of chronic enteritis, virus and/or disseminated fungi infection.
3. Malignant neoplasm shall include but not be limited to Kaposi's sarcoma, central nervous system lymphoma, hairy cell leukaemia and/or other malignancies now known or which become known as immediate cause of the incurring of medical expenses in the presence of acquired immune deficiency.
4. Acquired Immune Deficiency Syndrome shall include Human Immune Deficiency (HIV) Virus, encephalopathy (dementia), and HIV Wasting Syndrome.

Clause 17 WAR RESTRICTION CLAUSE

It is hereby agreed that, notwithstanding the provisions of this Policy , if an Insured incurs Medical expenses as a direct or indirect consequence of his active participation in war or warlike operations, (whether war be declared or not) or of invasion, act of foreign enemy, hostilities, mutiny, riot, civil commotion, civil war, rebellion, revolution, insurrection, conspiracy, military or usurped power, martial law or state of siege, or any of the events or causes which determine the proclamation or maintenance of martial law or state of siege, no payment shall be made under the terms of this policy.

COMPREHENSIVE GROUP MEDICAL INSURANCE PROVISIONS

CLAUSE 1 - BENEFITS

The Insurance Company shall reimburse the necessary reasonable and customary medical expenses incurred by an Insured as set forth in *(c) Insurance Coverage – Policy Specifications* for the kinds of care described herein during the continuance of the Policy in excess of Co-payment / Co-insurance as set forth in (c) Insurance Coverage – Policy Specifications and up to the Maximum Benefit as set forth in (c) Insurance Coverage - Policy Specifications with respect to each one individual, subject to the provisions set forth in this Policy. (See Clause 9 of this Comprehensive Group Medical insurance Provisions for "Maternity/ Obstetrical Benefits").

CLAUSE 2 - DEFINITIONS

"Insured" shall be deemed to refer to:

1. a full time active Employee of the Policyholder , Resident in Nepal who are within the age limits set forth in (b.) Eligibility – Policy Specifications for all benefits provided under this plan , who is insured under the terms and provisions of this Policy; and
2. if Dependants of such Employees are eligible under the terms of this Policy, to an insured Dependant; and
3. to any other person related to Policyholder who is considered eligible for such coverage by the Insurance Company.

"Physician" means only a doctor or surgeon who is a doctor of medicine or equivalent, legally licensed to practice medicine and qualified to render the treatment provided.

"Reasonable and Customary" shall be deemed to refer to a charge for medical care which shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals of the same sex and of comparable age and income, for a similar disease or injury.

"Disability" shall be deemed to mean a sickness or accidental bodily injury necessitating medical treatment by a licensed physician. All bodily injuries sustained in any one accident shall be considered one disability. All bodily disorders existing simultaneously, which are due to the same or related causes, shall be considered one disability. If a disability is due to causes, which are the same or related to the cause of a prior disability (including complications arising therefrom) the disability shall be considered a continuation of the prior disability and nor a separate disability. However, for cases requiring hospital confinement, after 90 days following the latest discharge from the hospital, subsequent hospital confinement arising from the same cause shall be considered a new disability; for cases not requiring hospital confinement, a new disability is established after a period of 90 days has elapsed following the day upon which the last reimbursed expenses was incurred, unless expenses are not reimbursed because of the exhaustion of the maximum benefit.

"Hospital" means only an institution licensed as a hospital (if licensing is required) and operated for the care and treatment of sick and injured persons, which institution provides 24-hour nursing care and has facilities for both diagnosis and except in the case of a hospital primarily concerned with treatment of chronic diseases, for major surgery. The term hospital shall not be construed to include a hotel, rest home, nursing home, convalescent home, place for custodial care, home for the aged, or a place used primarily for the confinement or treatment of drug addicts or alcoholics.

"Hospital Confinement" means that a person is registered as a bed patient in a hospital (as defined above) and incurs a daily room and board charge.

"Surgical Operation" means only the following :

(1) a cutting operation;
(2) suturing a wound;
(3) treatment of a fracture;
(4) reduction of a dislocation;
(5) radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for the removal of a tumor;
(6) electrocauterization;
(7) diagnostic and therapeutic endoscopic procedures;
(8) injection treatment of hemorrhoids and varicose veins.

"Maximum Benefit" as set forth in (c) Insurance Coverage – Policy Specifications is the total amount, which will be paid in respect of any one Insured during the Policy year.

"Eligible Expenses" mean the actual expenses incurred by an insured, which are reasonable and customary for necessary medical care and services, administered by or ordered by a physician licensed to practice medicine.

"Co-payment": Fixed amount of Eligible expenses which must be incurred by an insured before any benefits are payable hereunder. The Co-payment shall be the amount set forth in (C.) Insurance Coverage of the Policy Specifications for each insured.

"Coinsurance": A percentage amount of Eligible Expenses which must be incurred by an insured before any benefits are payable hereunder. The coinsurance shall be the percentage set forth in (c) Insurance coverage of the Policy Specifications for each insured.

CLAUSE 3 - INSURANCE COVERAGE

The insurance coverage applicable to each insured in accordance with the provisions of Clause 9 of the Policy - General provisions, shall be as set forth in (c) Insurance Coverage – Policy Specifications. Such coverage shall include the following Eligible Expenses.

(i) The expenses incurred by the Insured for reasonable and customary charges made by the hospital for room, board and general nursing care furnished during his hospital confinement, but not to exceed the daily benefit maximum for each day of confinement as set forth in (c) Insurance Coverage – Policy Specifications.
(ii) All other hospital services and supplies for medical care in the hospital.
(iii) Anesthetics and their administration.
(iv) Ambulance service for travel to and from a local hospital.
(v) Physicians' services for surgery and other medical care excluding dental services unless for the treatment immediately below.
(vi) Dental services rendered by a physician, dentist or dental surgeon for the treatment of accidental injuries to sound natural teeth through violent external means within six months of the accident (the treatment to include replacement of such natural teeth within said period).
(vii) Private duty professional nursing service by a registered graduate nurse other than a close relative or one residing in the Insured's home.
(viii) The following other services and supplies:
- Treatments by X-ray and by radium or other radioactive substances;
- Treatments by a physiotherapist other than a close relative;
- Drugs and medicines dispensed by a pharmacist;
- Surgical Dressings;
- Artificial limbs and eyes when necessitated by accidental bodily injuries or diseases occurring while covered under this Policy;
- Casts, splints, trusses, braces and crutches;
- Rental of wheelchair, hospital bed or iron lung.

(ix) Treatment in connection with pregnancy as provided in Clause 9.
(x) Post Hospitalization follow-up visits: Two (2) follow-up doctor's visits incurred within three (3) months of hospital discharge and related to the same disability are payable at 100%. Pre-hospitalization immediate relevant medical tests & expenses prior to hospitalization required by the attending physician of the hospital where insured is hospitalized.

CLAUSE 4 - DEPENDANT COVERAGE

Dependants Eligibility

The term "Dependant" shall be deemed to refer only to :

1) The legal wife or husband of an insured (but not including those legally separated), or the person living with an Insured in a recognized husband and wife relationship, who is registered as such in the records of the Policyholder; and

2) An Insured's unmarried children, step-children and children legally adopted, who are within the age limits set forth in (f) Eligibility of Dependants – Policy Specifications living in the Insured's household and having the same permanent residence of the Insured or absent therefrom only to attend school. Such children must be dependant upon the Insured for support and registered as Dependants of the Insrued in the records of the Policyholder.

In the event that the age limit set forth in (f) Eligibility of Dependants – Policy Specifications is beyond nineteen years, such children over age nineteen shall only be eligible if they are full-time students at an accredited college or university.

If any person defined as a Dependant is also eligible to participate as an Insured or Employee under this Policy, such person shall not be eligible as a Dependant hereunder. When both husband and wife living in the same household are insured as Insured or Employees, the children shall be eligible only as Dependants of the husband.

Dependants - Date Insured

Any Insured who has Dependants shall be eligible for Dependants insurance on the date the insured become insured under this Policy, or on the day the Insured first acquires such Dependants whichever is later.

A. When the provision (a) Basis of Insurance – Policy Specifications stipulates that insurance is non-contributory, the Dependants shall become insured upon premium payment as follows:

   i) If the Insured has one or more Dependants on the effective date of his insurance as an Insured or Employee under this Policy, the insurance for such Dependants shall become effective on that date.

   ii) If the Insured acquires one or more Dependants after the effective date of his insurance as an Insured under this Policy, such Dependants shall become insured automatically.

B. When the provision (a) Basis of Insurance – Policy Specifications stipulates that insurance is contributory, the insurance for the Dependants of an Insured who makes written request to the Policyholder for such Dependants' insurance on a form approved by the Insurance Company and who agrees to make the required contribution and pays the premium, shall become effective as follows:

   i) If the Insured has one or more Dependants on the effective date of his insurance as an Insured or Employee under this Policy, the insurance for such Dependants shall become effective on that date.

   ii) If the Insured acquires one or more Dependants after the effective date of his insurance as an Insured or Employee under this Policy such Dependants shall become insured on the date he makes written request and payment of any required increase in contributions due to a resulting change in enrollment category. If, however, such written request is made more than 31 days after the Insured acquired such Dependants evidence of the good health of such Dependants must be furnished. If such evidence is submitted, the Dependants shall be insured as of the date communicated by the Insurance Company.

   iii) If request to participate is made by the Insured after the end of the 31st day period immediately following the first day he is both eligible and actively at work on full-time, or is made after previous termination of insurance because of failure to make a required contribution, evidence of the good health of each Dependant the Insured then has, satisfactory to the Insurance Company, must be furnished by him before such Dependants may become insured. If such evidence is submitted for any individual Dependant, such Dependant shall be insured as of the date communicated by the Insurance Company.

Dependants - Termination of Individual Insurance

A Dependant's insurance under this Policy shall automatically terminate

i) if the Insured or Employee's insurance as an Insured or Employee under this Policy terminates;
ii) if the insured Dependant ceases to be eligible as a Dependant;
iii) if this Policy terminates;
iv) if the Insued fails to make, when due, any required contribution; or
v) if “no longer active " as defined below.

“No longer active " shall, for all purposes of this Policy, be deemed to occur when a Dependant becomes totally disabled, which means the day he is unable because of injury or sickness to perform all the normal activities of a person in good health of the same age and sex and/or he is confined at home, in a medical facility, or elsewhere. However, a Dependant who is totally disabled, will nevertheless be considered in "active" until the Policyholder, acting on a basis precluding individual selection, terminates the insurance by notifying the Insurance Company to that effect or by discontinuing premium payment of his insurance, but in no event shall the insurance of any such Dependant be continued beyond 90 days during which such total disability commences.

CLAUSE 5 - EXTENSION OF BENEFITS

Notwithstanding the provisions of Clause 10 of the Policy - General Provisions and Clause 4 of Comprehensive Group Medical Insuracne Provisions, provided the Policy is still in effect at the time such hospital expenses are incurred, benefits hereunder will continue to be payable with respect to any disability resulting in a hospital confinement which is in progress on the date of termination of individual insurance for the duration of that confinement. In no event, however, will such benefits be payable for expenses incurred beyond the end of the Policy month following the month termination of individual insurance would normally occur.

CLAUSE 6 - EXCLUSIONS

This Policy does not insure and no benefits shall be payable for or on account of :

1. self-inflicted injury while sane or insane; treatment of chronic alcoholism, drug addiction, desensitization and nervous or mental disorders;
2. injury or illness resulting from active participation in insurrection or war, declared or undeclared, or as a result of a riot, strike or civil commotion;
3. rest cures, sanitaria or custodial care or periods of quarantine or isolation;
4. cosmetic or plastic surgery including related medicines and products unless medical treatment necessitated by an accidental injury occurring while the Insured is covered under this Policy;
5. dental examinations, x-rays, extractions, fillings and general dental care; except as provided in (c) Insurance Coverage- Policy Specifications and in Clause 3 – Insurance Coverage – Comprehensive Group Medical Insurance Policy. If no amount of insurance is shown under (c) Insurance Coverage – Policy Specifications in respect of Dental Benefit , then no benefits are payable on account of Dental.
6. supply or fitting of eye glasses or hearing aids; correction of refraction error by means of glasses, contact lenses, surgery, laser, and/or other methods, vision tests which are not related to specific symptoms or disease; except as provided in (c) Insurance Coverage- Policy Specifications and in clause 3- Insurance Coverage – Comprehensive Group Medical Insurance Policy. . If no amount of insurance is shown under (c) Insurance Coverage – Policy Specifications in respect of Optical Benefit , then no benefits are payable on account of Optical.
7. general health examinations; examinations for check-up purposes not incident to, or necessary to, diagnosis of a sickness or accidental bodily injury;
8. Ayurvedic treatment, Homeopathy treatment; except as provided in (c) Insurance Coverage- Policy Specifications. If no amount of insurance is shown under (c) Insurance Coverage – Policy Specifications in respect of Ayurvedic/ Homeopathy Benefit , then no benefits are payable on account of Ayurvedic/ Homeopathy.
9. Hirsutism, Podiatrist services, Dietician services. Expenses related to uncevered conditions including any complication arising therefrom, sexual disorgers, expenses incurred on account of the following items which include but are not limited to:

   Durable medical appliances (e.g., nebuliser)
   Anorexia, obesity, insomnia, baldness;
   Contraceptive measures;
   Ovulation induction, invitro-fertilization (IVF);
   Herbal medicines;
   Vitamins, except when prescribed for the following conditions –
   - Pernicious Anaemia
   - Scurvey
   - Rickets
   - Pellagra
   - Malabsorption
   - Poly Neuritis
   - Kwashiorkor

   Preventive treatment and vaccinations, circumcision, accupuncture;

10. transportation other than licensed ambulance service.
11. any disability which originated prior to the effective date of the Insured's coverage hereunder; this exclusion will cease to apply, however, after 90 days of continuous coverage under this Rider without medical care / treatment having been incurred anywhere or symptoms present which would have caused a prudent person to seek medical care / treatment. This includes but is not limited to use of medicines for the condition.
12. pregnancy including resulting childbirth, abortion or miscarriage, except as provided in Clause 9 - Maternity/Obstetrical Benefits of this Comprehensive Group Medical Insurance Provisions and (c) Insurance Coverage – Policy Specifications.
    If no amount of insurance is shown under (c) Insurance Coverage – Policy Specifications in respect of Clause 9 - Maternity/Obstetrical Benefits of this Comprehensive Group Medical Insurance Provisions, then no benefits are payable on account of pregnancy.
13. injury or illness covered under Workmen's Compensation or similar laws arising out of the Insured's occupation.
14. Any investigation, treatment or surgical operations for congenital anomalies/birth defects or complications arising from such congenital anomalies or physical defects present at and existing from the time of birth regardless of the time of discovery or the time of such treatment or surgical treatment;
15. Accquired Immune Deficiency Syndrome (AIDS) or AIDS related disabilities.

    No benefits shall be paid under this Policy, in the event of an Insured's loss of a covered event by an opportunistic infection, a malignant neoplasm or suicide, if at the time of such occurance, there is present in the subject Insured an Acquired Immune Deficiency Syndrome (AIDS).

1. For the purpose of this Clause, the terms "Acquired Immune Deficiency Syndrome" shall have the meanings assigned to it by the World Health Organization. A copy of the definition is maintained in the Company's Head Office in the country of issue of the Policy.
2. Opportunistic infection includes but is not limited to pneumocystis carinii pneumonia, organism of chronic enteritis, virus and/or disseminated fungi infection.
3. Malignant neoplasm shall include but not be limited to Kaposi's sarcoma, central nervous system lymphoma, hairy cell leukaemia and/or other malignancies now known or which become known as immediate cause of the incurring of medical expenses in the presence of acquired immune deficiency.
4. Acquired Immune Deficiency Syndrome shall include Human Immune Deficiency (HIV) Virus, encephalopathy (dementia), and HIV Wasting Syndrome.

16. Out-patient benefits, except as provided in (c) –Insurance Coverage- Policy Specifications. If no amount of insurance is shown in (c) Insurance Coverage- Policy Specifications in respect of out-patient benefits, then no benefits are payable on account of out-patient.

CLAUSE 7 - NON-DUPLICATION OF BENEFITS

The benefits of this Policy will not duplicate the benefits of any other group plan or statutory plan for which an Insured may be eligible. When any Insured is also covered by any such duplicate benefits, the benefits under this Policy will be reduced to an amount which, when added to such duplicate benefits, will equal 100% of the benefits provided by this Policy.

If only this Policy provides for non-duplication of benefits, benefits will be paid first by all other duplicate plans. When benefits are payable by more than one plan having a non-duplication of benefits provision, benefits will be payable as follows :

1. The plan covering the Insured as an Employee or Insured will determine its benefits before a plan which covers such person as a Dependant.
2. The plan covering the Insured as Dependant of a male Insured determines its benefits before a plan covering him as a Dependant of a female Insured.
3. If 1 and 2 do not establish an order or priority, the plan, which has covered the Insured for the longer period of time, determines its benefits first.

The foregoing does not apply to any benefits which any Insured receives or is entitled to receive from any individually owned insurance policy.

CLAUSE 8 - COMPUTATION OF PREMIUMS

The premium payable for the benefits provided by this Policy shall be determined by multiplying the number of units in each type of enrollment by the appropriate premium rate as set forth in (g) Computation of Premiums – Policy Specifications.

CLAUSE 9 - MATERNITY / OBSTETRICAL BENEFITS

The Insurance Company shall pay a pregnancy benefit in lieu of all other benefits under this Policy upto the maximum amount as set forth in (c) Insurance Coverage – Policy Specifications. The Maternity/Obstetrical Benefit is applicable to expenses incurred for room, board and general nursing care, special hospital services and ordinary nursing care of the baby while the mother is confined in the hospital, and for charges made by the physician, or registered midwife. This benefit is payable once for any one pregnancy. Pregnancy shall include childbirth, miscarriage or legal abortion, including any pre & post natal cares and all complications arising therefrom in connection with any one pregnancy.

Pregnancy benefits are available for insured wives of male Employees or Insured and for female Employees or Insured whether or not their husbands are enrolled as Dependants or any married female person considered eligible by the Insurance Company.

Reimbursement will only be made for Maternity/Obstetrical confinement expenses incurred after the Insured member has been enrolled in the appropriate category for at least 280 consecutive days. However, Maternity / Obstetrical confinement expenses incurred in case of pregnancy commencing after the enrollment or effective date of the Policy shall be paid.

In the event of termination of employment or relationship with Policycholder of a female Insured, coverage under this Clause for Maternity/Obstetrical expenses will nevertheless be provided without further premium payment for pregnancies which had their inception prior to such termination provided this Policy is still in effect at the time such expenses were incurred. For insured Dependant wives, no Maternity/Obstetrical Benefits are payable after coverage terminates.

COMPREHENSIVE GROUP MEDICAL INSURANCE POLICY SPECIFICATONS

POLICY HOLDER :
POLICY NUMBER :
POLICY EFFECTIVE DATE :

(a) BASIS OF INSURANCE:
The Basis of Insurance under this Policy shall be

For Employees : Non-Contributory Insurance **For Dependants :** Non-Contributory Insurance **For Others:** Not Applicable

Under this Provision, Contributory Insurance means Insurance for which the Insureds contribute towards the premium and Non-Contributory Insurance shall mean insurance which is provided at no cost to the Individual Insured or Employee under this Policy.

(b) ELIGIBILITY :
(See Clause 8 - The Policy-General Provisions and Clause 2 – Denifition of Insured – Comprehensive Group Medical Insurance Provisions)

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(c) INSURANCE COVERAGE:

As indicated in the List of Insured and Benefit or Premium Billing Details of effective period

HOSPITALIZATION	
Max Plan Limit per DISABILITY or; per ANNUAL	NPR xxxxx Each
(A) Room & Board Total Limit including ICU	NPR xxxxx
Room & Board Daily Limit	NPR xxxx
ICU No. of Days Limit	14 Days
(B) Other Hospitalization Expenses (Surgery/ Anesthesia/ Medicine/ Consultation etc.) excluding Room & Board and ICU Expenses	NPR xxxxx
Co-insurance	0%
Co-payment	0% / NPR XXXX

MATERNITY	
Caesarian / Ectopic / Extra-uterine Pregnancy	NPR XXXXX
Normal Delivery	NPR XXXXX
Legal Abortion / Miscarriage	NPR XXXXX
Pre-existing Maternity	(280 days waiting)

OUT-PATIENT	
Max ANNUAL Limit	
(A) Consultation Limit	NPR XXXXX
GP Office Visit	NPR XXXXX
GP Home Visit	NPR XXXXX
Specialist Visit	NPR XXXXX
(B) Investigation Limit	NPR XXXXX
(C) Medicine Limit	NPR XXXXX
Co-insurance	0%
Co-payment	0% / NPR XXXXX

DENTAL	
Max ANNUAL Limit	NPR X,XXX / YEAR (Inclusive of Sub-Limits for RCT to NPR XXXX and Cap for RC Treated Tooth up to NPR X,XXX Each)
Coverage Limited To:	
Consultation	NPR XXXXX
Medication	NPR XXXX
Scaling, Filing, Routine Extractions; Imaging / X-ray	NPR XXXX
Root Canal Treatment	NPR XXXX
Cap for Root Canal Treated Tooth	NPR XXXX
Note: Aesthetics and Dentures are NOT covered.	
Co-insurance	0%
Co-payment	0% / NPR 0

OPTICAL	
Max ANNUAL Limit	NPR X,XXX / YEAR (Inclusive of Sub-Limits for
Coverage Limited To:	Frames up to NPR XXXX and Prescribed Lense up to NPR XXXX)
Consultation for Errors of Refraction;	
Test for Errors of Refraction	NPR XXXX
Prescribed Medicine	NPR XXXX
Cost of prescribed frames for refraction correction	NPR XXX
Cost of prescribed glass lenses for refraction	NPR XXXX
Note: Cost of contact Lenses are NOT covered.	
Co-insurance	0%
Co-payment	0% / NPR 0

(d) CHANGES IN INSURANCE COVERAGE :
(See Clause 9 - The Policy General Provisions)
Any changes in insurance coverage due to Clause 9 - The Policy General Provisions shall be effective on the premium due date coinciding with or next following the change.

(e) TERMINATION OF INDIVIDUAL INSURED'S INSURANCE :
(See Clause 10 - The Policy General Provisions).
The Insured's insurance shall terminate under the provisions of Clause 10 – The Policy General Provisions on the date the Insured reaches his 65 birthday unless extended, upon request from Policyholder and acceptance by the Insurance Company.

(f) ELIGIBILITY OF DEPENDANTS :
(See Clause 4 of this Comprehensive Group Medical Insurance Provisions)

Dependant Spouses: Dependent Spouses are eligible aged between Minimum 16 years & Maximum 65 years.
Dependant Children: Dependent Children are eligible aged between Minimum 0 days; Maximum 19 years (extendedble up to Age 25 if Full Time Student, Dependent on an Insured Parent, Unmarried, Unemployed, and lives with an Insured Parent).

(g) COMPUTATION OF PREMIUM :
(See Clause 8 of this Comprehensive Group Medical Insurance Provisions)

Annual Premium per Member Per Year (PMPY) will be calculated at the following Rates:

Type of Enrolment	Benefit	Annual Rate
Employee/ Insured / Dependent	Hospitalization- NPR xxxxx Plan	As Per Billing
Married Female Employee or Insured /Spouse under age xx	In Patient Maternity- NPR XXXXX Plan	Not Applicable
Employee/ Insured / Dependent	General Out-Patient- NPR XXXXX Plan	Not Applicable
Employee /Insured / Dependent	Dental Out-Patient	Not Applicable
Employee/ Insured / Dependent	Optical Out-Patient	Not Applicable

(h) CURRENCY:
(See Clause 6: Currency of The Policy – General Provisions)

The currency used for all transactions e.g. Premium and Claims will be Nepalese Currency.

_____
Registrar

_____
Date