Group Mediclaim Insurance Policy

Whereas the, Insured designated in the Schedule hereto has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this contract and is deemed to be incorporated herein has applied to NATIONAL INSURANCE COMPANY LTD. (herein after called the Company) for the insurance herein after set forth in respect of Person(s) named in the Schedule hereto (herein after called the Insured Person) and has paid premium as consideration for such insurance.

Now this policy witnesseth, that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any disease or suffer from any illness (herein after called disease) or sustain any bodily injury through accident (hereinafter called injury) and if such disease or injury shall require any such insured person upon the advice of a duly qualified Physician/Medical Specialist/Medical Practitioner (hereinafter called Medical Practitioner) or of a duly qualified surgeon (hereinafter called Surgeon) to incur Hospitalisation Expenses for Medical/Surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called Hospital) as an inpatient the Company will pay to the Insured person the amount of such expenses as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person but not exceeding the Sum Insured in aggregate for the person in any period of Insurance as mentioned in the Schedule hereto.

1.0 In the event of any claim/s becoming admissible under this scheme, the Company will pay to the Insured person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person but not exceeding the Sum Insured in aggregate mentioned in the Schedule hereto.

A. **Room, Boarding,Nursing expenses** as provided by the Hospital/Nursing Home **Room Rent Limit:1% of Sum Insured per day subject to maximum of Rs.5,000. If admitted in IC unit-2% of Sum Insured per day subject to maximum of Rs.10,000. Overall limit under this head:25% of Sum Insured per** illness.

B. Surgeon, Anesthetist Medical Practitioner, Consultants Specials fees. **Maximum limit per illness-25% of Sum Insured.**

C. Anesthesia, Blood, Oxygen, OT charges, Surgical appliances, Medicines, drugs, Diagnostic Material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of pacemaker, artificial limbs and **cost of stent and implant**. **Maximum limit per illness- 50% of Sum Insured.**

Note : **(a) Hospitalization expenses of person donating an organ during the course of organ transplant will also be payable subject to the sub limits under "C" above applicable to the insured person.**

(b)Ambulance charges up to 1% of Sum Insured subject to a maximum limit of Rs.Rs.1000/- in a policy year will be reimbursed provided registered ambulance is used. This benefit is available only for shifting patient from residence to hospital if admitted to ICU or Emergency Ward or from one hospital to another subject to the sub limits under "C" above.

© Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the Sum Insured for the person as mentioned in the Schedule.

2 Definition

2.1 Insured Person: Means Person(s) named in the schedule of the policy

2.2 Entire Contract: This Policy,Prospectus,Proposal and declaration given by the insured constitute the complete contract of this policy. Any alteration with the mutual consent of the insured and the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

2.3 Period of Policy:This insurance policy is issued for a period of one year as shown in the schedule.

2.4 **Hospital/Nursing Home**, means any institution in India established for indoor care and treatment of sickness and injuries and which

Either

(a) has been registered either as a hospital or Nursing Home with the local authorities and is under the supervision of the registered and qualified medical practitioner

OR

(b) should comply with minimum criteria as under:

i. It should have at least 15 inpatient beds. In Class "C" towns condition of number of beds may be reduced to 10
ii. Fully equipped Operation Theatre of its own wherever surgical operations are carried out.
iii. Fully qualified nursing staff under its employment round the clock
iv. Fully qualified Doctor(s) should be in charge round the clock

2.4.1 The term, `**Hospital/Nursing Home'**, shall not include an establishment which is a place of rest, a place for the aged, a place for drug addiction or place of alcoholics, a hotel or a similar place.

2.5 **Surgical Operation** means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life

2.6 Expenses of Hospitalisation for minimum period of 24 hours are admissible. However this time limit is not applied to specific treatments i.e. Dialysis, Parentral Chemotherapy, Radiotherapy, Eye Surgery, Lithotripsy (Kidney Stone removal), D & C, Tonsillectomy**, Dental Surgery due to accident, Hysterectomy, Coronary Angioplasty, Coronary Angiography, Surgery of Gall Bladder, Pancreas & Bile duct, surgey of Hernia, Surgey of Hydrocele, Surgery of Prostate, Gastrointestinal surgey, Genital Surgery, Surgery of Nose, Surgery of Throat, Surgery of Appendix, Surgery of Urinay System,Arthroscopic Knee Surgery, Laparoscopic Therapeutic Surgeries, Any surgery under Anaesthesia, Treatment of Fractures/Dislocation excluding hairline fracture, Contracture releases & minor reconstructive procedures of limbs which otherwise require hospitalization taken in the Hospital/Nursing Home under the network of TPA and the Insured is discharged on the same day. The treatment will be considered under Hospitalisation Benefit.**

Relaxation to 24 hours minimum duration for hospitalization is also applicable:

A) If they are carried out in day care center networked by TPAs where requirement of minimum number of beds are overlooked but it must have (a) Fully equipped Operation Theatre (b) Fully qualified Day care staff (c) Fully qualified Surgeons/Post Operative attending Doctors.

B) If it necessitates hospitalization & involves specialized infrastructural facilities available only in hospital but due to technological advancement hospitalization is required for less than 24 hours and/or the surgical procedure involved has to be done under General anaesthesia.

Note: Procedures/treatments usually done in Out Patient Department(OPD) are not payable under the policy even if converted to Day Care Surgery Procedure or as inpatient in hospital for more than 24 hours.

3.0 **Any One Illness** will be deemed to mean continuous period of illness and it includes relapse within **105** days from the date of discharge from the Hospital/Nursing Home where treatment may have been taken. Occurrence of same illness after a lapse of **105** days as stated above will be considered as fresh illness for the purpose of this policy.

3.1 **Pre Hospitalisation:** Relevant Medical Expenses incurred during period up to 30 days prior to hospitalisation/domiciliary hospitalisation on disease/illness/injury sustained will be considered as part of claim mentioned under item 1.0 above

3.2 **Post Hospitalisation:** Relevant Medical Expenses incurred up to 60 days after hospitalisation/ domiciliary hospitalisation on disease/illness/injury sustained will be considered as part of claim mentioned under item 1.0 above

3.3 **Medical Practitioner** means a person who holds a degree/diploma as a recognised institution and is registered by Medical Council or respective State of India. The term Medical Practitioner would include Physician, Specialist and Surgeon.

3.4 **Qualified Nurse** means a person who holds a certificate of a recognised Nursing Council and who is employed on the recommendations of the attending Medical Practitioner.

3.5 Preexisting Diseases means any ailment/disease/injury that the person is suffering from
(known/not known ,treated/untreated, declared or not declared in the proposal) whilst taking the policy.
Any complications arising from pre-existing ailment/disease/injury will be considered as Preexisting Diseases.

3.6 Third Party Administrators (TPA)means a Third Party Administrator, who, for the time being, is licensed by the Insurance Regulatory and Development Authority, and is engaged, for a fee or remuneration, by whatever name called as may be specified in the agreement with the Company, for the provision of health services.

3.7 ID card means the card issued to the insured person by the TPA to avail cashless facility in the Network Hospitals.

3.8 Network Hospital means hospital that has agreed with the tPA to participate for providing cashless health services to the insured persons. The list is maintained by and available with the TPA and the same is subject to amendment from time to time.

3.9 Cashless Facility means the TPA may authorize upon the insureds' request for direct settlement of admissible claim as per agreed charges between Network Hospitals & the TPA. In such cases the TPA will directly settle all eligible amounts with the Network Hospitals and the insured person may not have to pay any bills after the end of the treatment at hospital to the extent the claim is covered under the policy.

3.10 In- Patient: An insured person who is admitted to hospital and stays for atleast 24 hours for the sole purpose of receiving the treatment for suffered ailment/illness/disease/injury/accident during the currency of the policy.

3.11 Hospitalization Period: The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease/ailment contracted/injuries sustained during the period of policy. The minimum period of stay shall be 24 hours other than cases mentioned in 2.6.

3.12 Reasonable and Customary Expenses: means reasonable and customary surgical/medical treatment expenses with in the scope of cover of this policy to treat the condition for which the insured person was hospitalised.

3.13 Limit of Indemnity: means the amount stated in the schedule against the name of each insured person which represents maximum liability for any and all claims made during the policy period in respect of that insured person with regard to hospitalisation taking place during currency of the policy.

The Company shall not be liable to make any payment under this Policy in respect of any expenses whatsoever incurred by any person in connection with or in respect of :

4.1 All diseases/injuries which are pre - existing when the cover incepts for the first time. **However,those diseases will be covered after four continuous claim free policy years. For the purpose of applying this condition, the period of cover under Mediclaim policy taken from National Insurance Company only will be considered.**

This exclusion will also apply to any complications arising from pre-existing ailment/disease/injuries. Such complications will be considered as a part of the pre existing health condition or disease. To illustrate, if a person is suffering from hypertension or diabetes or both hypertension and diabetes at the time of taking the policy, then policy shall be subject to following exclusions.

Diabetes	**Hypertension**	**Diabetes & Hypertension**
Diabetic Retinopathy	**Coronary Artery Disease**	**Diabetic Retinopathy**
Diabetic Nephropathy	**Cerebro Vascular Accident**	**Diabetic Nephropathy**
Diabetic Foot/wound	**Hypertensive Nephropathy**	**Diabetic Foot/wound**
Diabetic Angiopathy	**Internal Bleed/ Haemorrhages**	**Diabetic Angiopathy**
Diabetic Neuropathy		**Diabetic Neuropathy**
Hyper/Hypoglycaemic shocks		**Hyper/Hypoglycaemic shocks**
		Coronary Artery Disease
		Cerebro Vascular Accident
		Hypertensive Nephropathy
		Internal Bleed/ Haemorrhages

4.2 Any disease other than those stated in Clause 4.3, contracted by the Insured Person during the first 30 days from the commencement date of the policy. This condition 4.2 shall not however apply in case of the Insured Person having been covered under this Scheme or group insurance scheme with our company for a continuous period of preceding 12 months without any break or is hospitalized due to accidental injuries suffered after inception of the policy.

4.3 During the first one year of the operation of the policy the expenses on treatment of Benign ENT disorders & surgeries like Tonsilectomy/ Adenoidectomy/Mastoidectomy/Tympanoplasty.

Treatment of diseases such as Cataract, Benign Prostatic Hyperthropathy, Hysterectomy, Hernia, Hydrocele, Congenital Internal Diseases,Fissures/ Fistula in anus, Piles, Sinusitis and related disorders, Polycystic ovarian diseases, Non-infective arthritis, Undiscended testis, Surgery of gall bladder & bile duct excluding malignancy,Surgery of Genito-urinary system excluding malignancy, Pilonidal Sinus, Gout & Rheumatism, Hypertension, Diabetes, Calculus diseases, Surgery for prolapsed intervertebral disc unless arising from accident, surgery of varicose veins are not payable for first two years of operation of the policy.

Treatment for Joint replacement due to degenerative conditions, Age related osteoarthritis and osteoporosis are not payable for first four years of operation of the policy.

If these diseases are pre-existing at the time of proposal, will be covered only after four continuous claim free policy years.

Note: If continuity of cover is not maintained with National Insurance Company Limited subsequent cover will be treated as fresh for application of clauses 4.1, 4.2 & 4.3 above.

4.4 Injury or disease directly or indirectly caused by or arising from or attributable to War Invasion Act of Foreign Enemy Warlike operations (whether war be declared or not) and Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

4.5 Circumcision unless necessary for treatment or a disease not excluded hereunder or as may be necessitated due to an accident, vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to as accident or as part of any illness.

4.6 Surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc.

4.7 Dental treatment or surgery-corrective,cosmetic or aesthetic procedure, filling of cavity, root canal, wear & tear unless arising due to an accident and requiring hospitalisation.

4.8 Convalescence general debility `Run Down' condition or rest cure, congenital external disease or defects or anomalies, sterility, infertility/sub fertility or assisted conception procedures, venereal disease, intentional self-injury,suicide, all psychiatric & psychosomatic disorders/diseases, accidents due to misuse or abuse of drugs/alcohol or use of intoxicating substances.

4.9 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotrophic Virus Type III (HTLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or variations Deficiency Syndrome or any Syndrome or condition or a similar kind commonly referred to as AIDS, complications of AIDs and other sexually transmitted diseases(STD).

4.10 Expenses incurred primarily for evaluation/diagnostic purposes not followed by active treatment during hospitalization.

4.11 Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician.

4.12 Treatment arising from or traceable to pregnancy/ childbirth including caesarean section, miscarriage, abortion or complications thereof including changes in chronic conditions arising out of pregnancy.

4.13 Naturopathy, **unproven procedure/treatment, experimental or alternative medicine/treatment including acupuncture, acupressure, magneto-therapy etc.**

4.14 Expenses on irrelevant investigations/treatment; private nursing charges, referral fee to family physician, outstation Doctor/Surgeon/ consultants' fees etc.

4.15 Genetical disorders/stem cell implantation/surgery

4.16 External/ durable medical/Non-medical equipments of any kind used for diagnosis/treatment including CPAP, CAPD, infusion Pump etc., ambulatory devices like walker/ crutches/ belts/ collars/caps/ splints/ slings/ braces/ stockings/ diabetic foot-wear/ glucometer/ thermometer & similar related items & any medical equipment which could be used at home subsequently.

4.17 Non-medical expenses including personal comfort/ convenience items/ services such as telephone/ television/ aya/ barber/ beauty services/ diet charges/ baby food/ cosmetics/napkins/ toiletries/ guest services etc.

4.18 Change of treatment from one pathy to another unless being agreed/allowed & recommended by the consultant under whom treatment is taken.

4.19 Treatment for obesity or condition arising therefrom(including morbid obesity) and any other weight control program/services/supplies.

4.20 Arising from any hazardous activity including scuba diving, motor racing, parachuting, hand gliding, rock or mountain climbing etc. unless agreed by insurer.

4.21 Treatment received in convalescent home/hospital, health hydro/nature care clinic & similar establishments.

4.22 Stay in hospital for domestic reason where no active regular treatment is given by specialist.

4.23 Out-patient diagnostic/medical/surgical procedures/treatments, non-prescribed drugs/medical supplies/hormone replacement therapy, sex change or any treatment related to this.

4.24 Massages/Steambath/Surodhara & alike Ayurvedic treatment.

4.25 Any kind of service charges/surcharges, admission fees/registration charges etc. levied by the hospital.

4.26 Doctor's home visit charges/attendant, nursing charges during pre & post hospitalization period.

4.27 Treatment which the insured was on before hospitalization and required to be on after discharge for the ailment/disease/injury different from the one for which hospitalization was necessary.

5**. Conditions**

5.1 Every notice of communication to be given or made under this policy shall be delivered in writing at the address as shown in the Schedule.

5.2 The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by the duly authorised official of the Company. The due payment of premium and the observance and fulfillment of the terms provisions conditions and endorsement of this policy by the Insured person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms provisions conditions and endorsement on this policy shall be valid unless made in writing and signed by an authorised official of the Company.

5.3 Upon the happening of any event, which may give rise to a claim under this policy notice with full particulars shall be sent to the Company within 7 days from the date of Injury / Hospitalisation/Domiciliary Hospitalisation.

5.4 The Insured person shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the Claim.

5.5 Any Medical Practitioner authorised by the Company shall be allowed to examine the Insured person in case of any alleged injury or disease requiring hospitalisation when and so often as the same may reasonably be required on behalf of the Company.

5.6 The Company shall not be liable to make any payment under this policy in respect of any claim in such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured person or by any other person acting on his behalf.

5.7 If at the time when any claim arises under this policy there is in existence any other insurance (other than Cancer Insurance policy in collaboration with Indian Cancer Society) whether it be effected by or on behalf of any insured person in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses the Company shall not be liable to pay or contribute more than its ratable proportion of any loss, liability, compensation, costs or expenses. The benefits under this policy shall be in excess of the benefits available under the Cancer Insurance Policy.

5.8 The Policy may be renewed by mutual consent. The Company shall not however be bound to give notice that it is due for renewal and the Company may at any time cancel this policy by sending the Insured 30 (thirty) days notice by Registered Letter at Insured's last known address and in such event the Company shall refund to the Insured a prorata premium for unexpired period of Insurance The Company shall however, remain liable for any claim which arise prior to the date of cancellation The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's Short period rate only (table given here below) provided no claim has occurred up to the date of cancellation.

Period of risk	Rate of premium to be charged
Up to 1month	1/4 of the annual rate
Up to 3 months	1/2 of the annual rate
Up to 6 months	3/4 of the annual rate
Exceeding 6 months	Full annual rate

5.9 If any dispute or difference shall arise as to the quantum to be paid under the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they can not agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to

any right of action or suit upon this Policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

5.10 If the Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.11 All medical surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

5.12 **Low Claim Ratio Discount (Bonus):** Low claim ratio discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the Group Mediclaim Policy has not been in force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims ratio under the Group Mediclaim Policy	Discount %
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	30
Not exceeding 25%	30

5.13 **High Clam Ratio Loading (Malus):** The total premium payable at renewal of the Group Mediclaim Policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the Group Mediclaim Policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the Group Mediclaim Policy has not been in force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims Ratio under the Group Mediclaim Policy	Loading
Between 80 % and 100 %	25
Between 101 % and 125 %	55
Between 126 % and 150 %	90
Between 151 % and 175 %	120
Between 176 % and 200 %	150
Over 200 %	Cover to be reviewed

5.15 **Maternity Expenses Benefit Extension:**

5.15.1 This is an optional cover, which can be obtained on payment of 10% of the total basic premium for all the Insured Persons under the policy. Total basic premium means the

total premium computed before applying Group Discount and/or High Claim ratio Loading or Low Claim Discount and Special Discount in lieu of Agency Commission.

5.15.2 Option for Maternity Benefit has to be exercised at the inception of the Policy period and no refund is allowable in cases of Insured's cancellation of this option during currency of the policy.

5.15.3 The maximum benefit allowable under this clause will be up to Rs.50, 000/- or the Sum Insured opted by the member of the group whichever is lower.

5.15.4 Special conditions applicable to maternity expenses benefit extension.

5.15.4.1 These benefits are applicable only if the expenses are incurred in hospital/nursing home as inpatient in India.

5.15.4.2 A waiting period of nine months is applicable for payment of and claim relating to normal delivery or caesarean section or abdominal operation for extra uterine pregnancy. This waiting period may be relaxed only in the case of delivery, miscarriage or abortion induced by accident or other medical emergency

5.15.4.3 Claims in respect of deliveries for only first two children and/or operations associated therewith will be considered in respect of any one Insured person covered under the policy or any renewal thereof. Those insured person who are already having two or more living children will not be eligible for this benefit

5.15.4.4 Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve (12) weeks from the date of conception are not covered.

5.15.4.5 Pre-natal and post-natal expenses are not covered unless admitted in hospital/nursing home and treatment is taken there.

Note: When Group Mediclaim Policy is extended to include Maternity Expenses benefit, the exclusion 4.12 of the policy stands deleted.

6. **Procedure for availing Cashless Access Services in Network Hospital/Nursing Home.**

Claims in respect of Cashless Access Services will be through the list of the network of Hospitals/Nursing Homes and is subject to pre admission authorization. The TPA shall, upon getting the related medical information from the insured persons/ network provider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter/ guarantee of payment letter to the Hospital/Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as a patient.

The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured person that denial of Cashless Access is in no way construed to be denial of treatment. The insured person may obtain the treatment as per his/her treating doctors advice and later on submit the full claim papers to the TPA for reimbursement subject to admissibility of the claim as per terms and conditions of the policy.

Pre authorization for Cashless Access Services in Network hospital/Nursing Home is within the authority of TPA and will be given after verification of required documents pertaining treatment of the insured to the satisfaction of TPA.

7. **CLAIM DOCUMENTS: Final claim along with hospital receipted original Bills/Cash memos/reports, claim form and list of documents as listed below should be submitted to the Company / TPA within 30 days from date of discharge from the Hospital and where post-hospitalization treatment is not completed, it shall be within 30days from the date of completion of Post-hospitalization treatment.**

a. **Original bills, receipts and discharge certificate / card from the hospital.**
b. **Medical history of the patient recorded by the Hospital.**
c. **Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.**
d. **Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending medical practitioner / surgeon demanding such tests.**
e. **Attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis and bill / receipts etc.**
f. **Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.**
g. **Any other information required by TPA / Insurance Company.**

NOTE: Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.