

Issuing Office

National Mediclaim Policy

Whereas the proposer designated in the Schedule hereto has by a proposal together with declaration and medical reports, which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to National Insurance Company Ltd. (hereinafter called the Company), for the insurance hereinafter set forth, in respect of person(s) named in the Schedule hereto (hereinafter called the Insured Persons) and has paid the premium as consideration for such insurance.

1 PREAMBLE

The Company undertakes that if during the Policy Period stated in the Schedule, any Insured Person(s) shall suffer any illness or disease (hereinafter called Illness) or sustain any bodily injury due to an Accident (hereinafter called Injury), requiring Hospitalisation of such Insured Person(s), for In-Patient Care at any hospital/nursing home (hereinafter called Hospital) or for Day Care Treatment at any Day Care Center, following the Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the Hospital or the Insured, Reasonable and Customary Charges incurred for Medically Necessary Treatment towards the Coverage mentioned herein.

Provided further that, the amount payable under the Policy in respect of all such claims during the Policy Period shall be subject to the coverage, terms, exclusions, conditions, definitions and sub limits contained herein as well as shown in the Table of Benefits, and shall not exceed the Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) and Reinstated Basic Sum Insured (if applicable as per terms) of the Insured Person.

2 DEFINITION

Standard Definitions

- 2.1 Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- 2.2 Any One Illness** means continuous period of Illness and it includes relapse within forty five (45) days from the date of last consultation with the Hospital where treatment was taken.
- 2.3 AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
- Central or State Government AYUSH Hospital or
 - Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy; or
 - AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - Having at least 5 in-patient beds;
 - Having qualified AYUSH Medical Practitioner in charge round the clock;
 - Having dedicated AYUSH therapy sections as required;
 - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative
- 2.4 Cashless Facility** means a facility extended by the Company to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Company to the extent pre-authorization approved.
- 2.5 Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
- 2.6 Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
- a) Internal Congenital Anomaly**
Congenital Anomaly which is not in the visible and accessible parts of the body.
- b) External Congenital Anomaly**
Congenital Anomaly which is in the visible and accessible parts of the body.
- 2.7 Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the Insured will bear a specified percentage of the admissible claims amount. A Co-Payment does not reduce the Sum Insured.
- 2.8 Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Company without an associated increase in premium.

2.9 Day Care Centre means any Institution established for Day Care Treatment of Illness and/ or Injuries or a medical setup with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- i. has qualified Nursing staff under its employment;
- ii. has qualified Medical Practitioner (s) in charge;
- iii. has a fully equipped operation theatre of its own where Surgical Procedures are carried out
- iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

2.10 Day Care Treatment means medical treatment, and/or Surgical Procedure (as listed in Appendix I) which is:

- i. undertaken under general or local anesthesia in a Hospital/Day Care Centre in less than twenty four (24) hrs because of technological advancement, and
 - ii. which would have otherwise required a Hospitalisation of more than twenty four (24) hours.
- Treatment normally taken on an Out-Patient basis is not included in the scope of this Definition.

2.11 Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as Waiting Periods and coverage of Pre-Existing Diseases. Coverage is not available for the period for which no premium is received.

2.12 Hospital means any Institution established for In-Patient Care and Day Care Treatment of Illness/ Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

- i. has qualified nursing staff under its employment round the clock;
- ii. has at least ten (10) In-Patient beds, in those towns having a population of less than ten lacs and fifteen (15) inpatient beds in all other places;
- iii. has qualified Medical Practitioner (s) in charge round the clock;
- iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
- v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

2.13 Hospitalisation means admission in a Hospital for a minimum period of twenty four (24) consecutive 'In-Patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.

2.14 Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

2.15 Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

- i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
- ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
 - a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - b) it needs ongoing or long-term control or relief of symptoms
 - c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
 - d) it continues indefinitely
 - e) it recurs or is likely to recur

2.16 Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

2.17 In-Patient Care means treatment for which the Insured Person has to stay in a Hospital for more than twenty four (24) hours for a covered event.

2.18 Intensive Care Unit means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.19 ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.20 Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

- 2.21 Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.
- 2.22 Medical Practitioner** means 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 the licence.
- 2.23 Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which
- is required for the medical management of Illness or Injury suffered by the Insured Person;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a Medical Practitioner;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 2.24 Network Provider** means hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured Person by a Cashless Facility.
In cities with Preferred Provider Network (Definition 2.46), PPN are the only Network Providers.
- 2.25 Non- Network Provider** means any Hospital, Day Care Centre or other provider that is not part of the network.
- 2.26 Notification of Claim** means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.
- 2.27 OPD (Out-Patient) Treatment** means the one in which the Insured Person visits a clinic / Hospital or associated facility like a consultation room for Diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a Day Care or In-Patient.
- 2.28 AIDS** means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.
- 2.29 Pre Existing Disease** means any condition, ailment, injury or disease
- That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement or
 - For which Medical Advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy issued by the Company or its reinstatement.
- 2.30 Pre-hospitalisation Medical Expenses** means Medical Expenses incurred during predefined number of days preceding the Hospitalisation of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Company.
- 2.31 Post-hospitalisation Medical Expenses** means Medical Expenses incurred during predefined number of days immediately after the Insured Person is discharged from the Hospital provided that:
- Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
 - The inpatient hospitalisation claim for such hospitalisation is admissible by the Company.
- 2.32 Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- 2.33 Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/ Injury involved.
- 2.34 Renewal** means the terms on which the Contract of Insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound Exclusions and for all Waiting Periods.
- 2.35 Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses.

2.36Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.37Unproven/ Experimental Treatment means treatment, including drug experimental therapy, which is not based on established medical practice in India, is experimental or unproven.

Specific Definitions

2.38AYUSH Treatment refers to the medical and/ or Hospitalisation treatments given Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

2.39Break in Policy occurs at the end of the existing Policy Period when the premium due on a given Policy is not paid on or before the Renewal date or within Grace Period.

2.40Contract means prospectus, proposal, Policy, and the policy Schedule. Any alteration with the mutual consent of the Insured Person and the Company can be made only by a duly signed and sealed endorsement on the Policy.

2.41Diagnosis means diagnosis by a Medical Practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.

2.42ID Card means the card issued to the Insured Person by the TPA for availing Cashless Facility in the Network Provider.

2.43Insured/ Insured Person means person(s) named in the Schedule of the Policy.

2.44Mental Illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

2.45Policy Period means period of one (01) year as mentioned in the Schedule for which the Policy is issued.

2.46Preferred Provider Network (PPN) means Network Providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time.

2.47Proposer means an eligible person who proposes to enter into insurance Contract with the Company, to cover self and/ or any other eligible person(s), and pays the premium as consideration for such insurance.

2.48Psychiatrist means a Medical Practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist.

2.49Schedule means a document forming part of the Policy, containing details including name of the Insured Person(s), age, relation with the Proposer, Basic Sum Insured, Cumulative Bonus, premium and the Policy Period.

2.50Sum Insured means the Basic Sum Insured and the Cumulative Bonus (CB) accrued in respect of the Insured Person(s) as mentioned in the Schedule. Preventive Health Checkup expenses are payable over and above the Sum Insured, wherever applicable.

7.48.1 Basic Sum Insured means the Sum Insured in respect of the insured person (s) as mentioned in the Schedule, without any Cumulative Bonus (CB) accrued.

2.51Third Party Administrator (TPA) means a Company registered with the Authority, and engaged by an Insurer, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services.

2.52Waiting Period means a period from the inception of this Policy during which specified Illness/treatments are not covered. On completion of the Waiting Period, Illness/treatments shall be covered provided the Policy has been continuously renewed without any break.

3 BENEFITS COVERED UNDER THE POLICY

Coverage – Sub Limits

The Company shall indemnify the expenses incurred for all Hospitalisation(s) covered under the Policy, subject to the following Sub Limits applicable to broad heads as mentioned below.

3.1	Room Charges Room Rent, Intensive Care Unit charges and associated charges (including diet charges, nursing care by Qualified Nurse, RMO charges, administration charges for IV fluids/blood transfusion/injection) i. Room Rent per day shall be payable up to 1% of Sum Insured subject to max of ₹ 10,000 per day ii. ICU Charges per day shall be payable up to 2% of Sum Insured subject to max of ₹ 20,000 per day	Maximum amount admissible under Room Charges for Any One Illness shall be 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) as mentioned in the Schedule.
3.2	Medical Practitioner's Fees Fees for Medical Practitioners, including treating Medical Practitioners, Surgeons, Anaesthetists, Consultants, Specialists whose services has been utilized during the Hospitalisation	Maximum amount admissible under Medical Practitioner's Fees for Any One Illness shall be 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) as mentioned in the Schedule.
3.3	Other Expenses All other expenses related to the Hospitalisation: i. Anaesthesia, blood, oxygen, operation theatre charges and surgical appliances ii. Medicines and drugs iii. Diagnostic procedures iv. Prosthetics and other devices or equipment if implanted internally during a surgical procedure. v. Ambulance Charges, as per Section 3.9.6	Maximum amount admissible under Other Expenses for Any One Illness shall be 50% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) as mentioned in the Schedule.
3.4	Expenses for the following procedures inclusive of above sub limits (i.e., Section 3.1, 3.2, 3.3) i. Hemodialysis ii. Chemotherapy iii. Radiotherapy	Maximum amount admissible for Any One Illness shall be lower of 50% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus) or the PPN Package Rate.
3.5	Following Modern Treatments will be covered (wherever medically indicated) either as In patient or as part of Day Care Treatment in a Hospital, inclusive of above sub limits (i.e., Section 3.1, 3.2, 3.3): A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound) B. Balloon Sinuplasty C. Deep Brain stimulation D. Oral chemotherapy E. Immunotherapy- Monoclonal Antibody to be given as injection F. Intra vitreal injections G. Robotic surgeries H. Stereotactic radio surgeries I. Bronchial Thermoplasty J. Vaporisation of the prostate (Green laser treatment or holmium laser treatment) K. IONM - (Intra Operative Neuro Monitoring) L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Maximum amount admissible for any one Modern Treatment shall be 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus)
3.6	Expenses related to treatment necessitated due to participation as a non-professional in hazardous or adventure sports , inclusive of above sub limits (i.e., Section 3.1, 3.2, 3.3)	Maximum amount admissible for Any One Illness shall be lower of 25% of Sum Insured (i.e., Basic Sum Insured and Cumulative Bonus)
3.7	Pre Hospitalisation Medical expenses incurred before Hospitalisation.	Up to forty five (45) days immediately before the Insured Person is Hospitalised
3.8	Post Hospitalisation Medical expenses incurred after discharge from Hospital.	Up to sixty (60) days immediately after the Insured Person is discharged

Note: Sub limits as mentioned in Section 3.1, 3.2 and 3.3 above, will not apply in case of treatment undergone in a **Preferred Provider Network (PPN)** for a listed procedure as per eligible package.

3.9 Terms specific to Day Care Procedure, Ayurveda and Homeopathy, HIV/ AIDS Cover, Mental Illness Cover, Organ Donor's Medical Expenses, Ambulance Charges, Morbid Obesity Treatment and Correction of Refractive Error

In addition to the applicable Sub Limits (mentioned above), Hospitalisation due to any of the following shall be subject to the terms mentioned against each.

3.9.1 Day Care Procedure

The Company shall indemnify the Hospital/ Day Care Centre or the insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) for Day Care Treatment of procedures/surgeries (as listed in Appendix-I), provided that Day Care Treatment is undergone by the Insured Person in a Hospital/ Day Care Centre, but not in the Outpatient department of a Hospital. In case of any other surgeries/procedures (not listed in Appendix-I) which would have otherwise required a Hospitalisation of more than twenty four (24) hours, but due to advancement of medical science require Hospitalisation for less than twenty four (24) hours, shall be covered subject to prior approval of the Company/TPA.

3.9.2 Ayurveda and Homeopathy

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) incurred for Ayurveda and Homeopathy treatment, provided the treatment is undergone in an Ayush Hospital.

3.9.3 HIV/ AIDS Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following stages of HIV infection:

- i. Acute HIV infection – acute flu-like symptoms
- ii. Clinical latency – usually asymptomatic or mild symptoms
- iii. AIDS – full-blown disease; CD4 < 200

3.9.4 Mental Illness Cover

The Company shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to Mental Illnesses, provided the treatment shall be undertaken at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Psychiatrist (as defined in Definition 2.48) or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry.

Exclusions

Any kind of Psychological counselling, cognitive/ family/ group/ behavior/ palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

3.9.5 Organ Donor's Medical Expenses

The Company shall indemnify the Hospital or the Insured, the Medical Expenses (excluding Pre and Post Hospitalisation Expenses) incurred for organ donor's treatment during the course of organ transplant to any Insured Person.

Provided that,

- i. the donation conforms to 'The Transplantation of Human Organs Act 1994'
- ii. the Insured Person has been Medically Advised to undergo an organ transplant, or the Insured Person has been certified by a qualified Medical Practitioner to be suitable for organ donation.

Exclusions

The Company shall not be liable to make any payment in respect of any expenses incurred in connection with or in respect of

1. Cost of the organ to be transplanted.
2. Any other medical treatment or complication in respect of the organ donor (other than Insured Person), consequent to harvesting.

3.9.6 Ambulance Charges

The Company shall reimburse the Insured the expenses incurred for emergency ambulance charges, up to 1% of Sum Insured subject to maximum ₹ 2,000/- in a Policy Period for each Insured Person, for transportation to the Hospital or from the Hospital to another Hospital or from the Hospital to diagnostic center and return during the same Hospitalisation.

Ambulance charges shall be admissible provided a Hospitalisation claim has been admitted under the Policy.

3.9.7 Morbid Obesity Treatment

The Company shall indemnify the Hospital or the Insured, the Medical Expenses (including Pre and Post Hospitalisation Expenses) incurred for surgical treatment of obesity that fulfils **all** the following conditions and subject to Waiting Period of four (04) years as per Section 4.2.f.iv:

1. Treatment has been conducted is upon the advice of the Medical Practitioner, and
2. The surgery/Procedure conducted should be supported by clinical protocols, and
3. The Insured Person is 18 years of age or older, and
4. Body Mass Index (BMI) is;
 - b) greater than or equal to 40 or
 - c) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type 2 Diabetes

3.9.8 Correction of Refractive Error

The Company shall indemnify the Hospital or the Insured, the Medical Expenses (including Pre and Post Hospitalisation Expenses) incurred for expenses related to the treatment for correction of eye sight due to refractive error equal to or more than 7.5 dioptries, subject to Waiting Period of two (02) years as per Section 4.2.f.iii.

Note: The expenses that are not covered in this policy are placed under List-I of Appendix-II. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Appendix-II respectively.

3.10 OTHER BENEFITS

3.10.1 Reinstatement of Basic Sum Insured (available to Basic Sum Insured of ₹ 6L and above)

For Insured Persons with Basic Sum Insured of ₹ 6 lacs and above, in the event of available Sum Insured being exhausted anytime during the Policy Period on account of Hospitalisation claim(s), the Company shall reinstate the Basic Sum Insured (i.e., excluding any CB) to be utilized in any subsequent Hospitalisation(s), provided that

- i. Reinstatement of Basic Sum Insured shall be effected only after the date of discharge from the Hospital, for the Hospitalisation whose claim resulted in exhaustion of the Sum Insured.
- ii. Any Illness/ Injury for which a claim has been admitted or paid under the Policy prior to such reinstatement, shall not be considered under the Reinstated Basic Sum Insured
- iii. Reinstatement of Basic Sum Insured shall be available only in respect of the Insured Person whose Sum Insured is exhausted as specified above.
- iv. Reinstatement shall be allowed only once during the Policy Period for each eligible Insured Person.
- v. Reinstated Basic Sum Insured, if not exhausted, will not be carried forward to next Policy Period on Renewal

3.11 GOOD HEALTH INCENTIVE

3.11.1 Cumulative Bonus

For each claim free Policy Period (i.e., no claims are reported) provided the policy is continuously renewed with the Company without a Break in Policy, each Insured Person will be eligible to get a Cumulative Bonus (CB) at the rate of 5% of the Basic Sum Insured of the expiring Policy. CB accrued for a claim free Policy Period shall be available on next Renewal. CB shall be accumulated for each subsequent claim free Policy Periods and the maximum CB shall not exceed 50% of the Basic Sum Insured of the renewed Policy. Wherever, due to reduction in Basic Sum Insured on renewal, the accumulated CB exceeds 50% of the reduced Basic Sum Insured, then CB shall be restricted to 50% of the reduced Basic Sum Insured.

In case of claim(s) during a Policy Period in respect of an Insured Person, who has accumulated CB for earlier claim free Policy Periods, the accumulated CB will be reduced on the next Renewal at the rate of 5% of Basic Sum Insured of the expiring policy. However, Basic Sum Insured will be maintained and not be reduced.

3.11.2 Preventive Health Check Up

Expenses of preventive health check-up/ prescribed diagnostic tests will be reimbursed once at the end of a **block of four (04) continuous Policy Periods** provided **no claims are reported** during the block and the policy has been continuously renewed with the Company without a Break in Policy. Expenses payable shall be up to **1% of the average Basic Sum Insured** of the block, subject to a maximum of ₹ 5,000 per Insured Person. Claim for health check-up benefits may be lodged at least forty five (45) days before the expiry of the fifth Policy Period

Note: Claims under Section 3.11.2 shall not be counted as a claim under the Policy.

4 EXCLUSIONS (Standard Exclusions)

The Company shall not be liable to make any payment under the Policy till the expiry of Waiting Period mentioned below, in respect of any expenses incurred in connection with or in respect of:

4.1. Pre-Existing Diseases (Excl 01)

- a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of forty eight (48) months of continuous coverage after the date of inception of the first policy with us.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of forty eight (48) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2. Specified disease/procedure waiting period (Excl 02)

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days/ one year/ two year/ four years (as specified against specific disease/ procedure) of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing Diseases, then the longer of the two waiting periods shall apply.

- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f) List of specific diseases/procedures

i. 90 Days Waiting Period (Life style conditions)

- a. Hypertension and related complications
- b. Diabetes and related complications
- c. Cardiac conditions

ii. One year Waiting Period

- a. Benign ENT disorders
- b. Tonsillectomy
- c. Adenoidectomy
- d. Mastoidectomy
- e. Tympanoplasty

iii. Two years Waiting Period

- a. Cataract and age related eye ailments
- b. Refractive error of the eye more than 7.5 dioptries.
- d. Benign prostatic hypertrophy

- e. Hernia
- f. Hydrocele
- g. Fissure/Fistula in anus
- h. Piles (Haemorrhoids)
- i. Sinusitis and related disorders
- j. Polycystic ovarian disease
- k. Non-infective arthritis
- l. Pilonidal sinus
- m. Gout and Rheumatism
- n. Calculus diseases
- o. Surgery of gall bladder and bile duct excluding malignancy
- p. Surgery of genito-urinary system excluding malignancy
- q. Surgery for prolapsed intervertebral disc unless arising from accident
- r. Surgery of varicose vein
- s. Hysterectomy
- t. Congenital Internal Anomaly

Above diseases/treatments under 4.2.f).i, ii, iii shall be covered after the specified Waiting Period, provided they are not Pre-Existing Diseases.

iv. Four years Waiting Period

- a. Joint replacement unless necessitated due to an accident
- b. Osteoarthritis and osteoporosis
- c. Obesity and its complications
- d. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Above diseases/treatments under 4.2.f).iv if pre-existing also, shall be covered after single Waiting Period of four (04) years only.

4.3. First 30 days waiting period (Excl 03)

- a) Expenses related to the treatment of any illness within thirty (30) days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve (12) months.
- c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.4. Investigation & Evaluation (Excl 04)

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

4.5. Rest Cure, Rehabilitation and Respite Care (Excl 05)

- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.6. Obesity/ Weight Control (Excl 06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI);
 - a. greater than or equal to 40 or
 - b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type2 Diabetes

4.7. Change-of-Gender Treatments (Excl 07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.8. Cosmetic or Plastic Surgery (Excl 08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.9. Hazardous or Adventure Sports (Excl 09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.10. Breach of Law (Excl 10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.11. Excluded Providers (Excl 11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Company and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.12. Drug/Alcohol Abuse (Excl 12)

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof (Excl 12).

4.13. Non Medical Admissions (Excl 13)

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons (Excl 13).

4.14. Vitamins, Tonics (Excl 14)

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioners part of hospitalization claim or day care procedure

4.15. Refractive Error (Excl 15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.

4.16. Unproven Treatments (Excl 16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.17. Birth control, Sterility and Infertility (Excl 17)

Expenses related to sterility and infertility. This includes:

- i. Any type of sterilization
- ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- iii. Gestational Surrogacy
- iv. Reversal of sterilization

4.18. Maternity (Excl 18)

- i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

5 SPECIFIC EXCLUSIONS

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

5.1. Hormone Replacement Therapy

Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders.

5.2. General Debility, Congenital External Anomaly

General debility, Congenital external anomaly.

5.3. Self Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

5.4. Stem Cell Surgery

Stem Cell Surgery (except Hematopoietic stem cells for bone marrow transplant for haematological conditions).

5.5. Circumcision

Circumcision unless necessary for treatment of a disease (if not excluded otherwise) or necessitated due to an accident.

5.6. Vaccination or Inoculation.

Vaccination or inoculation unless forming part of treatment and requires Hospitalisation.

5.7. Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy)

Massages, steam bath, expenses for alternative or AYUSH treatments (other than Ayurveda and Homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.

5.8. Dental treatment

Dental treatment, unless necessitated due to an Injury.

5.9. Domiciliary Hospitalization & Out Patient Department (OPD) treatment

Any expenses incurred on Domiciliary Hospitalization and OPD treatment

5.10. Stay in Hospital which is not Medically Necessary.

Stay in hospital which is not medically necessary.

5.11. Spectacles, Contact Lens, Hearing Aid, Cochlear Implants

Spectacles, contact lens, hearing aid, cochlear implants.

5.12. Non Prescription Drug

Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in respective Appendix-II).

5.13. Treatment not Related to Disease for which Claim is Made

Treatment which the insured person was on before Hospitalisation for the Illness/Injury, different from the one for which claim for Hospitalisation has been made.

5.14. Equipments

External/durable medical/non-medical equipments/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic footwear, glucometer, thermometer and similar related items (as listed in respective Appendix-II) and any medical equipment which could be used at home subsequently.

5.15. Items of personal comfort

Items of personal comfort and convenience (as listed in respective Appendix-II) including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

5.16. Service charge/ registration fee

Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in respective Appendix-II) levied by the hospital.

5.17. Home visit charges

Home visit charges during Pre and Post Hospitalisation of doctor, aya, attendant and nurse.

5.18. War

War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

5.19. Radioactivity

Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

- a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
- b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
- c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing)

micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

5.20. Treatment taken outside the geographical limits of India

5.21. Permanently Excluded Diseases

In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

6 GENERAL TERMS AND CLAUSES

Standard General Terms and Conditions

6.1 Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

6.2 Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

6.3 Claim Settlement

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

6.4 Multiple Policies

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6.5 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
- c) any other act fitted to deceive; and
- d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6.6 Cancellation

- i. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud
- ii. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Period of risk	Rate of premium to be charged
Up to 1 month	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

6.7 Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

6.8 Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

6.9 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.
- v. No loading shall apply on renewals based on individual claims experience.

6.10 Withdrawal of Product

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

6.11 Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

6.12 Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

6.13 Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

6.14 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

Specific General Terms and Conditions

6.15 Communication

- i. All communication should be made in writing.
- ii. For Policies serviced by TPA, ID card, PPN/Network Provider related issues to be communicated to the TPA at the address mentioned in the Schedule. For claim serviced by the Company, the Policy related issues to be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule.
- iii. Any change of address, state of health or any other change affecting any of the Insured Person, shall be communicated to the Policy issuing office of the Company at the address mentioned in the Schedule
- iv. The Company or TPA shall communicate to the Insured at the address mentioned in the Schedule.

6.16 Physical Examination

Any Medical Practitioner authorised by the Company shall be allowed to examine the Insured Person in the event of any alleged Illness/Injury requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company.

6.17 Claim Procedure

6.17.1 Notification of Claim

In order to lodge a claim under the Policy for any Hospitalisation, the Insured Person/Insured Person's representative shall notify the TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) in writing by letter, e-mail, fax providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit.

Claim Intimation in case of Cashless facility	TPA must be informed:
In the event of planned Hospitalisation	At least seventy two (72) hours prior to the Insured Person's admission to Network Provider
In the event of emergency Hospitalisation	Within twenty four (24) hours of the Insured Person's admission to Network Provider

Claim Intimation in case of Reimbursement	Company/TPA must be informed:
In the event of planned Hospitalisation	At least seventy two (72) hours prior to the Insured Person's admission to Hospital
In the event of emergency Hospitalisation	Within twenty four (24) hours of the Insured Person's admission to Hospital

6.17.2 Procedure for Cashless Claims

- i. Cashless Facility for treatment in Network Providers can be availed, if TPA service is opted.
- ii. Treatment may be taken in a Network Provider and is subject to pre authorization by the TPA. Booklet containing list of Network Provider shall be provided by the TPA. Updated list of Network Provider is available on website of the Company and the TPA mentioned in the Schedule.
- iii. Cashless request form available with the Network Provider and TPA shall be completed and sent to the TPA for authorization.
- iv. The TPA upon getting cashless request form and related medical information from the Insured Person/ Network Provider shall issue pre-authorization letter to the Hospital after verification.
- v. At the time of discharge, the Insured Person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- vi. The TPA reserves the right to deny pre-authorization in case the Insured Person/ Network Provider is unable to provide any required details related to the pre authorization request.
- vii. In case of denial of Cashless Facility, the Insured Person may obtain the treatment as per treating Medical Practitioner's advice and submit the necessary documents for reimbursement of claim.

6.17.3 Procedure for Reimbursement of Claims

For reimbursement of claims the Insured Person shall submit the necessary documents to TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) within the prescribed time limit.

6.17.4 Documents

The claim is to be supported with the following original documents and submitted within the prescribed time limit.

- i. Completed claim form
- ii. Medical practitioner's prescription advising admission for inpatient treatment.
- iii. Cash-memo from the hospital (s)/chemist (s) supported by proper prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.

- iv. Payment receipt, investigation test reports and associated plates/CDs in original, supported by the prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.
- v. Attending medical practitioner's certificate regarding Diagnosis along with date of Diagnosis and bill, receipts etc.
- vi. Surgeon's certificate regarding Diagnosis and nature of operation performed along with bills, receipts etc.
- vii. Bills, receipt, sticker of the Implants.
- viii. Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary, break up of final bill from the hospital etc.
- ix. Any other document required by Company/TPA.

Note

In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents listed under condition 6.17.4 and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.

6.17.5 Time limit for submission of claim documents to the Company/ TPA

Type of claim	Time limit
Reimbursement of Hospitalisation, Pre Hospitalisation expenses and ambulance charges	Within thirty (30) days of date of discharge from Hospital
Reimbursement of post Hospitalisation expenses	Within thirty (30) days from completion of Post Hospitalisation treatment
Reimbursement of Preventive Health Check-Up expenses	At least forty five (45) days before the expiry of the fifth Policy Period

Waiver

Time limit for claim intimation and submission of documents may be waived in cases where the Insured/ Insured Person or his/ her representative applies and explains to the satisfaction of the Company, that the circumstances under which Insured/ Insured Person was placed, it was not possible to intimate the claim/submit the documents within the prescribed time limit.

6.17.6 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the Policy.

The services offered by a TPA shall not include

- i. Claim settlement and claim rejection;
- ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.17.7 Optional Co-payment

The Insured may opt for Optional Co-payment, with discount in premium. In such cases, each admissible claim under the Policy shall be subject to the same Co-payment percentage. Any change in Optional Co-payment may be done only during Renewal. Insured may choose either of the two Co-payment options:

- 20% Co-payment on each admissible claim under the Policy, with a 15% discount in total premium.
- 15% Co-payment on each admissible claim under the Policy, with a 10% discount in total premium.

6.18 Payment of Claim

All claims under the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

6.19 Territorial Limit

All medical treatment for the purpose of this Policy will have to be taken in India only.

6.20 Territorial Jurisdiction

All disputes or differences under or in relation to the Policy shall be determined by the Indian court and according to Indian law.

6.21 Arbitration

- i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred for arbitration as per Arbitration and Conciliation Act 1996, as amended from time to time.
- ii. 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 the Policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the Policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

6.22 Disclaimer

If the Company shall disclaim liability to the Insured Person for any claim hereunder and if the Insured Person shall not within twelve (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.

6.23 Enhancement of Basic Sum Insured

Basic Sum Insured can be enhanced only at the time of Renewal. Basic Sum Insured can be enhanced subject to discretion of the Company. For the incremental portion of the Basic Sum Insured, the Waiting Periods and conditions as mentioned in Exclusion 4.1, 4.2, 4.3 shall apply afresh.

6.24 Adjustment of Premium for Overseas Travel Insurance Policy

If during the Policy Period any of the Insured Person is also covered by an Overseas Travel Insurance Policy issued by the Company, the Policy shall be inoperative in respect of the Insured Person(s) for the number of days the Overseas Travel Insurance Policy is in force. Proportionate premium for such number of days shall be adjusted against the Renewal premium, provided the Insured has informed the Company in writing before leaving India, and submits an application, stating the details of visit(s) abroad, along with copies of the Overseas Travel Insurance Policy, within fifteen (15) days of return. The maximum premium refundable and adjusted on Renewal shall be limited to 80% of premium of the expiring Policy, in respect of the Insured Person(s) covered under Overseas Travel Insurance Policy.

7 REDRESSAL OF GRIEVANCE

In case of any grievance the insured person may contact the company through

Website: <https://nationalinsurance.nic.co.in/>

Toll free: 1800 345 0330

E-mail: customer.relations@nic.co.in

Phn : (033) 2283 1742

Post: National Insurance Co. Ltd.,

6A Middleton Street, 7th Floor,

CRM Dept.,

Kolkata - 700 071

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer (Office in-Charge) at that location.

For updated details of grievance officer, kindly refer the link: <https://nationalinsurance.nic.co.in/>

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (Annexure III).

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

TABLE OF BENEFITS

Name	National Mediclaim Policy
Basic Sum Insured (excluding CB)	₹ 1L – 10 L
Slab	₹ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10 L
Coverage	
Hospitalisation	<p>Sub limits</p> <p>A. Room Charges – Up to 25% of SI for Any One Illness Room Rent– Up to 1% of SI per day subject to max of ₹ 10,000 ICU Charges– Up to 2% of SI per day subject to max of ₹ 20,000</p> <p>B. Medical Practitioner’s fee – Up to 25% for Any One Illness</p> <p>C. Others – Up to 50% of SI for Any One Illness <i>Sub limit will not apply in case of Hospitalisation in a Preferred Provider Network (PPN) as per eligible package</i></p> <p>D. Hemodialysis, Chemotherapy, Radiotherapy Restricted to 50% of Sum Insured or the PPN Package Rate, whichever is lower (inclusive of above sub limits)</p> <p>E. Coverage for Modern Treatment (12 nos) – Up to 25% of SI for each treatment</p> <p>F. Expenses due to hazardous or adventure sports (non-professionals)– Up to 25% of SI</p>
System of Medicine	Allopathy, Ayurveda and Homeopathy Covered up to SI
In Built Features	Pre hospitalisation - 45 days immediately before hospitalisation Post hospitalisation - 60 days immediately after discharge
	Organ Donor’s hospitalisation expenses only
	Ambulance Charges – 1% of SI subject to maximum of ₹ 2,000 in a Policy Period
	Hospitalisation coverage for HIV/ AIDS and Mental Illness
	Treatment of Morbid Obesity and Refractive Error of at least 7.5D, subject to Waiting Periods
	Reinstatement of Basic SI – Once in a Policy Period, available to Policy with Basic SI ₹ 6L and above
Others	
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the Company shall be covered after 4 year Waiting Period
Enhancement of Basic SI	On Renewal No limit
Good Health Incentives	
Cumulative Bonus	Increase by 5% of Basic SI in respect of each claim free Policy Period Decrease by 5% of Basic SI for each year with claim reported Maximum accumulation, 50% of the Basic SI of the renewed Policy
Preventive Health check up	Every 4 claim free years, prescribed diagnostics tests up to 1% of the average Basic SI per insured person, subject to maximum ₹ 5,000/-
Discounts	
Copayment (optional)	If opted, policyholder may choose either of the two copayment options- <ul style="list-style-type: none"> • 20% Co-payment on each admissible claim, with a 15% discount in premium • 15% Co-payment on each admissible claim, with a 10% discount in premium
Online Discount	10% discount in premium (for new and Renewal, ONLY where no intermediary is involved)
Covid-19 Vaccination Discount	Discount of 5% is allowed on individual premium if the Insured Person has received 2 doses of COVID-19 vaccine. Children (Insured Persons less than 18 years) may be allowed discount provided both parents are vaccinated.

Note: SI here means Basic SI and Cumulative Bonus (CB), unless otherwise specified.

No loading shall apply on Renewals based on individual claims experience

Insurance is the subject matter of solicitation

Please preserve the policy for all future reference.

Day Care Procedure - Day care procedures will include following day care surgeries and day care treatment

- Microsurgical operations on the middle ear**
 1. Stapedotomy
 2. Stapedectomy
 3. Revision of a stapedectomy
 4. Other operations on the auditory ossicles
 5. Myringoplasty (Type -I Tympanoplasty)
 6. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
 7. Revision of a tympanoplasty
 8. Other microsurgical operations on the middle ear
- Other operations on the middle and internal ear**
 9. Myringotomy
 10. Removal of a tympanic drain
 11. Incision of the mastoid process and middle ear
 12. Mastoidectomy
 13. Reconstruction of the middle ear
 14. Other excisions of the middle and inner ear
 15. Fenestration of the inner ear
 16. Revision of a fenestration of the inner ear
 17. Incision (opening) and destruction (elimination) of the inner ear
 18. Other operations on the middle and inner ear
- Operations on the nose and the nasal sinuses**
 19. Excision and destruction of diseased tissue of the nose
 20. Operations on the turbinates (nasal concha)
 21. Other operations on the nose
 22. Nasal sinus aspiration
- Operations on the eyes**
 23. Incision of tear glands
 24. Other operations on the tear ducts
 25. Incision of diseased eyelids
 26. Excision and destruction of diseased tissue of the eyelid
 27. Operations on the canthus and epicanthus
 28. Corrective surgery for entropion and ectropion
 29. Corrective surgery for blepharoptosis
 30. Removal of a foreign body from the conjunctiva
 31. Removal of a foreign body from the cornea
 32. Incision of the cornea
 33. Operations for pterygium
 34. Other operations on the cornea
 35. Removal of a foreign body from the lens of the eye
 36. Removal of a foreign body from the posterior chamber of the eye
 37. Removal of a foreign body from the orbit and eyeball
 38. Operation of cataract
- Operations on the skin and subcutaneous tissues**
 39. Incision of a pilonidal sinus
 40. Other incisions of the skin and subcutaneous tissues
 41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
 42. Local excision of diseased tissue of the skin and subcutaneous tissues
 43. Other excisions of the skin and subcutaneous tissues
 44. Simple restoration of surface continuity of the skin and subcutaneous tissues
 45. Free skin transplantation, donor site
 46. Free skin transplantation, recipient site
 47. Revision of skin plasty
 48. Other restoration and reconstruction of the skin and subcutaneous tissues
 49. Chemosurgery to the skin
 50. Destruction of diseased tissue in the skin and subcutaneous tissues
- Operations on the tongue**
 51. Incision, excision and destruction of diseased tissue of the tongue
 52. Partial glossectomy
 53. Glossectomy
 54. Reconstruction of the tongue
 55. Other operations on the tongue
- Operations on the salivary glands and salivary ducts**
 56. Incision and lancing of a salivary gland and a salivary duct
 57. Excision of diseased tissue of a salivary gland and a salivary duct
 58. Resection of a salivary gland
 59. Reconstruction of a salivary gland and a salivary duct
 60. Other operations on the salivary glands and salivary ducts
- Other operations on the mouth and face**
 61. External incision and drainage in the region of the mouth, jaw and face
 62. Incision of the hard and soft palate
 63. Excision and destruction of diseased hard and soft palate
 64. Incision, excision and destruction in the mouth
 65. Plastic surgery to the floor of the mouth
 66. Palatoplasty
 67. Other operations in the mouth
- Operations on the tonsils and adenoids**
 68. Transoral incision and drainage of a pharyngeal abscess
 69. Tonsillectomy without adenoidectomy
 70. Tonsillectomy with adenoidectomy
 71. Excision and destruction of a lingual tonsil
- Other operations on the tonsils and adenoids**
 72. Other operations on the tonsils and adenoids
- Trauma surgery and orthopaedics**
 73. Incision on bone, septic and aseptic
 74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
 75. Suture and other operations on tendons and tendon sheath
 76. Reduction of dislocation under GA
 77. Arthroscopic knee aspiration
- Operations on the breast**
 78. Incision of the breast
 79. Operations on the nipple
- Operations on the digestive tract**
 80. Incision and excision of tissue in the perianal region
 81. Surgical treatment of anal fistulas
 82. Surgical treatment of haemorrhoids
 83. Division of the anal sphincter (sphincterotomy)
 84. Other operations on the anus
 85. Ultrasound guided aspirations
 86. Sclerotherapy etc.
- Operations on the female sexual organs**
 87. Incision of the ovary
 88. Insufflation of the Fallopian tubes
 89. Other operations on the Fallopian tube
 90. Dilatation of the cervical canal
 91. Conisation of the uterine cervix
 92. Other operations on the uterine cervix
 93. Incision of the uterus (hysterotomy)
 94. Therapeutic curettage
 95. Culdotomy
 96. Incision of the vagina
 97. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
 98. Incision of the vulva
 99. Operations on Bartholin's glands (cyst)
- Operations on the prostate and seminal vesicles**
 100. Incision of the prostate
 101. Transurethral excision and destruction of prostate tissue
 102. Transurethral and percutaneous destruction of prostate tissue
 103. Open surgical excision and destruction of prostate tissue
 104. Radical prostatovesiculectomy
 105. Other excision and destruction of prostate tissue
 106. Operations on the seminal vesicles
 107. Incision and excision of periprostatic tissue
 108. Other operations on the prostate
- Operations on the scrotum and tunica vaginalis testis**
 109. Incision of the scrotum and tunica vaginalis testis
 110. Operation on a testicular hydrocele
 111. Excision and destruction of diseased scrotal tissue
 112. Plastic reconstruction of the scrotum and tunica vaginalis testis
 113. Other operations on the scrotum and tunica vaginalis testis
- Operations on the testes**
 114. Incision of the testes
 115. Excision and destruction of diseased tissue of the testes
 116. Unilateral orchidectomy
 117. Bilateral orchidectomy
 118. Orchidopexy
 119. Abdominal exploration in cryptorchidism
 120. Surgical repositioning of an abdominal testis
 121. Reconstruction of the testis
 122. Implantation, exchange and removal of a testicular prosthesis
 123. Other operations on the testis
- Operations on the spermatic cord, epididymis and ductus deferens**
 124. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
 125. Excision in the area of the epididymis
 126. Epididymectomy
 127. Reconstruction of the spermatic cord
 128. Reconstruction of the ductus deferens and epididymis
 129. Other operations on the spermatic cord, epididymis and ductus deferens
- Operations on the penis**
 130. Operations on the foreskin
 131. Local excision and destruction of diseased tissue of the penis
 132. Amputation of the penis
 133. Plastic reconstruction of the penis
 134. Other operations on the penis
- Operations on the urinary system**
 135. Cystoscopic removal of stones
- Other Operations**
 136. Lithotripsy
 137. Coronary angiography
 138. Hemodialysis
 139. Radiotherapy for Cancer
 140. Cancer Chemotherapy

Note:

- i. Day Care Treatment will include above Day Care Procedures
- ii. Any surgery/procedure (not listed above) which due to advancement of medical science requires Hospitalisation for less than 24 hours will require prior approval from Company/TPA.
- iii. The standard Exclusions and Waiting Periods are applicable to all of the above Day Care Procedures / Surgeries depending on the medical condition / disease under treatment. Only 24 hours Hospitalisation is not mandatory.

List I – List of which coverage is not available in the policy	
Sl	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY
List II – Items that are to be subsumed into Room Charges	
Sl	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS

5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
List III – Items that are to be subsumed into Procedure Charges	
Sl	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE
List IV – Items that are to be subsumed into costs of treatment	
Sl	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION\STERILLIUM
17	Glucometer & Strips
18	URINE BAG

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT– Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor,

	Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanschiramnagar, Saharanpur	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in