

Issuing Office

National Mediclaim Policy

Whereas the proposer designated in the Schedule hereto has by a proposal together with declaration and medical reports (if applicable), 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

2.1 Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.2 Age / Aged means completed years on last birthday as on Policy commencement date.

2.3 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.

2.4 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.

2.5 AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered AYUSH Medical Practitioner in charge round the clock;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.6 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:

- a. Central or State Government AYUSH Hospital or
- b. Teaching hospital attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/ Central Council for Homeopathy; or
- c. 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:
 - i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

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

- 2.8 Break in policy** means the period of gap that occurs at the end of the existing Policy Period / Instalment Premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or Grace Period.
- 2.9 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 or a Non Network Provider to the extent pre-authorization approved.
- 2.10 Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
- 2.11 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.
- 2.12 Contract** 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.
- 2.13 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.
- 2.14 Cumulative Bonus** means any increase or addition in the Sum Insured granted by the Company without an associated increase in premium.
- 2.15 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:
- has qualified Nursing staff under its employment;
 - has qualified Medical Practitioner (s) in charge;
 - has a fully equipped operation theatre of its own where Surgical Procedures are carried out
 - maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
- 2.16 Day Care Treatment** means medical treatment, and/or Surgical Procedure which is:
- undertaken under general or local anesthesia in a Hospital/Day Care Centre in less than twenty-four (24) hrs because of technological advancement, and
 - 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.
- 2.17 Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.
- 2.18 Diagnosis** means diagnosis by a Medical Practitioner, supported by clinical, radiological, histological and laboratory evidence, acceptable to the Company.
- 2.19 Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to Waiting Periods and coverage of Pre-Existing Diseases. The Grace Period for payment of the premium shall be thirty days.
In case of Premium payment in instalments, if the due instalment premium is paid within Grace Period, coverage shall be available during the Grace Period.
In case of Renewal, Coverage shall not be available during the period for which no premium is received.
- 2.20 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:
- has qualified nursing staff under its employment round the clock;
 - has at least ten (10) in-Patient beds, in those towns having a population of less than ten lacs and fifteen (15) in-patient beds in all other places;
 - has qualified Medical Practitioner (s) in charge round the clock;
 - has a fully equipped operation theatre of its own where surgical procedures are carried out
 - maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

- 2.21 Hospitalisation** means admission in a Hospital for a minimum period of twenty four consecutive **Inpatient Care** hours except for procedures/ treatments, where such admission could be for a period of less than twenty four consecutive hours.
- 2.22 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
- 2.23 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.
- 2.24 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.
- 2.25 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.
- 2.26 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.
- 2.27 I D card** means the card issued to the Insured Person by the TPA for availing Cashless Facility.
- 2.28 Insured/ Insured Person** means person(s) named in the Schedule of the Policy.
- 2.29 Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
- 2.30 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.
- 2.31 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.
- 2.32 Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which
- i. is required for the medical management of Illness or Injury suffered by the Insured Person;
 - ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - iii. must have been prescribed by a Medical Practitioner;
 - iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
- 2.33 Mental 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.
- 2.34 Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
- 2.35 Network Provider** means Hospitals or Day Care Centers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured Person by a Cashless Facility.
- 2.36 Non- Network Provider** means any Hospital, Day Care Centre that is not part of the network.

- 2.37 Notification of Claim** means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.
- 2.38 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.
- 2.39 Pre-Existing Disease (PED)** means any condition, ailment, injury or disease:
- a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
 - b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
- 2.40 Pre-hospitalisation Medical Expenses** means Medical Expenses incurred during predefined number of days preceding the Hospitalisation of the Insured Person, provided that:
- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Company.
- 2.41 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:
- i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
 - ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Company.
- 2.42 Policy Period** means period of one (01) year as mentioned in the Schedule for which the Policy is issued.
- 2.43 Portability** means a facility provided to the policyholders (including all members under family cover), to transfer the credits gained for, Pre-Existing Diseases and Specific Waiting Periods from one insurer to another insurer.
- 2.44 Preferred 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.
- 2.45 Proposer** 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.
- 2.46 Psychiatrist** 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.
- 2.47 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.
- 2.48 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.
- 2.49 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.
- 2.50 Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated charges.
- 2.51 Schedule** 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.
- 2.52 Sum 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.
- 2.52.1 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.

2.53 Surgery 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.

2.54 Third 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.

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

2.56 Waiting 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 (excluding Oral 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): <table><tr><th>Modern Treatment</th><th>Coverage</th></tr><tr><td>Uterine Artery Embolization and HIFU (High intensity focused ultrasound)</td><td>Limit is for Procedure cost only</td></tr><tr><td>Balloon Sinuplasty</td><td>Limit is for Balloon cost only</td></tr><tr><td>Deep Brain Stimulation</td><td>Limit is for implants including batteries only</td></tr><tr><td>Oral Chemotherapy</td><td>Only cost of medicines payable under this limit, other incidental charges like investigations and consultation charges not payable.</td></tr><tr><td>Immunotherapy - Monoclonal Antibody to be given as injection</td><td>Limit is for cost of injections only.</td></tr><tr><td>Intravitreal injections</td><td>Limit is for complete treatment, including Pre & Post Hospitalization</td></tr><tr><td>Robotic Surgery</td><td>Limit is for robotic component only.</td></tr><tr><td>Stereotactic Radio surgeries</td><td>Limit is for radiation procedure.</td></tr><tr><td>Bronchial Thermoplasty</td><td>Limit is for complete treatment, including Pre & Post Hospitalization</td></tr></table>	Modern Treatment	Coverage	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Limit is for Procedure cost only	Balloon Sinuplasty	Limit is for Balloon cost only	Deep Brain Stimulation	Limit is for implants including batteries only	Oral Chemotherapy	Only cost of medicines payable under this limit, other incidental charges like investigations and consultation charges not payable.	Immunotherapy - Monoclonal Antibody to be given as injection	Limit is for cost of injections only.	Intravitreal injections	Limit is for complete treatment, including Pre & Post Hospitalization	Robotic Surgery	Limit is for robotic component only.	Stereotactic Radio surgeries	Limit is for radiation procedure.	Bronchial Thermoplasty	Limit is for complete treatment, including Pre & Post Hospitalization	Maximum amount admissible for the related modern procedure / component / medicine of each modern treatment shall be 25% of Sum Insured (i.e. Basic Sum Insured and Cumulative Bonus) during the Policy Period.
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	Vaporization of the prostate (Green laser treatment or holmium laser treatment)	Limit is for LASER component only.	
	IONM - (Intra Operative Neuro Monitoring)	Limit is for IONM procedure only.	
	Stem cell therapy - Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Limit is for complete treatment, including Pre & Post Hospitalization	
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, AYUSH, 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 Medical Expenses (including Pre and Post Hospitalisation Expenses) for Day Care Treatments requiring Hospitalization as an In-Patient for less than 24 hours undergone by the Insured Person in a Hospital/ Day Care Centre, but not in the Outpatient department of a Hospital.

3.9.2 AYUSH Treatment

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Period up to the limit of Sum Insured as specified in the Policy Schedule in any AYUSH Hospital.

3.9.3 HIV/ AIDS Cover

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

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

3.9.4 Mental Illness Cover

The Company shall indemnify 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 or a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.

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 Medical Expenses incurred in respect of an organ donor's Hospitalisation during the Policy Period for harvesting of the organ donated to an Insured Person, provided that:

- The organ donation confirms to the Transplantation of Human Organs Act 1994 (and its amendments from time to time)
- The organ is used for an Insured Person and the Insured Person has been medically advised to undergo an organ transplant
- The Medical Expenses shall be incurred in respect of the organ donor as an in-patient in a Hospital.
- Claim has been admitted under Section "In patient treatment" in respect of the Insured Person undergoing the organ transplant.

Exclusions

The Company shall not be liable to make payment for any claim under this Cover which arises for or in connection with any of the following:

- Pre-hospitalization Medical Expenses or Post-Hospitalization Medical Expenses of the organ donor.
- Costs directly or indirectly associated with the acquisition of the donor's organ.
- Medical Expenses where the organ transplant is experimental or investigational.
- Any medical treatment or complication in respect of the donor, consequent to harvesting.

v. Any expenses related to organ transportation or preservation.

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 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 three (03) 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;
 - 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 Type 2 Diabetes

3.9.8 Correction of Refractive Error

The Company shall indemnify 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 dioptres, 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 Annexure-I. 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 Annexure-I 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 by the Insured Person and admitted by the Company) 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.

Note:

- a) No Cumulative Bonus will be added if the Policy is not renewed with the Company by the end of the Grace Period.
- b) The Cumulative Bonus will not be accumulated in excess of 50% of the Basic Sum Insured under the current Policy with the Company under any circumstances.
- c) Any Cumulative Bonus that has accrued for a Policy Period will be credited at the end of that Period if the policy is renewed with the Company within Grace Period and will be available for any claims made in the subsequent Period.
- d) **Merging of Policies or Migration from Individual to Floater Policy:** If the Insured Persons in the expiring Policy are covered under Individual policy/policies and such expiring Policy has been Renewed with the Company on a Family Floater basis then the

Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest percentage of Cumulative Bonus applicable on the lowest Sum Insured of the last Policy Period amongst all the expiring individual policies being merged.

e) **Revision in Sum Insured:** If the Sum Insured under the Policy has been increased/decreased at the time of Renewal, the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Period.

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** and admitted 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: Availing benefit under Section 3.11.2 shall not be counted as a claim under the Policy.

4. WAITING PERIOD - 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 thirty six (36) 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 thirty six (36) months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

4.2. Specific 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/ three 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 namely)**
 - 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 dioptres.
 - c. Benign prostatic hypertrophy
 - d. Hernia
 - e. Hydrocele
 - f. Fissure/Fistula in anus
 - g. Piles (Haemorrhoids)
 - h. Sinusitis and related disorders
 - i. Polycystic ovarian disease
 - j. Non-infective arthritis
 - k. Pilonidal sinus
 - l. Gout and Rheumatism
 - m. Calculus diseases
 - n. Surgery of gall bladder and bile duct excluding malignancy
 - o. Surgery of genito-urinary system excluding malignancy
 - p. Surgery for prolapsed intervertebral disc unless arising from accident
 - q. Surgery of varicose vein
 - r. Hysterectomy
 - s. 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. Three years Waiting Period

Following diseases shall be covered after **three** years of continuous cover from the inception of the Policy:

- 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.

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.

5 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. 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.

5.2. 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.

5.3. 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

5.4. 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.

5.5. 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.

5.6. 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.

5.7. 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.

5.8. 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.

5.9. Drug/Alcohol Abuse (Excl 12)

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

5.10. 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).

5.11. 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

5.12. Refractive Error (Excl 15)

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

5.13. Unproven Treatments (Excl16)

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.

5.14. 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

5.15. 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

5.16. Hormone Replacement Therapy

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

5.17. General Debility, Congenital External Anomaly

General debility, congenital external anomaly.

5.18. Self Inflicted Injury

Treatment for intentional self-inflicted injury, attempted suicide.

5.19. Stem Cell Surgery

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

5.20. Circumcision

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

5.21. Vaccination or Inoculation.

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

5.22. Massages, Steam Bath, Alternative Treatment (Other than AYUSH treatment)

Massages, steam bath, expenses for alternative treatments (other than AYUSH treatment), acupuncture, acupressure, magnetotherapy and similar treatment.

5.23. Dental treatment

Dental treatment, unless necessitated due to an Injury.

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

Any expenses incurred on Domiciliary Hospitalization and OPD treatment

5.25. Stay in Hospital which is not Medically Necessary.

Stay in hospital which is not medically necessary.

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

Spectacles, contact lens, hearing aid, cochlear implants.

5.27. 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.

5.28. 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.

5.29. 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 and any medical equipment which could be used at home subsequently.

5.30. Items of personal comfort

Items of personal comfort and convenience including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.

5.31. Service charge/ registration fee

Any kind of service charges including surcharges, admission fees, registration charges and similar charges levied by the hospital.

5.32. Home visit charges

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

5.33. 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.

5.34. 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.

5.35. Treatment taken outside the geographical limits of India

6. GENERAL TERMS AND CLAUSES

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 15 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. 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 or established 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 his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall refund proportionate premium for unexpired policy period, if there is no claim(s) made during the policy period.
- Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed under the Policy.

6.7 Migration

The Insured Person will have the option to migrate the Policy to an alternative health insurance product offered by the Company by applying for Migration of the policy at least 30 days before the policy renewal date as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under this Policy offered by the Company,

- i. The Insured Person will get all the accrued continuity benefits for credits gained to the extent of the specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person.
- ii. Migration benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Migration benefit shall not apply to any other additional increased Sum Insured.

The Proposal may be subject to fresh Underwriting as per terms of conditions of the migrated product, if the insured is not continuously covered for at least 36 months under the previous product.

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 15 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 this Policy offered by the Company,

- i. The proposed Insured Person will get all the accrued continuity benefits for specific waiting periods, waiting period for pre-existing diseases and Moratorium period of the Insured Person under the previous health insurance Policy.
- ii. Portability benefit will be offered to the extent of Sum Insured and accrued Cumulative Bonus (as part of the sum insured) of the previous policy. Portability benefit shall not apply to any other additional increased Sum Insured.

6.9 Renewal of Policy

- i. The Policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate to other similar health insurance products/plans offered by the Company.
- ii. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- iii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
- iv. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.

- v. 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.
- vi. No loading shall apply on renewals based on individual claims experience.
- vii. In case of non-continuance of the Policy by the Insured (due to death or any other valid and acceptable reason):
 - The Policy may be renewed by any Insured Person above eighteen (18) years of age, as the Insured.
 - Where only children (less than eighteen years of age) are covered, the Policy shall be allowed till the expiry of the Policy period. The legal guardian may be allowed to renew the Policy as Proposer, covering the children.

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 sixty continuous months of coverage (including Portability and Migration), no claim shall be contestable by the Company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as Moratorium Period. The moratorium would be applicable for the Basic Sums Insured of the first policy. Wherever, the Basic Sum Insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of Basic Sums Insured only on the enhanced limits.

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 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 thirty days from date of receipt of the policy document to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

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.

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
In the event of emergency Hospitalisation	Within twenty four (24) hours of the Insured Person's admission

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

- Cashless Facility for treatment can be availed, if TPA service is opted.
- Treatment may be taken in a Network Provider / PPN or Non Network Provider and is subject to pre-authorization by the TPA. Updated list of Network Provider/PPN is available on the website of the Company and the TPA mentioned in the schedule.
- Cashless request form available with the Network Provider and TPA shall be completed and sent to the TPA for authorization.
- The TPA upon getting cashless request form and related medical information from the Insured Person/ Network Provider shall issue a pre-authorization letter **within an hour** to the Hospital after verification.
- At the time of discharge, the Insured Person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
- The TPA shall grant the final authorization **within three hours of the receipt** of discharge authorization request from the Hospital.
- 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.
- 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 to the Company or the TPA 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.

- Completed claim form
- Medical practitioner's prescription advising admission for inpatient treatment.
- Cash-memo from the hospital (s)/chemist (s) supported by proper prescription from attending medical practitioner for Pre Hospitalisation, Hospitalisation and Post Hospitalisation.
- 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.
- Attending medical practitioner's certificate regarding Diagnosis along with date of Diagnosis and bill, receipts etc.
- Surgeon's certificate regarding Diagnosis and nature of operation performed along with bills, receipts etc.
- Bills, receipt, sticker of the Implants.
- Bills, payment receipts, medical history of the patient recorded, discharge certificate/ summary, break up of final bill from the hospital etc.
- 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 25% discount in total premium.
- 10% Co-payment on each admissible claim under the Policy, with a 12.5% 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 may be enhanced only at the time of renewal subject to the availability of the higher slabs in the Policy. 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. Coverage on enhanced sum insured shall be available after the completion of Waiting Periods.

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.

6.25 Premium Payment in installments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly or Quarterly, as mentioned in the policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy).

- i. Grace Period (as defined) would be given to pay the instalment premium due for the policy.
- ii. If Installment Premium is not paid within Grace Period, the Policy shall be cancelled and no refund shall be allowed. However, if the installment premium is paid in instalments within the Grace Period, coverage shall be available during the Grace Period.

- iii. In case of a claim being admissible under the Policy, all the remaining installments for the Policy Period shall become due and payable immediately.
- iv. Change of Premium Paying Frequency can be opted only at the time of renewal

7. REDRESSAL OF GRIEVANCE

In case of any grievance related to the Policy, the insured person may submit in writing to the Policy Issuing Office or Grievance cell at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact: Customer Relationship Management Dept., National Insurance Company Limited, Premises No. 18-0374, Plot no. CBD-81, New Town, Kolkata - 700156, email: customer.relations@nic.co.in, griho@nic.co.in

For more information on grievance mechanism, and to download grievance form, visit our website <https://nationalinsurance.nic.co.in>

Bima Bharosa (an Integrated Grievance Management System earlier known as IGMS) - <https://bimabharosa.irdai.gov.in/>

Insurance Ombudsman – The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as listed in Annexure -II. The updated list of Office of Insurance Ombudsman are available on IRDAI website: <https://irdai.gov.in/> and on the website of Council for Insurance Ombudsman: <https://www.cioins.co.in/>

Helpline Number: 1800 345 0330

Dedicated Email ID for Senior Citizens: health.srcitizens@nic.co.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	Sub limits 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 B. Medical Practitioner's fee – Up to 25% for Any One Illness 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> D. Hemodialysis, Chemotherapy (excluding Oral Chemotherapy), Radiotherapy Restricted to 50% of Sum Insured or the PPN Package Rate, whichever is lower (inclusive of above sub limits) E. Coverage for Modern Treatment – Up to 25% of SI for each treatment F. Expenses due to hazardous or adventure sports (non-professionals) – Up to 25% of SI
System of Medicine	Allopathy and AYUSH , 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 3 years 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	
Co-payment (optional)	If opted, policyholder may choose either of the two co-payment options- 20% Co-payment on each admissible claim, with a 25% discount in premium 10% Co-payment on each admissible claim, with a 12.5% discount in premium
Online Discount	10% discount in premium (for new and Renewal, ONLY where no intermediary is involved)
Add-ons (cover available on payment of additional premium)	
Home Care	INR 10,000/ 15,000/ 20,000/ 25,000/ 30,000/ 35,000/ 40,000/ 45,000/ 50,000, subject to 10% of Basic SI under base Policy
Non-Medical Expenses (available to SI 5 lacs & above)	Up to 10% of Basic Sum Insured (excluding Cumulative Bonus, if any) of base Policy and shall be part of the base Policy Basic Sum Insured (excluding Cumulative Bonus, if any).

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.

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	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, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6 th Floor, Tilak Marg, Relief Road, Ahmedabad-380001 Tel: 079 -25501201/ 02/ 05/ 06 Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, 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@cioins.co.in
Madhya Pradesh, Chhattisgarh	Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & 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 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	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 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: Bimalokpal.jaipur@cioins.co.in

Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College, M.G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gaziपुर, 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, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Orayya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P.-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in