

RELIANCE

GENERAL
INSURANCE

RGI -
BoI SWASTHYA
BIMA

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IRDAI Registration No. 103.

Reliance General Insurance Company Limited.

Registered Office & Corporate Office: Reliance Centre,
South Wing, 4th Floor, Off. Western Express Highway,
Santacruz (East), Mumbai - 400 055.

UIN: RELHGP21515V022021

Corporate Identity No.: U66603MH2000PLC128300.

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RGI/MCOM/CO/RGI - BoI SWASTHYA BIMA POLICY
WORDINGS/Ver.0.1/151020.

An ISO 9001:2015 Certified Company

POLICY WORDINGS

Group Mediclaim Policy Wordings for RGI - Bol Swasthya Bima

Preamble

WHEREAS the Policyholder designated in the Schedule to this Group Mediclaim having by a proposal and declaration together with any statement, report or other document which shall be the basis of the contract and shall be deemed to be incorporated herein, has applied to Reliance General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the Policy Period as specified in the Schedule, any claim is incurred which becomes admissible and payable under this Policy then the Company shall pay for such claim, as per terms conditions and benefits and exclusions and the limit of Sum insured as set forth in this Policy.

1. Definitions

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meanings set forth:

1. **"Accident"** means a sudden, unforeseen and involuntary event caused by external visible and violent means.
2. **"Age"** means the completed age of the Insured person as on his last birthday. The minimum Entry Age shall be 91 days from the date of birth and the maximum Entry Age shall be 79 years. The maximum entry age for dependent children is 25 years.
3. **"Act"** means the Insurance Act, 1938 (4 of 1938).
4. **"Ambulance"** A road vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
5. **"Annexure"** A document attached and marked as Annexure to this Policy.
6. **"Any one illness"** means continuous Period of illness and includes relapse within 45 days from the date of last consultation with the Hospital where treatment has been taken.
7. **"Authority"** means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of IRDA Act 1999.
8. **"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(s) in charge;
 - 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.
9. **"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:
- i. Central or State Government AYUSH Hospital or
 - ii. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
 - iii. 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:
 - a. Having at least 5 in-patients beds;
 - b. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - d. Maintaining daily records of the patient and making the accessible to the insurance company's authorized representative.
10. **"Alternate/AYUSH Treatment"** refers to the medical and /or **Hospitalization** treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
11. **"Bank Rate"** means Bank Rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claims has fallen due.
12. **"Break in Policy"** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
13. **"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 insurer to the extent of pre-authorization is approved.
14. **Certificate Expiry Date/Certificate End Date:** means the date and time at which coverage expires for the Insured and is as specifically appearing in the Certificate of Insurance.

15. **Certificate of Insurance/Policy Schedule/ Schedule:** means the certificate issued to the Policyholder / Insured in line with the terms and conditions as agreed upon in the Master Policy attached to and forming part of this insurance contract mentioning details including but not limited to, details of the Insured Persons, Certificate Period Start Date, Certificate Expiry Date, coverage, sections and benefits applicable, the Sum Insured, the Policy Period, premium paid (including duties, taxes and levies thereon).
16. **“Child”** means biological or legally adopted son or daughter of the Policyholder whose completed age is less than 25 years as on the Certificate Period Start Date.
17. **“Claim”** means a demand made by the Policyholder or on his/her behalf, for payment under any Benefit, as covered under the Policy.
18. **“Complaint” or “Grievance”** means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a complainant with insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, distribution channels, intermediaries, insurance intermediaries or other regulated entities.
19. **“Complainant”** means a policyholder or prospect or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer or a distribution channel.
20. **Condition Precedent:** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
21. **“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”** means a Congenital anomaly which is not in the visible and accessible parts of the body.
- b. **“External Congenital anomaly”** means a Congenital anomaly which is in the visible and accessible parts of the body.
22. **“Co-Payment”** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the sum insured.
23. **“Cumulative Bonus”** means any increase or addition in the **Sum Insured** granted by the insurer without an associated increase in premium.
24. **“Day Care Treatment”** refers to medical treatment, and /or surgical procedure which is:
- a. Undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hours because of technological advancement, and
- b. Which would have otherwise required a hospitalisation of more than 24 hours.
- c. Treatment normally taken on an out-patient basis is not included in scope of this definition.
- d. Day care treatment shall include only procedures listed in Annexure D.
25. **“Day care centre”** means any institution established for day care treatment of disease/ injuries or a medical setup within 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 will make them accessible to the insurance company's authorized personnel.
26. **“Deductible”** means a cost-sharing requirement under a health insurance policy that provides that the Company will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer, A deductible does not reduce the sum insured.
27. **“Dependent”** means financially dependent on the Insured Person and does not have independent source of income.
28. **“Dental Treatment”** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
29. **“Disclosure to information norm”** The **Policy** shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
30. **“Distribution Channels”** means persons and entities authorised by the Authority to involve in sale and service of insurance products. For the purpose of this policy it means the Distribution Channels who is an Intermediary of the Company.
31. **“Domiciliary hospitalisation”** means medical treatment for an illness/disease/injury which in the normal course require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
- a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital/or
- b. the patient takes treatment at home on account of non-availability of room in a hospital.
32. **“Emergency Care”** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

33. **"Family"** means as defined in the policy schedule. For the purposes of this Policy, only the Insured, his/her legally wedded spouse and dependent Children are allowed to be covered as the Family.
34. **"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 period and coverage of Pre-existing diseases. Coverage is not available for the period for which no premium is received.
35. **"Hospital"** means any institution established for in-patient care and day care treatment of illness and / or 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 the 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 10 inpatient beds, in towns having a population of less than 10,00,000 and 15 inpatient 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 makes these accessible to the Insurance company's authorized personnel.
36. **"Hospitalisation"** means admission in a hospital for a minimum period of 24 consecutive 'In-patient care' hours except for specified procedures/treatments where such admission could be for a period of less than 24 consecutive hours.
37. **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
- Acute condition - Acute condition is 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
 - Chronic condition - A chronic condition is defined as a disease, illness, or Injury that has one or more of the following characteristics:
 - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
 - it needs ongoing or long-term control or relief of symptoms
 - it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
 - it continues indefinitely
 - it recurs or is likely to recur
38. **"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.
39. **"Intensive Care Unit (ICU)"** 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 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.
40. **"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 intensivists charges.
41. **"In-Patient Care/In-Patient Treatment"** means treatment for which the Insured person has to stay in a hospital for more than 24 hours for a covered event.
42. **"Insurer/Company"** means Reliance General Insurance Company Limited.
43. **"Insured/Insured Person"** A person accepted by the Company to be insured under this Policy and who meets and continues to meet all the eligibility requirements and whose name specifically appears under Insured /Insured Person in the Policy Schedule and with respect to whom the premium has been received by the Company.
44. **"Life Threatening Medical Condition/Life Threatening Condition"** is a medical condition suffered by the Insured Person which has any of the following characteristics:
 - Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate)' or
 - Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or
 - Critical Care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or
 - Critical Care being provided in critical care areas such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department and
 - Is certified by the attending Medical Practitioner as a Life Threatening Medical Condition
45. **"Maternity Expenses"** Maternity expenses means;
 - Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during **Hospitalization**);

- ii. expenses towards lawful medical termination of pregnancy during the policy period.
46. **“Master Policy Holder”** Master Policy Holder is the Bank of India (BoI), who facilitates selling and solicitation of this Policy and has agreed on the coverage, premiums terms and conditions of this Policy. This pre-agreed terms and conditions is called the Master Policy. These pre-agreed terms and condition as per the Master Policy shall be then the basis of the coverage offered to the prospective Certificate Holders/ Insured who solicited for insurance protection.
47. **“Master Policy Period”** means the period commencing from the Master Policy Period Start Date and ending on the Master Policy Period End Date and as specifically appearing in the Master Policy or the date of cancellation /termination of the Master Policy, whichever is earlier.
48. **“Master Policy Period End Date”** means the date and time on which the Master Policy expires, as specifically appearing in the Master Policy.
49. **“Master Policy Period Start Date”** means the date and time on which the Master Policy commences, as specifically appearing in the Master Policy.
50. **“Medical Advice”** means any consultation or advice from a medical practitioner including issuance of any prescription or follow-up prescription.
51. **“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.
52. **“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 his license and should not be the insured or close family member.
- Medical Practitioner for Mental Illness** shall be in accordance with The Mental Healthcare Act, 2017.
- ‘Physician’**, wherever mentioned under this Policy shall also satisfy the definition of a **Medical Practitioner**.
53. **“Mental Illness”** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize 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 sub normality of intelligence.
54. **“Medically necessary treatment”** means any treatment, tests, medication, or stay in hospital or part of a stay in a hospital which
- Is required for the medical management of the illness or injury suffered by the insured;
 - 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.
55. **“Migration”** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
56. **“Network Provider”** means hospitals or health care providers enlisted by an insurer ,TPA or jointly by the Company and TPA to provide medical services to an insured on payment by a cashless facility.
57. **“Nominee”** means the person whose name specifically appears as such in the Policy Schedule and is the person to whom the proceeds under this Policy, if any, shall become payable in the event of the death of the Policyholder/Insured Person. Nominee for all other Insured Person(s) shall be the Policyholder himself.
58. **“Non- Network Provider”** means any hospital, day care centre or other provider that is not part of the network provider.
59. **Notification of Claim:** means the process of intimating a Claim to the Company or TPA through any of the recognized modes of communication.
60. **“New Born Baby”** means baby born during the policy period and is aged upto 90 days.
61. **“Out-Patient (OPD) Treatment”** means the one in which the Insured 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.
62. **“Policy”** is the Company's contract of insurance with the Policyholder providing cover as detailed in this Policy Terms& conditions, the Proposal Form, Master Policy, Policy Schedule or Certificate of Insurance, Endorsements, if any and Annexures, form part of the contract and must be read together.
63. **Policyholder:** means the person who is the Proposer and whose name specifically appears in the Policy Schedule or Certificate of Insurance as Policyholder. The Policyholder can alternatively be called as Certificate Holder.
64. **“Policy period”** means the period between the inception date/Joining Date and the Certificate expiry

date/date of exit as specified in the Certificate of Insurance /Schedule to this Policy or the cancellation of this policy, whichever is earlier.

65. **“Joining Date”**: “Joining Date” means the date and time at which the Insured enrolled into the scheme and is Certificate Period Start Date as appearing in the Certificate of Insurance. It must lie within the Master Policy Period.
66. **“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 incurred for the same condition for which the Insured Person's hospitalisation was required, and
 - the in-patient hospitalisation claims for such hospitalisation is admissible by the Company.
67. **“Portability”** means the right accorded to an Individual health insurance policyholder (including all members under family cover) to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
68. **“Pre-existing Disease”** means any condition, ailment or injury or disease.
- That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer 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 insurer or its reinstatement.
69. **“Pre-hospitalisation medical expenses”** means Medical expenses incurred during predefined number of days preceding the hospitalization 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 claims for such hospitalisation is admissible by the Insurance Company.
70. **“Proposal form”** means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.
71. **“Prospect”** means any person who is a potential customer of an insurer and likely to enter into an insurance contract either directly with the insurer or through a distribution channel.
72. **“Prospectus”**: means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.
73. **“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.
74. **“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.
75. **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.
76. **“Room Rent”** means the amount charged by a hospital towards Room and Boarding expenses and shall include associated medical expenses.
77. **“Senior Citizen”** means any person who has completed sixty or more years of age as on the date of commencement/Policy Period Start Date or renewal of policy.
78. **“Sum Insured”** means the sum as specified in the Schedule to this Policy against the name of Insured/Insured Person/s. Alternatively this can be referred as the “Base Sum Insured”.
79. **“Reinstated Sum Insured”** means the Sum Insured that is reinstated after the Base Sum Insured is completely exhausted within a given Policy Period.
80. **“Surgery or Surgical Procedure”** 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 from suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.
81. **“Telemedicine”** means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any
82. **“Third party administrator (TPA)”** Third party administrator or TPA means any person who is licensed under the IRDA (Third Party Administrators - Health Services) Regulations 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company to service this policy, for the purposes of providing health services.
83. **“Unproven/ Experimental treatment”** means the treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

2. Scope Of Cover

All Certificates of Insurance/Schedules issued under this Master Policy will be subject to terms and conditions as agreed upon in the Master Policy.

The Company hereby agrees subject to the terms, conditions and exclusions contained or expressed herein, to compensate the Policyholder as per the covers and benefits opted in the Master Policy.

The Company shall indemnify the Policyholder/Insured up to the limits specified in the Policy Schedule/Certificate of Insurance, subject to other terms and conditions of this Policy.

In addition to the terms laid out herein, liability arising due to any treatment relating to Mental Illness shall be assessed in accordance with the relevant provisions of The Mental Healthcare Act, 2017.

The Company's total liability in aggregate for all claims paid under the Policy shall not exceed the Sum Insured (and reinstated Sum Insured where applicable) of the respective Insured Person.

Benefits

2.1. In Patient Hospitalization

This benefit covers Medical Expenses incurred by the Insured Person during the Policy Period on In-Patient Hospitalisation for illness/injury contracted or sustained by the Insured/Insured Person. Medical Expenses shall include:

- i. Room Rent
- ii. Nursing Expenses
- iii. Intensive Care Unit (ICU) Charges
- iv. Fees of Medical Practitioner including Surgeon and anaesthetist
- v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
- vi. Medicines, drugs and consumables
- vii. Diagnostics procedures
- viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure unless specifically excluded

The benefit is subject to the Sum Insured, limits on Room Rent and ICU charges and other terms, conditions, exclusions and deductible as stated in the Policy Schedule/Certificate of Insurance.

2.2. Domiciliary Hospitalization

This benefit covers payment of Medical Expenses incurred during the Policy Period for Medically Necessary Treatment pertaining to Domiciliary Hospitalisation of the Insured Person provided that:

The payment under Domiciliary hospitalisation benefit shall be limited to 10% of the Sum Insured as specified in the Certificate of Insurance/Schedule, and shall, in no case cover expenses incurred for:

- a. Treatment of any of the following diseases/illness/injury:

- Asthma
- Bronchitis
- Chronic nephritis and nephritic syndrome
- Diarrhea & all types of dysenteries including gastroenteritis.
- Diabetes mellitus and insipidus
- Epilepsy
- Hypertension
- Influenza, cough and cold
- All psychiatric or psychosomatic disorders
- Pyrexia of unknown origin for less than 10 days
- Tonsillitis and upper respiratory tract infection including laryngitis & pharyngitis
- Arthritis, gout and rheumatism.

2.3. Day Care Treatment

This benefit covers upto the Sum Insured, the medical expenses incurred for medically necessary treatment pertaining to Day care treatment of the Insured/Insured person, on the written advice of a Medical Practitioner.

The list of covered Day Care Treatments is appended as per Annexure D.

2.4. Pre-Hospitalization Medical Expenses

This benefit covers relevant Pre-hospitalization medical expenses incurred by the Insured/ Insured Person for up to 30 days during the Policy period.

2.5. Post-Hospitalization Medical Expenses

This benefit covers relevant Post-hospitalization medical expenses incurred by the Insured/ Insured Person for up to 60 days during the Policy period.

This shall also cover the relevant Physiotherapy expenses/charges incurred post-surgery by the Insured /Insured person up to a period of 60 days following the surgery.

2.6. Donor Expenses

The Company will indemnify the Policyholder/Insured Person up to 50% of Base Sum Insured as mentioned in the Certificate of Insurance/Policy Schedule, for the Medical Expenses incurred, during hospitalization, in respect of the donor for any organ transplant surgery conducted during the Policy Period, provided:

- i. The organ donation is in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.
- ii. The Company has admitted the Insured Person's claim under the Policy.
- iii. The organ donated is for the Insured Person's use.

The Company will not pay the donor's Pre-hospitalization and Post-hospitalization expenses or any other Medical Expenses for the donor consequent to the harvesting.

2.7. Re-instatement of Base Sum Insured

It is agreed that one re-instatement up to the 25% Base Sum Insured will be automatically done after the Base Sum Insured have been utilized completely for claims incurred under the Policy for the Policy Period, provided that:

- i. For a claim to be admissible under Re-instated Sum Insured it should be admissible under the Benefit 2.1, 2.2, 2.3, 2.9, 2.10 or 2.11.
- ii. The payment of claims in aggregate under Re-instated Sum Insured during a Policy Period shall be Upto 25% of Base Sum Insured.
- iii. The Reinstatement Benefit Sum Insured cannot be used for any claim for which a claim has arisen out or is a consequence of or its related to or is a complication of an Illness or Accident for which a claim has already been admitted under the current Policy in relation to an Insured Person.
- iv. The Re-instated Sum Insured for a Policy Period can be utilized only after the Base Sum Insured has been completely exhausted in that Policy Period.
- v. The unutilized Re-instated Sum Insured cannot be carried forward to any subsequent Policy Period.
- vi. The Sum Insured will be restored only once in a Policy Period .

2.8. Ambulance

The Company will reimburse the expenses incurred on an road ambulance offered by a Hospital or Ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention), provided that:

- i. the Company's maximum liability shall be limited to Rs.1000 per hospitalization ,
- ii. The Company have accepted an in-patient Hospitalisation claim for the same Insured Person and for the same Claim,
- iii. The coverage includes the cost of the transportation of the Insured Person from a Hospital to the nearest Hospital which is prepared to admit the Insured Person and provide the necessary medical services, provided that transportation has been prescribed by a Medical Practitioner and is medically necessary.

2.9. Alternate (AYUSH) Treatment

The Company will pay the medical expenses for the in-patient treatment that is taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy, subject to:

- i. The Company's maximum liability per Policy Period shall be limited to 10% of the Sum Insured as mentioned in the Certificate of Insurance/ Schedule, and

- ii. The Company has accepted an in-patient Hospitalisation for the Insured Person
- iii. The AYUSH treatment should be carried out in an AYUSH Hospital as defined under the Policy.
- iv. Pre Hospitalisation and Post Hospitalisation Expenses, Day Care Treatments and Domiciliary Hospitalisation expenses are not payable under this benefit.
- v. All preventive and rejuvenation treatments (non-curative in nature) including, without limitation, treatments that are not medically necessary. This includes but not limited to treatments at Spa, Massages and Health Rejuvenation Procedure.

This benefit is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

2.10. HIV/AIDS

The Company will pay for hospitalization expenses requiring more than 24 hours of admission because of ailments related to HIV/AIDS conditions

2.11. Modern Treatment

This Company will indemnify the Insured Person upto 50% of Sum Insured for the Medical Expenses incurred during the Policy Period on In Patient Treatment or Day Care Treatment or Domiciliary Hospitalisation for the below mentioned Modern Treatment Methods:

- i. Uterine Artery Embolization and HIFU
- ii. Balloon Sinuplasty
- iii. Deep Brain Stimulation
- iv. Oral Chemotherapy
- v. Immunotherapy-Monoclonal Antibody to be given as injection
- vi. Intra Vitreal injections
- vii. Robot surgeries
- viii. Stereotactic radio surgeries
- ix. Bronchial Thermoplasty
- x. Vaporization of the prostate (Green laser treatment or holmium laser treatment)
- xi. IONM- (Intra Operative Neutro Monitoring)
- xii. Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions

The claim under this benefit shall be subject to all other terms under Sections 2.1 to 2.10

3. Waiting Period

The Waiting Periods as defined in Clause 3.1, 3.2 &3.3 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly, irrespective of whether the Sum Insured is on individual or floater basis.

If there is any Break in Policy then the waiting periods including that for Pre-existing Disease shall be applicable

afresh and the look-back period of 4 years for Pre-existing Disease shall be counted from the fresh Certificate Period Start Date.

The Company shall not be liable to make any payment under the Policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below

3.1. Pre-Existing Diseases(Code-Excl 01)

- i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with Insurer.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. 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.
- iv. Coverage under the policy after the expiry of 36 months for any Pre-existing disease is subject to the same being declared at the time of application and accepted by the Insurer.

3.2. Specific Waiting Period (Code-Excl 02)

Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 12 or 24 months of continuous coverage, as may be the case after

- i. the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an Accident.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. 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.
- iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- v. 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.

List for 12 months Waiting Period

- a. Cataract
- b. Benign Prostatic Hypertrophy
- c. Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
- d. Dilatation and curettage
- e. Hernia, hydrocele, congenital internal anomaly/diseases

- f. Skin and all internal tumors/cysts/nodules/ polyps of any kind including breast lumps unless malignant/adenoids and hemorrhoids
- g. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, any abscess related to Anal region, Gastric and Duodenal Ulcers
- h. Nasal Septum Deviation, Sinusitis and related disorders
- i. Dialysis required for chronic renal failure
- j. Gastric and Duodenal ulcers

List for 24 months Waiting Period

- a. Arthritis if non-infective, Osteoarthritis and Osteoporosis, Gout, Rheumatism & all vertebrae Disorders including but not limited to Spondylitis, Spondylosis, Spondylolisthesis & Intervertebral Disc Prolapse, Joint Replacement Surgery
- b. Benign ear, nose and throat (ENT) Disorders and Surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty)
- c. Surgery of Genito urinary system unless necessitated by malignancy
- d. Kidney Stone/ Ureteric Stone/ Lithotripsy / Gall Bladder Stone - Varicose veins and varicose ulcers.

3.3. First Thirty Days Waiting Period(Code-Excl 03)

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

4. Exclusions

4.1. General 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:

- i. **Investigation & Evaluation (Code: Excl04)**
 - a. Expenses related to any admission primarily for diagnostics and evaluation purposes
 - b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
- ii. **Rest Cure, rehabilitation and respite care (Code:Excl05)**

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

- a. 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.
- b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- iii. **Obesity/ Weight Control (Code:Excl06):**
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
 - a. Surgery to be conducted is upon the advice of the Doctor
 - b. The surgery/Procedure conducted should be supported by clinical protocols
 - c. The member has to be 18 years of age or older and
 - d. Body Mass Index (BMI);
 - greater than or equal to 40 or
 - 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:
 - o Obesity-related cardiomyopathy
 - o Coronary heart disease
 - o Severe Sleep Apnea
 - o Uncontrolled Type2 Diabetes
- iv. **Change-of-Gender treatments (Code: Excl 07):**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex
- v. **Cosmetic or Plastic Surgery (Code: 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
- vi. **Hazardous or Adventure sports (Code: 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.
- vii. **Breach of law (Code: 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
- viii. **Excluded Providers (Code: Excl 11):** Expenses incurred towards treatment in any Hospital or by

any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim. (For updated and detailed list of Excluded Providers refer website- www.reliancegeneral.co.in)

- ix. **Substance Abuse and Alcohol (Code: Excl12):**
Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof
- x. **Wellness and Rejuvenation (Code:Excl13):**
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.
- xi. **Dietary Supplements & Substances (Code: Excl14):** 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 practitioner as part of hospitalization claim or day care procedure
- xii. **Refractive Error (Code: Excl 15):** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
- xiii. **Unproven Treatments-Code (Code: 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.
- xiv. **Sterility and Infertility (Code: Excl 17):**
Expenses related to sterility and infertility. This includes:
 - a. Any type of contraception, sterilization
 - b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c. Gestational Surrogacy
 - d. Reversal of sterilization
- xv. **Maternity Expenses (Code - Excl 18)**
 - a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
 - b. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the **Policy Period**.
- xvi. **Circumcision:** Circumcision unless necessary for treatment of a disease not excluded hereinabove or as may be necessitated due to an accident.

- xvii. **Hearing Aids and Spectacles** : Cost of spectacles, contact lenses and hearing aids.
- xviii. **Dental Treatment**: Dental treatment or surgery of any kind unless requiring hospitalisation.
- xix. **Convalescence**: Convalescence, general debility, 'run-down' condition
- xx. **External Congenital Anomaly**: Treatment for congenital external disease or defects or anomalies,
- xxi. **Self Injury and STD's**: Any venereal disease any intentional self-injury
- xxii. **Non-Allopathy**: Any expenses related to Non-allopathic treatment, except for AYUSH treatment
- xxiii. **Non-Medical Expenses**: Any non-medical charges as mentioned in "Annexure A"
- xxiv. **RMO Charges**: Any RMO charges are not payable.
- xxv. **Paramedics Charges**: Any paramedics charges other than Nursing charges and standalone physiotherapist charges are not covered.
- xxvi. **Nuclear Attack**: Nuclear, Chemical or Biological attack/ 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 Clause
 - a. Nuclear attack/ 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/ 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/ weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Also excluded herein is any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above.
- xxvii. **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.

4.2. Permanent Exclusion

A permanent exclusion will be applied on Pre-Existing medical or physical condition or treatment of an Insured Person, if such exclusion is accepted by the Proposer and specifically mentioned in the Policy Schedule. This option, as per Company's underwriting policy, will be used for such condition(s) or treatment(s) as listed in Annexure F that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person.

5. Claims Procedure

The fulfilment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying with the following steps, shall be the condition precedent to the admissibility of the Claim.

Upon the discovery or happening of any Illness / Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admissibility of the Claim, the Policyholder/ Insured Person shall undertake the following:

5.1. Claims Intimation

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a Claim covered under the Policy, the Policyholder/ Insured Person, must notify to the TPA/Company either at the call center or in writing immediately.

In the event of

- i. Planned Hospitalization, the Policyholder /Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.
- ii. Emergency Hospitalization, the Policyholder/ Insured Person will intimate such admission within 24 hours of such admission.

The following details are to be provided to the TPA/Company at the time of intimation of Claim:

- i. Policy Number
- ii. Name of the Policyholder
- iii. Name of the Insured Person in whose relation the Claim is being lodged
- iv. Nature of Illness / Injury
- v. Name and address of the attending Medical Practitioner and Hospital
- vi. Date of Admission
- vii. Any other information as requested by the Company

5.2. Procedure for Cashless and Reimbursement of Claims

i. Cashless:

Cashless facility is available only at a Network

Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the TPA/Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured Person:

- a. Pre-authorization: Prior to Hospitalization, the Policyholder/ Insured Person must call the call centre of the TPA/Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.
- b. The TPA/Company will process the Policyholder's/ Insured Person's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Policyholder/ Insured Person and the TPA/Company will confirm such Cashless authorization / rejection in writing or by other means.
- c. If the procedure above is followed and the Policyholder's/ Insured Person's request for Cashless facility is authorized, the Policyholder/ Insured Person will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit). Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.
- d. The Company/TPA (On behalf of Company) reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Policyholder/ Insured Person shall, in any event, be required to settle all other expenses, co-payment and / or deductibles (if applicable), directly with the Hospital.
- e. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.
- f. There can be instances where the TPA/Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder/ Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the TPA/Company which will be considered subject to the Policy Terms & Conditions.

- g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 5.4 with the Network Hospital.

Note:

- Under Cashless facility, the TPA/Company may authorize upon the Policyholder's / Insured Person's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the TPA/Company. In such cases, the TPA/Company will directly settle all eligible amounts as per the Policy Terms & Conditions with the Network Hospital to the extent the Claim is covered under the Policy.
- The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on the Company's website.

ii. **Re-impbursement:**

In case of any Claim under the Benefits, where cashless facility is not availed, the list of documents as mentioned in Clause 5.4 shall be provided by the Policyholder/Insured Person, to TPA/Company immediately but not later than 30 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

5.3. Policyholder's / Insured Person's duty at the time of Claim

- i. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.
- ii. Forthwith intimate / file / submit a Claim in accordance with Clause 5 of this Policy.
- iii. If so requested by the TPA/Company, the Insured Person will have to submit himself for a medical examination by the TPA/Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.
- iv. The Policyholder/ Insured Person is required to check the applicable list of Network Hospitalization the TPA/Company's website or call centre before availing the Cashless services.
- v. On occurrence of an event which will lead to a Claim under this Policy, the Policyholder/ Insured Person shall:
 - a. Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
 - b. Assist and not hinder or prevent the Company's representatives in pursuance of

their duties for ascertaining the admissibility of the Claim under the Policy.

- vi. If the Policyholder / Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

5.4. Claim Documents

The Policyholder / Insured Person shall submit to the TPA/Company/ Network Hospital (as applicable) the following documents for or in support of the Claim:

- i. Duly completed and signed Claim Form, in original
- ii. Medical Practitioner's referral letter advising Hospitalization
- iii. Medical Practitioner's prescription advising drugs /diagnostic tests / consultation
- iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner
- v. Original bills from pharmacy / chemists
- vi. Original pathological / diagnostic test reports and payment receipts
- vii. Ambulance receipt and bill
- viii. First Information Report/ Final Police Report, if applicable
- ix. Post mortem report, if available
- x. Any other document as required by the Company to assess the Claim

When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

Note:

- a. Claim once paid under one Benefit cannot be paid again under any other Benefit.
- b. All invoices / bills should be in Insured Person's name.

5.5. Proportionate Deductions

Subject to the other Terms and Conditions of this Policy The Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

- i. The Insured Person chooses a higher room category than the category that is eligible as per the terms and conditions of the Policy. In this case, higher room category means a room category in which the room rent expenses charged by the Hospital is more expensive than the eligible room category as per the terms and conditions of the Policy.

- ii. The Insured Person chooses a room category in which the room rent charges are more than the applicable Sum Insured sub-limit (in percentage or Rupee terms) on the room rent as per the Policy terms and conditions.

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in Benefit-2.1 (i.e. In-Patient Hospitalisation) barring the below mentioned expense break ups:

- i. Cost of Pharmacy and Consumables
- ii. Cost of Implants and Medical Devices
- iii. Cost of Diagnostics

The proportional reduction will be done in a manner consistent with the below table :

Sr. No.	Header	Explanation
A	Actual Medical Bills Incurred	As per submitted documents
B	Covered Medical Expenses	A – Any expense not covered under Policy Benefits
C	Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
D	Covered Medical Expenses which shall be subject to Proportionate Deduction	B - cost of Pharmacy and consumables, implants and medical devices and diagnostics
E	Claim after Proportionate Deduction	D * Eligible Room Rent Limit + Actual Room Rent (If Actual Room Rent is within eligibility, then no deduction to be applied [E=D])
F	Ground up claim amount	E + cost of Pharmacy and consumables, implants and medical devices and diagnostics
G	Amount after Co-pay	F - Co-payment, if any on account of age
H	Payable claim amount	G – Deductions for Policy Deductibles and Limits

The Final Claim amount would be deducted, in the following progressive order, from

- a. Base Sum Insure
- b. Reinstated Sum Insured

Proportionate Deduction is subject to the following:

- i. Apart from the Associate Medical Expenses, no other expenses will be proportionately reduced
- ii. If the given Hospital do not follow differential billing or if there are items in the claim for which the Hospital do not follow differential billing, the Insurer shall not be proportionately reducing the Claims. This shall be applied in case of admissions in Government Hospitals and the Network Hospitals of the Insurer.

- iii. ICU charges shall not be proportionately reduced in all cases

5.6. Payment Terms

- i. This Policy covers medical treatment taken within India, and payments under this Policy shall be made in Indian Rupees within India.
- ii. Claims shall not be admissible under this Policy unless the TPA/Company has been provided with the complete documentation / information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.
- iii. The Company shall not indemnify the Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure 1 (List of Day Care Treatments).
- iv. The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Period.
- v. For Cashless Claims, the payment shall be made to the Network Hospital / TPA whose discharge would be complete and final.
- vi. For the Reimbursement Claims, the TPA/Company will pay the Policyholder/Insured Person.
- vii. The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form. The Company shall settle the claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a claim warrant an investigation in Company's opinion 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, Company shall settle the claim within 45 days from the date of receipt of last necessary document.
- viii. The Company shall also decide and communicate any rejection of claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a claim warrant an investigation in Company's opinion 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, Company shall also decide and communicate any rejection of the claim within 45 days from the date of receipt of last necessary document.

6. Terms and Conditions

6.1. Disclosure to Information Norm

The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of

misrepresentation, mis-description 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. Arbitration Clause

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

6.4. Complete discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6.5. 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

6.6. 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:

- i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- iii. any other act fitted to deceive; and
- iv. 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.

6.7. Claim Settlement (provision for Penal Interest)

- 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.

6.8. Cause of Action

Claims shall be payable under this Policy only if the cause of action arises in India.

6.9. Limitation Period

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 5 above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder

6.10. Withdrawal of Policy

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.

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. Renewal of Policy

- i. The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.
- 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 the 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. Renewal of Certificate of Insurance shall be allowed only as long as the Master Policy is in force, and such renewal shall be in line with agreed terms of renewal of the Master Policy.

6.12. Moratorium Period

After completion of eight continuous years under the Policy no look back to 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 8 continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim 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, deductibles as per the policy contract.

6.13. Reasonable Care

The Policyholder/ Insured Person shall take all reasonable steps to safeguard the interests against any Illness / Injury that may give rise to a Claim.

6.14. Material Change

The Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation / business at his own expense and the Company may adjust the scope of cover and/or premium, if necessary, accordingly.

6.15. Records to be maintained

The Policyholder/ Insured Person shall keep an accurate record containing all relevant medical records until final adjustment (if any) and resolution of all Claims under this Policy; and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the Company may require under this Policy.

6.16. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in possession of the Company and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

6.17. Policy Disputes

Any and all disputes or differences under or in relation to validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and subject to Indian law.

6.18. Cancellation / Termination (other than Free Look)

i. The Policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period at the short period scale as detailed below.

Refund % to be applied on Policy Premium

Policy Tenure - >	1 year
Cancellation date up to (x months) from Policy Period Start Date	Refund
Up to 1 month	75.0%
Up to 3 months	50.0%
Up to 6 months	25.0%
Beyond 6Months	0%

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 by the insured person under the Policy.

No refund of premium shall be made on Policy where premium is paid in instalments.

ii. 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.

6.19. Communication

Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder will be sent by the Company to his last known address or the address as shown in the Policy Schedule.

All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf.

Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

6.20. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy subject to underwriting decision of the Company

6.21. Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

6.22. Special Provisions

Any special provisions subject to which this Policy has

been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

6.23. Possibility of 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.

6.24. 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 insurer on medical examination of the insured persons 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 on cover or;
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

6.25. 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 atleast 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

For Detailed Guidelines on migration, kindly refer the [www.irdai.gov.in\(Circular-IRDA/HLT/REG/CIR/003/012020, Dated-01012020\)](http://www.irdai.gov.in(Circular-IRDA/HLT/REG/CIR/003/012020, Dated-01012020)

6.26. Continuity Benefit

Port in facility is available under this Policy only for the members already being covered under the existing health insurance Policy that is being offered to the account holders of the Bank of India by Bank of India. The rules for this port in facility are:

- i. The members covered under the existing policy can only avail the port in facility to this Policy. No new members would be allowed to port in.
- ii. The Sum Insured cannot be increased during

porting in. The Sum Insured has to be either same as the existing expiring policy or would increase to the nearest highest Sum Insured, if the same Sum Insured option is not available under this proposed policy.

- iii. The basis of Sum Insured and the family relationships covered under a given certificate / policy would remain same during in. A new family relationship cannot be added during the port in process.
- iv. Port in is available only to customers who continued their present policies. No Port in facility is available if the customer has not renewed his / her earlier policy. Grace period is 7 days. Port in available only on renewals. Mid period cancellation of the previous policy is not allowed to port in.
- v. Continuity benefits allowed as per the duration of policy one is holding in earlier/existing scheme operated by Bank of India and on renewal wishes to renew the policy with the Company, then he/ she shall be given the benefit of continuity on the expiring Policy's Sum Insured.

Sr. No.	Number of Years of Continuous coverage with the previous Policy for the account holders of Bank of India	Waiting Period to be Served with RGI in number of Years For 30 Days Waiting Period Exclusions
1.	Less than 1 Year	Waiting period of 30 days. Covered after 30 days from Certificate Period Start Date issued by the Company
	1 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	2 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	3 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	3 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	> 4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company

2.	Number of Years of Continuous coverage with the previous Policy	Waiting Period to be Served with RGI in number of Years for 1 Year Waiting Period Exclusions
	Less than 1 Year	Waiting Period of 1 year. Not Covered for first one year of the Certificate of Insurance issued by the RGI. Covered from the 1st renewal of the Certificate of Insurance issued by RGI.
	1 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	2 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	3 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	3 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	> 4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
3.	Number of Years of Continuous coverage with the previous Policy	Waiting Period to be Served with RGI in number of Years for 2 Year Waiting Period Exclusions
	Less than 1 Year	Waiting Period of 2 years. Not Covered for first two year of the Certificate of Insurance issued by the RGI. Covered from the 2nd renewal of the Certificate of Insurance issued by Company
	1 Year	Waiting Period of 1 year. Not Covered for first one year of the Certificate of Insurance issued by the RGI. Covered from the 1st renewal of the Certificate of Insurance issued by Company
	2 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	3 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	3 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	> 4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company

4.	Number of Years of Continuous coverage with the previous Policy	Waiting Period to be Served with the Company in number of Years for 3 Year Waiting Period Exclusions
	Less than 1 Year	Waiting Period of 3 years. Not Covered for first three year of the Certificate of Insurance issued by the RGI. Covered from the 3rd renewal of the Certificate of Insurance issued by the Company
	1 Year	Waiting Period of 2 years. Not Covered for first two year of the Certificate of Insurance issued by the RGI. Covered from the 2nd renewal of the Certificate of Insurance issued by the Company
	2 year	Waiting Period of 1 year. Not Covered for first one year of the Certificate of Insurance issued by the RGI. Covered from the 1st renewal of the Certificate of Insurance issued by the Company
	3 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	> 4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
5	Number of Years of Continuous coverage with the previous Policy	Waiting Period to be Served with the Company in number of Years for 4 Year Waiting Period Exclusions
	Less than 1 Year	Waiting Period of 4 years. Not Covered for first four year of the Certificate of Insurance issued by the Company. Covered from the 4th renewal of the Certificate of Insurance issued by Company
	1 Year	Waiting Period of 3 years. Not Covered for first three year of the Certificate of Insurance issued by the Company. Covered from the 3rd renewal of the Certificate of Insurance issued by RGI.
	2 year	Waiting Period of 2 years. Not Covered for first two year of the Certificate of Insurance issued by the Company. Covered from the 2nd renewal of the Certificate of Insurance issued by Company
	3 year	Waiting Period of 1 year. Not Covered for first one year of the Certificate of Insurance issued by the RGI. Covered from the 1st renewal of the Certificate of Insurance issued by Company
	4 year	No waiting Period. Covered from Certificate Period Start Date issued by the Company
	> 4 Year	No waiting Period. Covered from Certificate Period Start Date issued by the Company

6.27. 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.

For Detailed Guidelines on portability, kindly refer the www.irdai.gov.in/Circular-IRDA/HLT/REG/CIR/003/012020, dated 01012020)

6.28. 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

6.29. Redressal of Grievances

In case of any grievance the Insured Person may contact the Company through

Website: www.Relianceada.com

Toll free: 1800-3009

Dedicated Senior Citizen helpline: 022-33834185 (paid line)

E-mail: rgicl.services@relianceada.com

Fax: +91 22 3303 4662
 Courier: Any branch office, the correspondence address, during normal business hours.

Write to us at: Reliance General Insurance, (Correspondence Only) Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

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 at:

Grievance Redressal Officer

The Grievance Cell,

Reliance General Insurance Co. Limited

No. 1-89/3/B/40 to 42/ks/301, 3rd floor,

Krishe Block, Krishe Sapphire, Madhapur

Hyderabad – 500 081

Grievance Redressal officer email ID: rgicl.headgrievances@relianceada.com

(For updated details of grievance officer, kindly refer the link.

<https://reliancegeneral.co.in/Insurance/About-Us/Grievance-Redressal.aspx>

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.

The contact details of the Insurance Ombudsman offices have been provided as Annexure-B

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

7. Coverage Summary		
Benefits	Brief Description	Limits
In Patient Hospitalization	This cover indemnifies the insured for any medical expenses incurred on In-patient Treatment	Upto the Opted Sum Insured
Domiciliary Hospitalization	This cover indemnifies the Insured Person for the medical expenses incurred for treatment under Domiciliary hospitalization	10% of Sum Insured
Day Care Treatment	This cover indemnifies the insured for any medical expenses incurred on listed Day Care Treatments	Within the Sum Insured limit
Pre-Hospitalisation Medical Expenses	Covers 30 days Pre hospitalization expenses	Within the Sum Insured limit
Post-Hospitalization Medical Expenses	Covers 60 days post hospitalization expenses	Within the Sum Insured limit
Donor Expenses	This cover will indemnify the Insured Person for the Medical Expenses incurred during Hospitalization, in respect of donor for any organ transplant Surgery performed on insured	50% of Sum Insured
Reinstatement of Base Sum Insured	One time Re-instatement of Sum Insured on exhaustion of Base Sum Insured	25% of Sum Insured
Ambulance	The cover indemnifies the Insured Person for expenses on availing Ambulance services offered by a Hospital or by an Ambulance service provider on Inpatient hospitalization	Rs 1000 per hospitalization

Benefits	Brief Description	Limits
AYUSH Treatment	This cover will indemnify the Insured Person for the Medical Expenses incurred on in patient treatment under Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy	10% of Sum Insured
HIV / AIDS	Covers In-Patient Treatment related to HIV/AIDS conditions	Within the Sum Insured limit
Modern Treatment	This cover indemnifies the insured for the medical expenses incurred on treatment of listed Modern Treatment Methods	50% of Sum Insured

ANNEXURE-A

1. List I — Items for which coverage is not available in the policy

Sl. No.	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	LEGGING S
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	PHOTOCOPY ES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE

38	NEBULIZE R 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

2. List II — Items that are to be subsumed into Room Charges

Sl. No.	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

3. List III — Items that are to be subsumed into Procedure Charges

Sl. No.	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

4. List IV — Items that are to be subsumed into costs of treatment

Sl. No.	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

Annexure D – List of Day Care Procedures

1	Microsurgical operations on the middle ear
1.	Stapedotomy to treat various lesions in middle ear
2.	Revision of a stapedectomy
3.	Other operations on the auditory ossicles
4.	Myringoplasty (post-aura/endastral approach as well as simple Type -I Tympanoplasty)
5.	Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)
6.	Revision of a tympanoplasty
7.	Other microsurgical operations on the middle ear
2.	Other operations on the middle & 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
19.	Removal of Keratosis Obturans
3.	Operations on the nose & the nasal sinuses
20.	Excision and destruction of diseased tissue of the nose
21.	Operations on the turbinates (nasal concha)
22.	Other operations on the nose
23.	Nasal sinus aspiration Foreign body removal from nose
4.	Operations on the eyes
24.	Incision of tear glands
25.	Other operations on the tear ducts
26.	Incision of diseased eyelids
27.	Correction of Eyelid Ptosis by Levator Palpebrae Superioris Resection (bilateral)
28.	Correction of Eyelid Ptosis by Fascia Lata Graft (bilateral)
29.	Excision and destruction of diseased tissue of the eyelid
30.	Operations on the canthus and epicanthus
31.	Corrective surgery for entropion and ectropion
32.	Corrective surgery for blepharoptosis
33.	Removal of a foreign body from the conjunctiva
34.	Removal of a foreign body from the cornea
35.	Incision of the cornea
36.	Operations for pterygium
37.	Other operations on the cornea

38.	Removal of a foreign body from the lens of the eye
39.	Removal of a foreign body from the posterior chamber of the eye
40.	Removal of a foreign body from the orbit and eyeball
41.	Operation of cataract
42.	Diathermy/Cryotherapy to treat retinal tear
43.	Anterior chamber Paracentesis/Cyclodiathermy/ Cyclocryotherapy/Goniotomy/Trabeculotomy and Filtering and Allied Operations to treat glaucoma
44.	Enucleation of Eye without Implant
45.	Dacryocystorhinostomy for various lesions of Lacrimal Gland
46.	Laser Photocoagulation to treat Retinal Tear
5. Operations on the skin & subcutaneous	
47.	Incision of a pilonidal sinus
48.	Other incisions of the skin and subcutaneous tissues
49.	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
50.	Local excision of diseased tissue of the skin and subcutaneous tissues
51.	Other excisions of the skin and subcutaneous tissues
52.	Simple restoration of surface continuity of the skin and subcutaneous tissues
53.	Free skin transplantation, donor site
54.	Free skin transplantation, recipient site
55.	Revision of skin plasty
56.	Other restoration and reconstruction of the skin and subcutaneous tissues.
57.	Chemosurgery to the skin.
58.	Destruction of diseased tissue in the skin and subcutaneous tissues
59.	Reconstruction of Deformity/Defect in Nail Bed
6. Operations on the tongue	
60.	Incision, excision and destruction of diseased tissue of the tongue
61.	Partial glossectomy
62.	Glossectomy
63.	Reconstruction of the tongue
64.	Other operations on the tongue
7. Operations on the salivary glands & saliv	
65.	Incision and lancing of a salivary gland and a salivary duct
66.	Excision of diseased tissue of a salivary gland and a salivary duct
67.	Resection of a salivary gland
68.	Reconstruction of a salivary gland and a salivary duct
69.	Other operations on the salivary glands and salivary ducts

8. Other operations on the mouth & face	
70.	External incision and drainage in the region of the mouth, jaw and face
71.	Incision of the hard and soft palate
72.	Excision and destruction of diseased hard and soft palate
73.	Incision, excision and destruction in the mouth
74.	Palatoplasty
75.	Other operations in the mouth
9. Operations on the tonsils & adenoids	
76.	Transoral incision and drainage of a pharyngeal abscess
77.	Tonsillectomy without adenoidectomy
78.	Tonsillectomy with adenoidectomy
79.	Excision and destruction of a lingual tonsil
80.	Other operations on the tonsils and adenoids
81.	Trauma surgery and orthopaedics
82.	Incision on bone, septic and aseptic
83.	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
84.	Suture and other operations on tendons and tendon sheath
85.	Reduction of dislocation under GA
86.	Arthroscopic knee aspiration
87.	Adenoidectomy
10. Operations on the breast	
88.	Incision of the breast abscess
89.	Operations on the nipple
90.	Excision of single breast lump
11. Operations on the digestive tract, Kidney and Blad	
91.	Incision and excision of tissue in the perianal region
92.	Surgical treatment of anal fistulas
93.	Surgical treatment of hemorrhoids
94.	Division of the anal sphincter (sphincterotomy)
95.	Other operations on the anus
96.	Ultrasound guided aspirations
97.	Sclerotherapy, etc.
98.	Laparotomy for grading Lymphoma with Splenectomy/Liver/Lymph Node Biopsy
99.	Therapeutic Laparoscopy with Laser
100.	Cholecystectomy and Choledoch-Jejunostomy/ Duodenostomy/Gastrostomy/Exploration Common Bile Duct
101.	Esophagoscopy, gastroscopy, duodenoscopy with polypectomy / removal of foreign body/diathermy of bleeding lesions
102.	Lithotripsy/Nephrolithotomy for renal calculus
103.	Excision of renal cyst
104.	Drainage of Pyonephrosis/Perinephric Abscess
105.	Appendectomy with/without Drainage

12. Operations on the female sexual organs

106. Incision of the ovary
107. Insufflations of the Fallopian tubes
108. Other operations on the Fallopian tube
109. Dilatation of the cervical canal
110. Conisation of the uterine cervix
112. Therapeutic curettage with Colposcopy/Biopsy/ Diathermy/Cryosurgery/
113. Laser Therapy of Cervix for Various lesions of Uterus
114. Other operations on the uterine cervix
115. Incision of the uterus (hysterectomy)
116. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
117. Incision of vagina
118. Incision of vulva
119. Culdotomy
120. Operations on Bartholin's glands (cyst)
121. Salpingo-Oophorectomy via Laparotomy

13. Operations on the prostate

122. Incision of the prostate
123. Transurethral excision and destruction of prostate tissue
124. Transurethral and percutaneous destruction of prostate tissue
125. Open surgical excision and destruction of prostate tissue
126. Radical prostatovesiculectomy
127. Other excision and destruction of prostate tissue
128. Operations on the seminal vesicles
129. Incision and excision of periprostatic tissue
130. Other operations on the prostate

14. Operations on the scrotum & tunica vaginalis testis

131. Incision of the scrotum and tunica vaginalis testis
132. Operation on a testicular hydrocele
133. Excision and destruction of diseased scrotal tissue
134. Other operations on the scrotum and tunica vaginalis testis

15. Operations on the testes

135. Incision of the testes
136. Excision and destruction of diseased tissue of the testes
137. Unilateral orchidectomy
138. Bilateral orchidectomy
139. Orchidopexy
140. Abdominal exploration in cryptorchidism
141. Surgical repositioning of an abdominal testis
142. Reconstruction of the testis
143. Implantation, exchange and removal of a testicular prosthesis
144. Other operations on the testis

PORTABILITY FORM**PART – I**

1)	Name of the Policyholder/ Insured(s)	
2)	Date of Birth/Age	
3)	Address of the policyholder/insured	
4)	Details of existing insurer	
	i. Name of the product	
	ii. Sum Insured	
	iii. Cumulative Bonus	
	iv. Add-ons/riders taken	
	v. Policy number	
5)	Details of the proposed insurance	
	i. Name of the product proposed/intend to take	
	ii. Sum Insured Proposed	
	iii. Whether Cumulative Bonus to be converted to an enhanced sum insured	
6)	Reason(s) for portability	
7)	No. of family member to be included in the policy to be ported.	

Enclosure: Photocopy of the existing policy documents

Date: _____

Signature of the Proposer

PART-II

- Whether the PED exclusions / time bound exclusion have longer exclusion period than the existing policy: (Yes / No)
- If YES, please give written consent to the declaration below:

I am aware that the waiting period for the following disease(s)/treatment(s) is _____ days / years more than the previous policy terms. I hereby agree to observe the additional waiting period for the following disease(s) / treatment(s).

Date: _____

Signature of the Proposer

16.	Operations on the spermatic cord, epididymis und ductus deferens
145.	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
146.	Excision in the area of the epididymis
147.	Epididymectomy
17.	Operations on the penis
148.	Operations on the foreskin
149.	Local excision and destruction of diseased tissue of the penis
150.	Amputation of the penis
151.	Other operations on the penis
18.	Operations on the urinary system
152.	Cystoscopical removal of stones
153.	Catheterisation of Bladder
19.	Other Operations
154.	Lithotripsy
155.	Coronary angiography
156.	Biopsy of Temporal Artery for Various Lesions
157.	External Arterio-venous Shunt
158.	Haemodialysis
159.	Radiotherapy for Cancer
160.	Cancer Chemotherapy
161.	Endoscopic polypectomy
162.	Surgery for ligament tear
163.	Surgery for meniscus tear
164.	Surgery for hemoarthrosis/pyoarthrosis
165.	Removal of fracture pins/nails
166.	Removal of metal wire
167.	Closed reduction on fracture, luxation
168.	Reduction of dislocation under GA
169.	Epiphyseolysis with osteosynthesis
170.	Excision of Bursitis
171.	Tennis Elbow Release
172.	Excision of Various Lesions in Coccyx

Annexure F

Below mentioned Diseases maybe permanently excluded under the **Policy** in the case where such Diseases are **Pre-Existing** at the time of first proposal of this Product with the **Company**

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs • C40-C41 Malignant neoplasms of bone and articular cartilage • C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B - C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue • D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of

		I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system • Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 -Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 -

		Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 - Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 - Acute hepatitis B without delta-agent and without hepatic coma; B17.0 - Acute delta- (super)infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 - Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9 Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

Annexure-B Ombudsman list

Office Details	Jurisdiction of Office Union Territory, District)	Date Of Taking Charge
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.	10/3/2019
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka	4/23/2018
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bengaluru@ecoi.co.in	Madhya Pradesh, Chattisgarh	5/24/2018
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa	9/11/2019
CHANDIGARH - Dr. Dinesh Kumar Verma 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	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh	4/16/2018
CHENNAI - Shri M. Vasantha Krishna 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	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	5/3/2018

DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi	9/12/2019
GUWAHATI - Shri Kiriti .B. Saha 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@ecoi.co	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	5/2/2018
HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122. Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	6/11/2018
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan	4/13/2018
ERNAKULAM - Ms. Poonam Bodra 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	Kerala, Lakshadweep, Mahe-a part of Pondicherry. Mahe-a part of Pondicherry.	11/7/2018
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.	9/30/2019
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	5/4/2018

<p>LUCKNOW - Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in</p>	<p>Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratappgarh, 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.</p>	<p>9/11/2019</p>
<p>NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in</p>	<p>State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p>	<p>9/17/2019</p>

<p>PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in</p>	<p>Bihar, Jharkhand.</p>	<p>10/9/2019</p>
<p>PUNE - Shri Vinay Sah 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.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in</p>	<p>Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.</p>	<p>12/3/2019</p>