UNITED INDIA INSURANCE COMPANY LIMITED
REGD.& HEAD OFFICE : No.24, WHITES ROAD, CHENNAI-600014

Uni Group Health Insurance Policy

UIN:

Policy Terms and Conditions

I.**Preamble & Operating Clause**

This is a legal contract between the Policyholder and Us to provide the insurance cover detailed in the Policy to the Insured Persons up to the Sum Insured subject to

i. the receipt of full premium,

ii. disclosure to information norm including the information provided in the Proposal Form or the Request for Quote (RFQ) by the Proposer or by his/ her authorized Intermediary on behalf of him/her-self and all persons to be insured which is incorporated in the policy and is the basis of it; and

iii.the terms, conditions and exclusions of this Policy.

If during the policy period one or more Insured Person (s) is required to be hospitalised for treatment of an Illness or Injury at a Hospital/Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the medically necessary and Reasonable and Customary expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. The maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured opted as specified in the Schedule.

II.**DEFINITIONS**

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

A.Standard Definitions

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

2.Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

3.AYUSH Day Care Centre means and includes Community Health Care 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 Companyâ€™s authorized representative.

4.a. Having at least 5 in-patient 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;

5.Cashless facility means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured Person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorisation is approved.

6.Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

7.Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a.i. **Internal Congenital Anomaly** - Congenital anomaly which is not in the visible and accessible parts of the body.

a.ii.**External Congenital Anomaly** - Congenital anomaly which is in the visible and accessible parts of the body.

8.Co-Payment means 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.

9.Day Care Centre means any institution established for day care treatment of illness and / or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-

20.i) has qualified nursing staff under its employment;

20.ii) has qualified medical practitioner/s in charge;

20.iii)has fully equipped operation theatre of its own where surgical procedures are carried out;

20.iv)Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

10.Day Care Treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

ii.which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

11.Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer 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.

12.Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

13.Domiciliary Hospitalisation means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

32.a.the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

32.b.the patient takes treatment at home on account of non-availability of room in a hospital.

14.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.

15.Grace Period means the specified period of time immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

16.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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act or complies with all minimum criteria as under:

35.i.i) has qualified nursing staff under its employment round the clock;

35.i.ii)has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

1.i.iii) has qualified medical practitioner(s) in charge round the clock;

1.i.iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;

1.i.v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

17.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.

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

1.**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

2.**Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i..i. it needs on going or long-term monitoring through consultations, examinations, check-ups, and/ or tests.

i..ii. it needs on going or long-term control or relief of symptoms

i..iii.it requires rehabilitation for the patient or for the patient to be specially trained to cope with it.

i..iv.it continues indefinitely

i..v. it recurs or is likely to recur

19.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.

20.Inpatient Care means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

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

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

23.Maternity expenses means:

49.i.iii.a)medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation);

49.i.iii.b)expenses towards lawful medical termination of pregnancy during the Policy period.

24.Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

25.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.

26.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 its scope and jurisdiction of license.

27.Medically Necessary Treatment means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:

i. is required for the medical management of the illness or injury suffered by the insured;

ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii.must have been prescribed by a medical practitioner;

iv.must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

28.Migration means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

29.Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a cashless facility.

30.Non-Network Provider means any hospital, day care centre or other provider that is not part of the network.

31.New Born Baby means baby born during the Policy period and is aged up to 90 days.

32.Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

33.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.

34.Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

35.Pre-Existing Disease (PED) means any condition, ailment, injury, or disease:

i. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the Insurer or its reinstatement or

ii.For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the Insurer or its reinstatement.

36.Pre-hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii.The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

37.Post-hospitalisation Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

61.i.i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

61.i.ii.The inpatient hospitalisation claim for such hospitalisation is admissible by the insurance company.

38.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.

39.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.

40.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.

41.Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

42.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 and prolongation of life, performed in a hospital or day care Centre by a *medical practitioner*.

43.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.

B.Specific Definitions

1. **Age or Aged** means age of the Insured Person on last birthday as on date of commencement of the Policy.
2. **Alternative Treatments** are forms of Treatments other than "Allopathy","AYUSH" or "modern medicine".
3. **Annexure** means a document attached and marked as Annexure to this Policy.
4. **Ambulance** means 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. **Associated Medical Expenses** means hospitalisation related expenses on Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital; Anesthesia, blood, oxygen, operation theatre charges, surgical appliances and such other similar expenses with the exception of:
   a. cost of pharmacy and consumables medicines
   b. cost of implants/medical devices
   c. cost of diagnostics

   The scope of this definition is limited to admissible claims where a proportionate deduction is applicable, as per Note 1 of Clause III.A.1.
6. **AYUSH Treatment** means hospitalisation treatment given under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy systems.
7. **Benefit** means any benefit shown in the Policy Schedule and/or Certificate of Insurance.
8. **Base Sum Insured** means the Sum Insured for the Base Cover as specified in the Policy Schedule and/or Certificate of Insurance.
9. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
10. **Certificate of Insurance** means the certificate We issue to the Insured Person outlining the Insured Person's cover under the Policy.
11. **Clinical Psychologist** means a personâ€" (i) having a recognised qualification in Clinical Psychology from an institution approved and recognised, by the Rehabilitation Council of India, constituted under section 3 of the Rehabilitation Council of India Act, 1992 (34 of 1992); or (ii) having a Post-Graduate degree in Psychology or Clinical Psychology or Applied Psychology and a Master of Philosophy in Clinical Psychology or Medical and Social Psychology obtained after completion of a full-time course of two years which includes supervised clinical training from any University recognised by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956) and approved and recognised by the Rehabilitation Council of India Act, 1992 (34 of 1992) or such recognised qualifications as may be prescribed.
12. **Co-Morbidity** is the presence of one or more additional conditions co-occurring with a primary condition; in the countable sense of the term, a comorbidity is each additional condition.
13. **Cosmetic Surgery** means Surgery or medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
14. **Dentist** means a dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided.
15. **Effective Date** means the date shown on the Certificate of Insurance on which the Insured Person was first included under the Policy.
16. **Eligibility** means the provisions of the Policy that state the requirements to be complied with.
17. **Employee** means any member of Your staff who is proposed and sponsored by You and who becomes an Insured Person under this Policy.
18. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an emergency anymore.
19. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract.
20. **Home nursing** is arranged by the Hospital for a Qualified Nurse to visit the patient's home to give expert nursing services immediately after Hospital Treatment for as long as is required by medical necessity, visits for as long as is required by medical necessity for Treatment which would normally be provided in a Hospital. In either case, the Specialist who treated the patient must have recommended these services.
21. **Inception Date** means the inception date of this Policy as specified in the Policy Schedule or Certificate of Insurance when the coverage under the Policy commences.
22. **In-patient** means an Employee/ Member or Dependent who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving Treatment.
23. **Insured Person** means the Employee/ Member and/or Dependents named in the Policy Schedule/ Certificate of Insurance, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium is paid.
24. **IRDAI** means the Insurance Regulatory and Development Authority of India.
25. **Medical Assistance Service** is a service which provides Medical Advice, evacuation, assistance and repatriation. This service can be multi-lingual and is available 24 hours a day.
26. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, especially characterised by subnormality of intelligence
27. **Mental Healthcare Professional** meansâ€" (i) a psychiatrist (ii) a professional registered with the concerned State Authority or (iii) a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam or (iv) a Clinical Psychologist.
28. **Nominee** means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.
29. **Out-patient** means a patient who undergoes OPD treatment.
30. **Policy** is sent to You comprising of Policy wordings, Certificates of Insurance issued to the Insured Persons, group proposal form/RFQ and Policy Schedule/ Certificate Of Insurance which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.
31. **Policy Period** means the period between the Inception Date and the expiry date of the Policy as specified in the Policy Schedule/ Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.
32. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
33. **Preferred Provider Network (PPN)** means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the Insured Person. The updated list of network providers/PPN is available on our website (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the website of the TPA mentioned in the schedule and is subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.
34. **Psychiatrist** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956), or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956 (102 of 1956), or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act.
35. **Spouse** means the Employee's legal husband or wife proposed to be covered under the Policy.

36.Specialist is a Medical Practitioner who:
- Has received advanced specialist training;
- Practices a particular branch of medicine or Surgery;
- Is or has been appointed as a consultant in a Hospital or is or has been appointed to a position in a Hospital Which We acce as being of equivalent status.

It is clarified that a physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided is only a Specialist for the purpose of physiotherapy as described in the list of Benefits.

37.Sum Insured means, subject to the terms, conditions and exclusions of this Policy, the amount representing Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person and is as specified in the Policy Schedule and/or Certificate of Insurance against the particular Benefit(s).

38.Surgical Appliance and/or Medical Appliance means:
- An artificial limb, prosthesis or device which is required for the purpose of or in connection with a Surgery;
- An artificial device or prosthesis which is a necessary part of the Treatment immediately following Surgery for as long as such device or prosthesis is required by medical necessity.
- A prosthesis or appliance which is medically necessary and is part of the recuperation process on a Short-Term basis.

39.Service Partner is an assistance company utilized by Us to support You for facilitation of access to Network Providers and for providing Medical Assistance Services. In India such services will be provided by a TPA.

40.Sub Limit defines limitation on the amount of coverage available to cover a specific type of claim. A sublimit is part of, rather than in addition to, the limit that would otherwise apply to the admissible claim amount.

41.Third Party Administrator (TPA) means a Company who is licensed under the IRDAI (Third Party Administrators – Health Services) Regulations 2016, as amended from time to time, by the IRDAI and is engaged for a fee or remuneration by Us for the purposes of providing health services.

42.Treatment means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve Illness within the scope of the Policy.

43.Waiting Period means a time bound exclusion period related to condition(s) specified in the Policy Schedule or Certificate of Insurance or Policy which shall be served before a claim related to such condition(s) becomes admissible.

44.We/Our/Us means the United India Insurance Company Limited.

45.You/Your/Policyholder means the person named in the Policy Schedule who has concluded this Policy with Us.

III.COVERS UNDER THE POLICY

In the event of any claim arising as a result of treatment taken for an Injury or Illness during the Policy period which becomes payable under any applicable Base Cover and/or Optional Covers, then We shall indemnify the Reasonable and Customary Medical Expenses incurred or pay for the listed Benefits, in accordance with the terms, conditions and exclusions of the Policy subject to availability of the Sum Insured for the cover/ benefit applicable and subject to the limit, if any, specified in the Policy Schedule/ Certificate of Insurance. All limits mentioned in the Policy Schedule/ Certificate of Insurance are applicable for each Policy period of coverage.

Cover Type

The Policy provides cover on an Individual or Family Floater Sum Insured basis. A separate Sum Insured for each Insured Person, as specified in the Policy Schedule/Certificate of Insurance, is provided under Individual Sum Insured basis while under Family Floater Sum Insured basis, the Sum Insured limit is shared by the whole family of the group member as specified in the Policy Schedule/ Certificate of Insurance and Our total liability for the family cannot exceed the Sum Insured in a Policy period. The cover type basis shall be as specified in the Policy Schedule/ Certificate of Insurance. The basis of cover chosen for the Base Cover is applicable for the Optional Covers as well.

Relationships covered under the Policy are as specified in the Policy Schedule/ Certificate of Insurance.

A. Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner and are incurred on Medically Necessary Treatment of the Insured Person.

1.In-patient Hospitalisation Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment taken during Hospitalisation provided that the admission date of the Hospitalisation due to Illness or Injury is within the Policy period:

A. Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less, including nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

B. Charges for accommodation in ICU/CCU/HDU up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less,

C. Operation theatre cost,

D. Anaesthestics, Blood, Oxygen, Surgical Appliances and/ or Medical Appliances, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopaedic implants, infra cardiac valve replacements, vascular stents, and other medical expenses related to the treatment.

E. The fees charged by the Medical Practitioner, Surgeon, Specialists and Anaesthetists treating the Insured Person;

F. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;

G. Cost of Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalised such as but not limited to Radiology, Pathology tests, X-rays, MRI and CT Scans, Physiotherapy.

Note 1:

Proportionate Clause: *In case of admission to a room at rates exceeding the limits mentioned in the Policy Schedule/Certificate of Insurance (for Clause III.A.1.A), the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent. Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.*

Note 2:

Mental Illness Cover Limit:

In case of following mental illnesses the Inpatient Hospitalisation benefit will be covered up to the limit as mentioned in the schedule;

1.Schizophrenia (ICD - F20; F21; F25)
2.Bipolar Affective Disorders (ICD - F31; F34)
3.Depression (ICD - F32; F33)
4.Obsessive Compulsive Disorders (ICD - F42; F60.5)
5.Psychosis (ICD - F 22; F23; F28; F29)

All claims under this Benefit can be made as per the process defined under Clause VI. 3 and 4

2.Day Care Treatment Cover

We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment (as defined in Clause II.A.11) during the Policy Period following an Illness or Injury that occurs during the Policy Period provided the Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice.

The benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance, whichever is less.

All claims under this Benefit can be made as per the process defined under Clause VI.3 and VI.4

3.Pre – hospitalisation Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury that occurs during the Policy Period up to the number of days and up to the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:

(i) We have accepted a claim for In-patient Hospitalisation under Clause III.A.1 or III.A.2 above;

(ii) The Pre-hospitalisation Medical Expenses are related to the same Illness or Injury.
(iii)The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.
All claims under this Benefit can be made as per the process defined under Clause VI.4

4. Post – hospitalisation Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Post-hospitalisation Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period up to the number of days and up to the amount limit as specified in the Policy Schedule or Certificate of Insurance, provided that:
(i) We have accepted a claim for In-patient Hospitalisation under Clause III.A.1 or III.A.2 above;
(ii) The Pre-hospitalisation Medical Expenses are related to the same Illness or Injury.
(iii)The date of discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to the same Any One Illness for which We have accepted an In-patient Hospitalisation claim under Clause III.A.1 or III.A.2 above.
All claims under this Benefit can be made as per the process defined under Clause VI.4

5.Road Ambulance Cover

We will cover the costs incurred up to the limit as specified in the Policy Schedule or Certificate of Insurance on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. It becomes payable if a claim has been admitted under Clause III.A.1 or III.A.2 and the expenses are related to the same Illness or Injury.
We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified in the Policy Schedule or Certificate of Insurance:
(i) it is medically required to transfer the Insured Person to another Hospital or diagnostic centre during the course of Hospitalisation for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
(ii)it is medically required to transfer the Insured Person to another Hospital during the course of Hospitalisation due to lack of speciality treatment in the existing Hospital.
All claims under this Benefit can be made as per the process defined under Clause VI.4

6.Domiciliary Hospitalisation Cover

We will cover Medical Expenses, up to the limit specified in the Policy Schedule/ Certificate of Insurance, incurred for the Insured Person's Domiciliary Hospitalisation during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:
i. The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalisation;
ii. The treating Medical Practitioner confirms in writing that Domiciliary Hospitalisation was medically required and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital or the Insured Person satisfies Us that a Hospital bed was unavailable;
iii.We shall not be liable to pay for any claim in connection with:
a.Asthma, bronchitis, tonsillitis and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
b.Arthritis, gout and rheumatism;
c. Chronic nephritis and nephritic syndrome;
d.Diarrhoea and all type of dysenteries, including gastroenteritis;
e.Diabetes mellitus and insipidus;
f. Epilepsy;
g.Hypertension;
h.Psychiatric or psychosomatic disorders of all kinds;
i. Pyrexia of unknown origin.
All claims under this Benefit can be made as per the process defined under Clause VI.4

7.Donor Expenses Cover

We will cover the In-patient Hospitalisation Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated up to the limit as specified in the Policy Schedule or Certificate of Insurance provided that:
i. The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
ii. We have admitted a claim towards In-patient Hospitalisation under the Base Cover and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;
iii.We will not cover:
a.Pre-hospitalisation Medical Expenses or Post-hospitalisation Medical Expenses of the organ donor;
b.Screening expenses of the organ donor;
c. Costs associated with the acquisition of the donor's organ;
d.Transplant of any organ/tissue where the transplant is experimental or investigational;
e.Expenses related to organ transportation or preservation;
f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.
All claims under this Benefit can be made as per the process defined under Clause VI.3 and VI.4

8.Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claim under Clause III.A.1, expenses incurred on the following procedures (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital, shall be covered. The claim shall be subject to additional sub-limits indicated against them in the table below:

Sr. No.	Modern Treatment Methods & Advancement in Technology	Limits per Surgery
1.	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Uterine Artery Embolization & HIFU
2.	Balloon Sinuplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Balloon Sinuplasty
3.	Deep Brain Stimulation	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Deep Brain Stimulation
4.	Oral Chemotherapy	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Oral Chemotherapy
5.	Immunotherapy- Monoclonal Antibody to be given as injection	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period
6.	Intra vitreal Injections	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period
7.	Robotic Surgeries (including Robotic Assisted Surgeries)	•up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies •up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for other diseases
8.	Stereotactic Radio Surgeries	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Stereotactic Radio

		Surgeries
9.	Bronchial Thermoplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Bronchial Thermoplasty.
10.	Vaporisation of the Prostate (Green laser treatment or holmium laser treatment)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period.
11.	Intra Operative Neuro Monitoring (IONM)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Intra Operative Neuro Monitoring
12.	Stem Cell Therapy: Hematopoietic Stem cells for bone marrow transplant for haematological conditions to be covered only	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period

All claims under this Benefit can be made as per the process defined under Clause VI. 3 and 4
There are Optional covers available with the Policy.

Optional Covers:

Policy Terms and Conditions for Optional Covers (In conjunction with Policy Terms and Conditions)
This Policy may also provide Options to the Base Covers if these are specified to be applicable in the Policy Schedule and/or the Certificate of Insurance subject to (I) the terms, conditions, exclusions and limitations of the Options set out herein along with Optional Benefits (if any), (II) receipt of premium, statements in the proposal and information disclosed to Us by You or on Your behalf and on behalf of all persons to be insured which is incorporated into the Policy and is the basis of it.
All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base Cover (Section II of the Policy) shall apply.

Out- Patient Treatment Cover

A)Out- Patient Treatment Cover (over and above the basic Sum Insured)

We will cover the Reasonable and Customary Charges incurred for medically required consultations, visit(s) to a doctor, diagnostic tests and pharmacy expenses which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule or Certificate of Insurance.
Alternative Treatments shall also be covered under this Benefit.
The Benefit payable will be over and above the Base Sum Insured subject to any applicable Co-Payment as specified in the Policy Schedule/ Certificate of Insurance.
For the purpose of this Cover, Outpatient means an Insured person who is not hospitalised but who visits a hospital, clinic or associated facility for diagnosis or treatment.
The following exclusions will be applicable in addition to the exclusions under the Base Cover Terms and Conditions:

a. Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation, etc.
b. Cost of spectacles, etc. as Medical Aids.

If You have opted for the Dental Expenses and Vision Expenses Optional Covers separately, then the expenses paid under the said covers will not be payable under the Out-Patient Treatment Cover.
Exclusion 6 under Clause IV.C will stand deleted for this Option.
All claims under this Benefit can be made as per the process defined under Clause VI of the Base Cover Terms and Conditions and Clause III of the Optional Cover Terms and Conditions, as applicable.

B) Out- Patient Treatment Cover (within the basic Sum Insured)

We will cover the Reasonable and Customary Charges incurred for medically required consultations, visit(s) to a doctor, diagnostic tests and pharmacy expenses which are incurred on an out-patient basis up to the limits as specified in the Policy Schedule or Certificate of Insurance.
Alternative Treatments shall also be covered under this Benefit.
The Benefit payable will be within the Base Sum Insured subject to any applicable Co-Payment as specified in the Policy Schedule/ Certificate of Insurance.
For the purpose of this Cover, Outpatient means an Insured person who is not hospitalised but who visits a hospital, clinic or associated facility for diagnosis or treatment.
The following exclusions will be applicable in addition to the exclusions under the Base Cover Terms and Conditions:

a. Facilities and services availed for pleasure or rejuvenation or as a preventive aid, like beauty treatments, Panchakarma, purification, detoxification and rejuvenation, etc.
b. Cost of spectacles, etc. as Medical Aids.

If You have opted for the Dental Expenses and Vision Expenses Optional Covers separately, then the expenses paid under the said covers will not be payable under the Out-Patient Treatment Cover.
Exclusion 6 under Clause IV.C will stand deleted for this Option.
All claims under this Benefit can be made as per the process defined under Clause VI of the Base Cover Terms and Conditions and Clause III of the Optional Cover Terms and Conditions, as applicable.

Waiver of Proportionate Clause

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Note 1 (Proportionate Clause) under Clause III.A.1 (Base Covers) stands deleted for the members covered in the Policy as stated in the Schedule.
You/Insured Person shall continue to bear the differential between actual and eligible Room Rent.

IV.PERMANENT EXCLUSIONS & WAITING PERIODS

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

A.WAITING PERIODS

We shall not be liable to make any payment under this Policy caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

1.**Pre-Existing Disease Waiting Period (Code-Excl01)**

i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, of continuous coverage after the date of inception of the first policy with us.
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 (Insurance Product) Regulations 2024, then waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2.**Specific Waiting Period (Code-Excl02)**

i. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, of continuous coverage, as may be the case after 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.

vi. List of specific diseases/procedures:

a) Cataract
b) Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids
c) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal Diseases
d) Varicose Veins and Varicose Ulcers
e) Stones in the urinary, uro-genital and biliary systems including calculus diseases
f) Benign Prostate Hypertrophy, all types of Hydrocele
g) Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region
h) Chronic Supportive Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery
i) Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps (unless malignant), Polycystic Ovarian Diseases
j) Any Surgery of the genito-urinary system unless necessitated by malignancy
k) Age-related Macular Degeneration (ARMD)
l) All Neurodegenerative disorders
m) Waiting Period for Named Mental Illnesses

S. No.	Organ / Organ Systems	Illness / Surgeries
1.	Mental Disorders	1) Schizophrenia (ICD - F20; F21; F25) 2) Bipolar Affective Disorders (ICD - F31; F34) 3) Depression (ICD - F32; F33) 4) Obsessive Compulsive Disorders (ICD - F42; F60.5) 5) Psychosis (ICD - F 22; F23; F28; F29)

3. **Initial Waiting Period for Hospitalisation (Code-Excl03)**

i. Expenses related to the treatment of any illness within the number of days, as mentioned in the Policy schedule or Certificate of Insurance, 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.

B. Standard Permanent Exclusions

4. **Investigation & Evaluation (Code-Excl04)**

i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. **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:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional, and spiritual needs.

6. **Obesity/ Weight Control (Code-Excl06):**

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
i. Surgery to be conducted is upon the advice of the Doctor
ii. The surgery/Procedure conducted should be supported by clinical protocols
iii. The member has to be 18 years of age or older and
iv. Body Mass Index (BMI)
A. greater than or equal to 40 or
B. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
a. Obesity-related cardiomyopathy
b. Coronary heart disease
c. Severe Sleep Apnoea
d. Uncontrolled Type2 Diabetes

7. **Change-of-Gender treatments (Code-Excl07):**

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

8. **Cosmetic or Plastic Surgery (Code-Excl08):**

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.

9. **Hazardous or Adventure sports (Code- Excl09):**

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.

10. **Breach of law (Code-Excl10):**

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

11. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**

12. 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. **(Code-Excl13)**

13. 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 hospitalisation claim or day care procedure. **(Code-Excl14)**

14. **Refractive Error (Code-Excl15):**

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

15. **Unproven Treatments (Code- Excl16):**

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

16. **Sterility and Infertility (Code-Excl17):**

Expenses related to Sterility and Infertility. This includes:
i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

17. **Maternity (Code-Excl18):**

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

C.Specific Exclusions

1. All expenses, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
2. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack.
3. a) Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells except as provided for in clause III.8 (12) above;
   b) growth hormone therapy.
4. External Congenital Anomaly or defects.
5. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
6. Conditions for which treatment could have been done on an out-patient basis without any Hospitalisation.
7. Any treatment or part of a treatment that is not of a reasonable charge, is not a Medically Necessary Treatment; drugs or treatments which are not supported by a prescription.
8. Costs of donor screening or costs incurred in an organ transplant Surgery involving organs not harvested from a human body.
9. Any form of Alternative Treatment:
   i. Hydrotherapy, Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.
10. Dental Treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalisation. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way.
11. Routine eye examinations, cost of spectacles, multifocal lens, contact lenses.
12. a) Cost of hearing aids; including optometric therapy;
    b) cochlear implants unless necessitated by an Accident or required intra-operatively.
13. Vaccinations inoculations of any kind, except when required as part of hospitalization or a daycare procedure for treatment following an animal bite.
14. Any Treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall Treatment and products,
15. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
16. Any stay in Hospital without undertaking any Treatment or any other purpose other than for receiving eligible Treatment of a type that normally requires a stay in the Hospital.
17. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.
18. Certification / diagnosis / Treatment by a family member, or a person who stays with the Insured Person, save for the proven material costs which are eligible for reimbursement as per the applicable cover, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for.
19. Prostheses, corrective devices and and/or Medical Appliances, which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalised.
20. Treatment received outside India.
21. a) Instrument used in Treatment of Sleep Apnea Syndrome (C.P.A.P.); b) Oxygen Concentrator for Bronchial Asthmatic condition; c) Infusion pump or any other external devices used during or after Treatment.
22. Injury caused whilst flying or taking part in aerial activities (including cabin) except as a fare-paying passenger in a regular scheduled airline or air charter company.
23. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalised, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses. For complete list of non-medical expenses, please refer to the Annexure I "Non-Medical Expenses" and also on Our website.
24. Any opted Deductible (Per claim/ Aggregate/ Corporate) amount or percentage of admissible claim under Co-Payment, Sub Limit if applicable and as specified in the Policy Schedule/ Certificate of Insurance to this Policy.
25. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
26. Any physical, medical or mental condition or Treatment or service that is specifically excluded in the Policy Schedule/ Certificate of Insurance under Special Conditions.

V.TERMS AND CLAUSES

A.Standard Terms and Clauses

1. **Arbitration**
   The parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this policy. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.
2. **Disclosure of Information**
   The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.
   (Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).
3. **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.
4. **Claim Settlement (provision for Penal Interest)**
   i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
   ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Insured Person 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 Insured Person at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
   (Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due).
5. **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. **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 can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer.
   ii. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the

details of
iii. other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount
iv. as per the policy conditions, provided a written request for same has been submitted by the Insured Person. policy.

7 **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.

8. **Cancellation**

i. The policyholder may policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall refund proportionate premium for unexpired policy period.
ii. if there is
iii. no claim (s) reported during the policy period.
iv. The Company may cancel the policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving iv. 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

9. **Migration**

The Insured Person will be provided a facility to migrate the policy (including all members) to other health insurance products/plans offered by the company by applying for migration of the policy. 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.

10. **Portability**

The Insured Person will be provided facility 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 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.

10. **Renewal of Policy**

The policy shall ordinarily be renewable except on grounds of fraud or non-disclosure or misrepresentation by the Insured Person.
i. The Company will give notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
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 except when premium is paid in instalments.
vi. No loading shall apply on renewals based on individual claims experience.

12. **Withdrawal of Policy**

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

13. **Moratorium Period**

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

14. **Redressal of Grievances**

In case of any grievance the Insured Person may contact the Company through:
Website: www.uiic.co.in
Toll free: 1800 425 333 33
E-mail: customercare@uiic.co.in
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 24, Whites Road, Chennai, Tamil Nadu- 600014
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 customercare@uiic.co.in
For updated details of grievance officer, kindly refer the link https://uiic.co.in/en/customercare/grievance
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 - II
Grievance may also be lodged at IRDAI Integrated Grievance Management System: https://igms.irda.gov.in/

15. **Nomination**

The Insured Person 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.

B.Specific Terms and Clauses

1. **Parties to the Policy**

The only parties to this Policy are the Policyholder and Us.

2. **No Constructive Notice**

Any knowledge or information of any circumstance or condition in relation to You/Insured Person in Our possession or in the possession of any of Our officials shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve You/Insured Person from your/her duty of disclosure, notwithstanding subsequent acceptance of any premium.

3. **Eligibility**

To be eligible for coverage under the Policy, the Insured Person must be -

a. Either an employee of the policyholder where there is an employer/employee relationship OR a member of the group as defined in extant IRDAI guidelines on Group Health Insurance in case of Non-Employer-Employee policies

b. The relationships which may be covered under the Policy are-

i. Self

ii. Employee/member's legal Spouse, Life Partner (including live-in partner)
For the purpose of this clause, Life Partner (including live-in partner) shall be taken as declared at the time of inception of Policy and no change would be accepted during the Policy Period. However, the Insured may request for change at the time of Renewal of the cover.

iii. The Employee/member's children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Children above 18 years will continue to be covered along with parents up to the age of 26 years, provided they are unmarried/unemployed and dependent.

iv. Parents/Parents-in-law

v. The Employee/member's siblings shall be covered up to the age of 26 years, provided they are unmarried/unemployed and dependent.

vi. Any other relationship as specified in the Policy Schedule/Certificate of Insurance

c. Minimum Group size: The Policyholder shall ensure that the minimum number of Employees/members who will form a group to avail the Benefits under this Policy shall be 7 (Seven).

d. New Born Babies will be accepted for cover (subject to the limitations of the New Born Baby Benefit Cover) from birth if mother is covered and maternity cover is opted. Acceptance of New Born Babies as Insured Persons is subject to written notification on or before the last day of the month following the birth of the child and receipt of the agreed premium.

4. **Resonable Care**

The Insured Person understands and agrees to take all reasonable steps in order to safeguard against any Illnesses, Accident or Injury that may give rise to any claim under this Policy.

5. **Premium**

The premium for each Policy will be determined based on the available data of each group, coverage sought by the insured and applicable discounts and loadings. Payment of premiums will be available in Single mode. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a Condition Precedent to Our liability to make any payment under this Policy.

Premium will be subject to revision at the time of renewal of the Policy. Further, premium shall be paid in Indian Rupees and in favour of United India Insurance Company Ltd.

NOTE: Where Instalment facility is granted by Us for the payment of premium, it is to be in accordance with the schedule of payments agreed between the Policyholder and Us in writing.

Where premium is payable on an instalment basis, the revival period shall be 15 days. Wherever premiums are not received within the revival period, the Policy will be terminated effective from instalment due date and all claims that fall beyond such instalment due date shall not be paid. However, we will be liable to pay in respect of all claims where the Treatment/Admission/Accident has commenced/ occurred before the date of termination of such Policy.

For installment premium, in the event of cancellation of policy, we will refund premium on pro rata basis after deducting Our expenses.

Premium shall be refunded for all lives which have not registered a claim with Us under the Policy up to the date of cancellation.

6. **Role of Group Administrator/Policyholder**

i. The Policyholder should provide all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy including the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.

ii. Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the RFQ/ proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, or endorsement of the Policy.

iii. The Policy holder i.e. the Employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.

iv. The claims of the individual employees may be processed through the employer.

7. **Alterations in the Policy**

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us. All endorsement requests will be made by the Policyholder only.

8. **Material Information for administration**

The Insured Person and/ or the Policyholder must give Us all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy. You must give Us written notification specifying the details of the Insured Persons to be deleted and the details of the eligible persons proposed to be added to the Policy as Insured Persons.

Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation or endorsement of the Policy.

9. **Material Change**

It is Condition Precedent to Our liability under the Policy that You shall at Your own expense immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business of any Insured Person. We may, in Our discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

10. **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.

11. **Geographical Area**

The geographical scope of this Policy applies to events limited to India unless specified under this Policy in a particular Benefit or

definition. However, all admitted or payable claims shall be settled in India in Indian rupees.

12. **Addition and Deletion of a Member**

We shall include/exclude a group member/Employee of the Policyholder and/or his/her Dependent(s) as an Insured Person under the Policy in accordance with the following procedure:

A. **Additions**

- a. Employer – Employee Group:
- i) Newly appointed employee and his/her dependents
- ii) Newly wedded spouse of the employee,
- iii) New born child of the employee
- may be added to the Policy as an Insured Person during the Policy period provided that the application for cover has been accepted by Us, additional premium on pro-rata basis applied on the risk coverage duration for the Insured Person has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Person
- b. Non-Employer – Employee Group: As specified in the Policy Schedule

B. **Deletions:**

- a. Employer – Employee Group

i) Employee leaving the company/organization on account of resignation/retirement/termination and his/her dependents shall be deleted from the policy effective from the date of resignation/retirement/termination or till the last day of the month of resignation/retirement/termination at the option of the insured

ii) In the event of death of an employee, his/her dependents may continue to be covered until the expiry of the policy period at the option of the insured

- b. Non-Employer – Employee Group: As specified in the Policy Schedule

Refund of premium shall be made on a pro-rata basis, provided that no claim is paid/outstanding in respect of that Insured Person or his/her Dependents.

Throughout the Policy period, the Policyholder will notify Us of all and any changes in the membership of the Policy occurring in a month on or before the last day of the succeeding month.

13. **Endorsements**

The Policy will allow the following endorsements during the Policy period. Any request for endorsement must be made only in writing by the Policyholder. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later.

- Rectification in name of the proposer / Insured Person.
- Rectification in gender of the proposer/ Insured Person.
- Rectification in relationship of the Insured Person with the proposer.
- Rectification of age/ date of birth of the Insured Person
- Change in the correspondence address of the proposer.
- Change/updating in the contact details viz., phone number, E-mail ID, etc.
- Updating of alternate contact address of the proposer.
- Change in Nominee details.
- Deletion of Insured Person on death or upon leaving the group provided no claims are paid / outstanding.
- Addition of member (New Born Baby or newly wedded Spouse).

All endorsement requests shall be assessed by the underwriter and where required additional information/documents/ premium may be requested.

14. **Renewal Terms**

Alterations like increase/ decrease in Sum Insured or change in optional covers can be requested at the time of Renewal of the Policy. We reserve Our right to carry out assessment of the group and provide the Renewal quote in respect of the revised Policy.

We may in Our sole discretion, revise the premiums payable under the Policy or the terms of the cover, provided that all such changes are in accordance with the IRDAI rules and regulations as applicable from time to time.

15. **Our Right of Termination**

A. **Termination of Policy:**

Prior to the expiry of the Policy as shown in the Policy Schedule/ Certificate of Insurance, cover will end immediately for all Insured Persons, if:

i. there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

ii. there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis for all lives which have not registered a claim with Us, after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

iii. the Policyholder does not pay the premiums owed under the Policy within the Grace Period.

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If Treatment has been authorized or an approval for Cashless facility has been issued, we will not be held responsible for any Treatment costs if the Policy ends. However, we will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.

B. **Termination for Insured Person's cover**

Cover will end for a Member or dependent:

i. If the Policyholder stops paying premiums for the Insured Person(s) and their Dependents (if any);

ii. When this Policy terminates at the expiry of the period shown in the Policy Schedule/ Certificate of Insurance.

iii. If he or she dies;

iv. When a dependent insured person ceases to be a Dependent; unless otherwise agreed specifically for continuation till end of policy period;

v. If the Insured Person ceases to be a member of the group.

16. **Limitation of Liability**

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

17. **Operation of Policy & Certificate of Insurance**

The Policy shall be issued for the duration as specified in the Policy Schedule/ Certificate of Insurance. The Policy takes effect on the Inception Date stated in the Policy Schedule and/or the Certificate of Insurance and ends on the date of expiry of the Policy. For specific groups, upon request, all additions thereto by way of Certificate/s of Insurance shall be valid up to the Policy Period commencing from the actual date of addition to the Policy, it being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on Renewal of the Policy or until expiry of the Certificate of Insurance, whichever is later.

18. **Electronic Transactions**

The Policyholder/ Insured Person agrees to comply with all the terms and conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other services, shall constitute legally binding when done in compliance with Our terms for such facilities.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder/ Insured Person. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by the Policyholder/ Insured Person.

19.**Communications & Notices**

a) Any notice, direction or instruction or any other communication related to the Policy should be made in writing.

b) Such communication shall be sent to the address of the Company or through any other electronic modes at contact address as specified in the Policy Schedule.

c) No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us.

d) The Company shall communicate to The Policyholder/ Insured Person in writing, at the address as specified in the Policy Schedule/ Certificate of Insurance or through any other electronic mode at the contact address as specified in the policy schedule

20.**Territorial Jurisdiction**

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the policy shall be determined by the Indian court and according to Indian law.

VI.CLAIM PROCEDURE

d.A.Claim Process for Base Covers

1.**Claims Administration & Process**

1. Claims Administration & Process

It shall be the condition precedent to admission of Our liability under this Policy that the terms and conditions of making the payment of premium in full and on time, insofar as they relate to anything to be done or complied with by You or any Insured Person, are fulfilled including complying with the following in relation to claims:

1. On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.

2. The treatment should be taken as per the directions, advice and guidance of the treating Medical Practitioner. Any failure to follow such directions, Medical advice or guidance will prejudice the claim.

3. The Insured Person must submit to medical examination by Our Medical Practitioner or our authorized representative in case requested by Us and at Our cost, as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

4. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

2.**Notification of claim**

Upon the happening of any event which may give rise to a claim under this Policy, the insured person/insured person's representative shall notify the TPA in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

i. Within 24 hours from the date of emergency hospitalisation required or before the Insured Person's discharge from Hospital, whichever is earlier

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalisation.

3.**Procedure for Cashless claims**

1. Cashless facility for treatment in hospitals only shall be available to insured subject to pre-authorization by TPA.

2. Treatment may be taken in a network provider/PPN hospital. Booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the TPA mentioned in the schedule.

3. The customer may call the TPA's toll free phone number provided on the health ID card for intimation of a claim and related assistance. Please keep the ID number handy for easy reference.

4. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Insurance-desk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for pre- authorization.

5. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorisation letter to the hospital after verification.

6. Once the request for pre-authorisation has been granted, the treatment must take place within 15 days of the pre-authorisation date at a Network Provider and pre-authorisation shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalisation where Cashless Facility is pre-authorised by Us or the associated TPA, We will make the payment of the amounts assessed directly to the Network Provider.

7. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalisation to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under clause V.4 above.

8. At the time of discharge, the insured person shall verify and sign the discharge papers and final bill and pay for non-medical and inadmissible expenses.

Note: (Applicable to Clause V.C): Cashless facility for Hospitalisation expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider/ PPN hospital for Illness or Injury / Accident/ Critical Illness as the case may be which are covered under the Policy. For all cashless authorisations, the Insured Person will, in any event, be required to settle all non-admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and / or opted Deductible (Per claim/ Aggregate/ Corporate) (if applicable), directly with the Hospital.

9. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a Pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

10. In case of admission in PPN hospitals, duly filled and signed PPN declaration format available with the hospital must be submitted.

11. Claims for Pre and Post-Hospitalisation will be settled on a reimbursement basis on production of cash receipts alongwith supporting documents.

4.**Procedure for reimbursement of claims**

a.i.1 In non-network hospitals payment must be made up-front and for reimbursement of claims the insured person may submit the necessary documents to TPA within the prescribed time limit. Claims for Pre- and Post-Hospitalisation will be settled on reimbursement basis on production of relevant claim papers and cash receipts within the prescribed time limit.

5.**Documents**

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

i.i. Duly completed claim form;

i.ii. Photo ID and Age proof;

i.iii. Health Card, policy copy, photo ID, KYC documents;

i.iv. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed, along with date of diagnosis, investigation test reports etc. supported by the prescription from the attending medical practitioner.

i.v. Medical history of the patient as recorded (All previous consultation papers indicating history and treatment details for current ailment), bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital

i.vi. Discharge certificate/ summary from the hospital.

i.vii. Photo ID and Age proof;

i.viii. Health Card, policy copy, photo ID, KYC documents;

i.ix. Original final Hospital bill with detailed break-up with all original deposit and final payment receipt;

i.x. Original invoice with payment receipt and implant stickers for all implants used during Surgeries i.e. lens sticker and Invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery;

i.xi. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center;

i.xii. All original medicine / pharmacy bills along with the Medical Practitioner's prescription;

i.xiii. MLC / FIR copy – in Accidental cases only;
i.xiv. Copy of death summary and copy of death certificate (in death claims only);
i.xv. Pre and post-operative imaging reports;
i.xvi. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;
i.xvii. Cheque copy with name of proposer printed on the cheque leaf or copy of the first page of the bank passbook or the bank statement not later than 3 months.

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under clause VI.5.1 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

Type of claim	**Time limit for submission of documents to company/TPA**
Where Cashless Facility has been authorised	Immediately after discharge.
Reimbursement of hospitalisation,daycare and pre hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post hospitalisation treatment

Note:

a.i.1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
a.i.2. Waiver of clause V.B.4.v may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
a.i.3. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
a.i.4. All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.
a.i.5. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

6. **Scrutiny of Claim Documents**

a. TPA/ We shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/ Network Provider as the case may be.
If the deficiency in the necessary claim documents is not met or is partially met in 10 working days of the first intimation. We will send a maximum of 3 (three) reminders. We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
b. In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.
c. The Pre-Hospitalisation Medical Expenses Cover claim and Post- Hospitalisation Medical Expenses Cover claim shall be processed only after decision of the main Hospitalisation claim.

7. **Claim Assessment**

We will pay the fixed or indemnity amount as specified in the applicable Base or Optional cover in accordance with the terms of this Policy.
We will assess all admissible claims under the Policy in the following progressive order:
1. Application of Proportionate clause as per Note 1 of clause III.A.1.
2. Co-pay as applicable.
3. Limit/ Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/ Certificate of Insurance
4. Opted Deductible (Per claim/ Aggregate)

Claim Assessment for Benefit Plans:
We will pay fixed benefit amounts as specified in the Policy Schedule/ Certificate of Insurance in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts not specified in the Policy.

8. **Claim Rejection/ Repudiation**

If the company, for any reasons, decides to reject a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 15 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be. Where a rejection is communicated by Us, the Insured Person may, if so desired, within 15 days from the date of receipt of the claims decision represent to Us for reconsideration of the decision.

9. **Claim Payment Terms**

i. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
All claims will be payable in India and in Indian rupees.
ii. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.
iii. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.
iv. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for "Any one illness" under this Policy shall be applied as if they were under a single claim.
v. **For Cashless claims**, the payment shall be made to the Network Provider whose discharge would be complete and final.
vi. **For Reimbursement claims**, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

10. **Services offered by TPA**

Servicing of claims i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims, as per the terms and conditions of the policy.
The services offered by a TPA shall not include:
a) Claim settlement and claim rejection;
b) Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

11. **Payment of Claim**

All claims under the policy shall be payable in Indian currency only.

d.B. **Claim Process for Optional Covers**

1. **Claim Intimation**

In addition to the claim intimation process set out in the Base Cover, the following conditions apply in relation to the respective Options. Upon the discovery or occurrence of an Accident/ Critical Illness or any other contingency that may give rise to a claim

under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee, as the case may be, must notify Us/ Our TPA either at the call centre or in writing and shall undertake the following:
In the case of Accidental Death Benefit/ PTD/ PPD/ Critical Illness (if applicable) -The Insured Person or the Nominee, as the case may be, shall notify Us either at the call centre or in writing, within 10 days from the date of occurrence of such Accident/diagnc of a Critical Illness.

2. **Reimbursement Process**

In addition to the documents mentioned in the Base Cover claim reimbursement process, the following additional documents will be required for reimbursement claim for the respective Options.

Optional Cover	**Additional Documents Required**
Critical Illness – Benefit Cover	The Insured Person may submit the following documents for reimbursement of the claim to our policy issuing office at his/her own expense ninety (90) days from the date of first diagnosis of the Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be Medical certificate confirming the diagnosis of Critical Illness. Discharge certificate/ card from the Hospital, if any. Investigation test reports confirming the diagnosis. First consultation letter and subsequent prescriptions. Indoor case papers, if applicable. Specific documents listed under the respective Critical Illness. Any other documents as may be required by Us. In those cases, where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.
Out- Patient Cover	The Insured Person shall avail these benefits as defined in Policy T&C if opted for. **Submission of claim** Invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to the TPA Head Office **Assessment of claim documents** We shall assess the claim documents and ascertain the admissibility of claim. **Settlement & Repudiation of a claim** We shall settle claims, including its rejection, within 15 days of the receipt of the last 'necessary' document.
Dental Expenses Cover & Vision Expenses Cover	The Insured Person shall avail these Benefits as defined below, if opted for. **Submission of claim** Insured Person can send the claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by the Insured Person as the case may be, to Our branch office or head office. **Assessment of claim documents** We shall assess the claim documents and ascertain the admissibility of claim. **Settlement & Repudiation of a claim** We shall settle claims, including its rejection, within 15 days of the receipt of the last 'necessary' document. In respect of Orthodontic Treatment claims for Dependent Children below 18 years, pre-authorisation is a must. For claims in respect of Orthodontic Treatment towards Dependent Children below 18 years, the Employee/ Member or Dependent must send the following information prepared by the Dentist who is to carry out the proposed Treatment to Us before Treatment starts, so that We can confirm the Benefit that will be payable: •Full description of the proposed Treatment; •X-rays and study models; •An estimate of the cost of the Treatment. Any Benefit will be payable only if We have authorised the cover before Treatment starts.
Refractive Error Correction Expenses Cover	Prescription from Specialist Medical Practitioner specifying the refractive error and medical necessity of the Treatment.
Home Nursing Charges Cover	Bills from registered nursing service provider.
Air Ambulance Cover	Air ambulance ticket for registered service provider.
Emergency Evacuation Cover	In the event of an Insured Person requiring Emergency evacuation and repatriation, the Insured Person must notify Us immediately either at Our call centre or in writing. Emergency medical evacuations shall be pre-authorised by Us. Our team of Specialists in association with the Emergency assistance service provider shall determine the medical necessity of such Emergency evacuation or repatriation post which the same will be approved.
Medical Equipment Cover	Prescriptions of treating Specialist for support items and original invoice of actual Medical Expenses incurred.
Ultra-modern Treatment Cover	Certificate by qualified medical surgeons indicating the medical necessity of the procedure.
Birth Control Procedure Cover	All medical records and treating Medical Practitioner's certificate on the indication.
Infertility Treatment Cover	Certificate from Specialist Medical Practitioner detailing the cause of infertility, Treatment, procedure.
Deductible (Aggregate/ Per-Claim)	Any claim towards Hospitalisation during the Policy period must be submitted to Us for assessment in accordance with the claim process laid down under Clause VI of the Policy towards Cashless facility or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the Deductible, We will assess and pay such claim in accordance with Clause VI.6 and 7 of the Policy. Wherever such Hospitalisation claims as stated under Clause VI

	above is being covered under another policy held by the Insured Person, We will assess the claim on available photocopies duly attested by the Insured Person's insurer / TPA as the case may be.

We may call for any additional document/information as required based on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarity.

Annexure-I

Uni Group Health Insurance Policy

List I - Optional Items

Sr. No	Item	Payable / Not Payable
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Payable for cases who have undergone surgery of thoracic or lumbar spine.
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL / INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Payable in case of varicose vein surgery
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Reasonable costs for one sling in case of upper arm fractures is payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
22	Television Charges	Payable under room charges not if separately levied
23	SURCHARGES	Part of Room Charge, Not payable separately
24	ATTENDANT CHARGES	Not Payable - Part of Room Charges
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Payable up to 24 hours, shifting charges not payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSPITAL)	Not Payable
36	SPACER	Not Payable
37	SPIROMETRE	Device not payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
47	LUMBO SACRAL BELT	Payable for cases who have undergone surgery of lumbar spine
48	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Payable for cases who have undergone surgery of lumbar spine.
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Payable in post hospitalisation
53	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
55	ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day is payable.

56	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
57	NEBULISATION KIT	Payable reasonably if used during hospitalisation
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
64	PAN CAN	Not Payable
65	TROLLEY COVER	Not Payable
66	UROMETER, URINE JUG	Not Payable
67	AMBULANCE	Payable
68	VASOFIX SAFETY	Payable - maximum of 3 in 48 hours and then 1 in 24 hours

List II - Items that are to be subsumed into Room Charges

Sr. No	Item	Sr. No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	20	LUXURY TAX
2	HAND WASH	21	HVAC
3	SHOE COVER	22	HOUSE KEEPING CHARGES
4	CAPS	23	AIR CONDITIONER CHARGES
5	CRADLE CHARGES	24	IM IV INJECTION CHARGES
6	COMB	25	CLEAN SHEET
7	EAU DE-COLOGNE / ROOM FRESHNERS	26	BLANKET/WARMER BLANKET
8	FOOT COVER	27	ADMISSION KIT
9	GOWN	28	DIABETIC CHART CHARGES
10	SLIPPERS	29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
11	TISSUE PAPER	30	DISCHARGE PROCEDURE CHARGES
12	TOOTH PASTE	31	DAILY CHART CHARGES
13	TOOTH BRUSH	32	ENTRANCE PASS / VISTOR'S PASS CHARGES
14	BED PAN	33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
15	FACE MASK	34	FILE OPENING CHARGES
16	FLEXI MASK	35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
17	HAND HOLDER	36	PATIENT IDENTIFICATION BAND / NAME TAG
18	SPUTUM CUP	37	PULSE OXIMETER CHARGES
19	DISINFECTANT LOTIONS		

List III - Items that are to be subsumed into Procedure Charges

Sr. No	Item	Sr. No	Item
1	HAIR REMOVAL CREAM	13	SURGICAL DRILL
2	DISPOSABLES RAZORS CHARGES (for site preparations)	14	EYE KIT
3	EYE PAD	15	EYE DRAPE
4	EYE SHIELD	16	X-RAY FILM
5	CAMERA COVER	17	BOYLES APPARATUS CHARGES
6	DVD, CD CHARGES	18	COTTON
7	GAUZE SOFT	19	COTTON BANDAGE
8	GAUZE	20	SURGICAL
9	WARD AND THEATRE BOOKING CHARGES	21	APRON
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS	22	TORNIQUET
11	MICROSCOPE COVER	23	ORTHOBUNDLE, GYNAEC BUNDLE
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER		

List IV - Items that are to be subsumed into costs of treatment

Sr. No	Item	Sr. No	Item
1	ADMISSION/REGISTRATION CHARGS	10	HIV KIT
2	HOSPITALISATION FOR EVALUATION/DIAGNOSTIC PURPOSE	11	ANTISEPTIC MOUTHWASH
3	URINE CONTAINER	12	LOZENGES
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	13	MOUTH PAINT
5	BIPAP MACHINE	14	VACCINATION CHARGES
6	CPAP/ CAPD EQUIPMENTS	15	ALCOHOL SWABS
7	INFUSION PUMP-COST	16	SCRUB SOLUTIONS / STERILLIUM
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC	17	GLUCOMETER & STRIPS
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES, DIET CHARGES	18	URINE BAG

Annexure-II
Details of Insurance Ombudsmen

Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel No: 079 - 25501201/02/05/06. Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building 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@cioins.co.in
Madhya Pradesh, Chhattisgarh	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 Email: bimalokpal.bhopal@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar - 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI - 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in /div>
Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh	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@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Pan bazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe- a part of Union Territory of Puducherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, GorakhpurGorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, KasganjKashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020-41312555

The updated details of Insurance Ombudsman are also available at:
•IRDAI website: https://www.irdai.gov.in/
•General Insurance Council website: https://www.gicouncil.in/
•Our Company Website: https://uiic.co.in/
•From any of the offices of our Company.