

Preamble

We will provide the insurance cover detailed in the Policy to the Insured Persons up to the Sum Insured subject to:

- i. The terms, conditions and exclusions of this Policy.
- ii. Statements in the proposal/enrolment form 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.

Commencement of risk cover under the policy is subject to receipt of premium by Us.

While the policy is in force, and if the claim is admissible under the policy, then We shall pay You such Reasonable and Customary Medical Expenses incurred on treatment or pay for the listed benefit sum insured. The said treatment must be on the advice of a qualified Medical Practitioner.

Our liability at any time shall not exceed the maximum sum insured applicable for the benefit as specified in Your policy schedule or Certificate of insurance. In case of family floater, the sum insured shall be applicable for all the claims made by any or all the insured persons in the family whereas in case of individual, this shall be applicable for all the claims made by an individual insured person.

In case of any other sum insured restrictions, the same shall be clearly specified in Your Policy schedule/Certificate of Insurance.

Section 1 – Definitions

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

i. Standard Definitions

1. Accident

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Any one illness

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. Break in policy

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.

4. Cashless facility

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

5. Congenital Anomaly

Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body

6. Co-Payment

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 copayment does not reduce the Sum Insured.

7. Day Care Centre

A 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 –

- i. has qualified nursing staff under its employment;
- ii. has qualified medical practitioner/s in charge;
- iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
- iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

8. Day Care Treatment

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 hrs because of technological advancement, and
- ii. which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an outpatient basis is not included in the scope of this definition

9. Dental Treatment

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

10. Domiciliary Hospitalization

Domiciliary hospitalization 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:

- i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- ii. the patient takes treatment at home on account of non-availability of room in a hospital.

11. Grace Period

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of **pre-existing diseases (PED)**. For single premium payment policies, coverage is not available during the period for which no premium is received. However, If the premium is paid in instalments during the policy period, coverage will be available during the grace period also. The grace period for payment of the premium shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases (Quarterly/Half Yearly).

12. Hospital

A 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:

- i. has qualified nursing staff under its employment round the clock;
- ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
- iii. has qualified medical practitioner(s) in charge round the clock;
- iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

13. Hospitalization

Hospitalization 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.

14. Illness

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

(a) 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

(b) Chronic condition

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

- i. it needs ongoing or long term monitoring through consultations, examinations, check-ups, and /or tests
- ii. it needs ongoing or long-term control or relief of symptoms
- iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it iv. it continues indefinitely
- iv. it recurs or is likely to recur

15. Injury

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.

16. In-patient Care

Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

17. Maternity expenses

Maternity expenses means;

- a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- b. expenses towards lawful medical termination of pregnancy during the policy period.

18. Medical Advice

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

19. Medical Expenses

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.

20. Medical Practitioner

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.

21. Medically Necessary Treatment

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.

22. Network Provider

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.

23. OPD treatment

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.

24. Pre-Existing Disease (PED)

Pre-Existing Disease means any condition, ailment, injury or disease

- o That is/are diagnosed by a Physician not more than 36 months prior to the date of commencement of the Policy issued by the Insurer; or
- o For which medical advice or treatment was recommended by, or received from, a Physician not more than 36 months prior to the date of commencement of the Policy.

25. Pre-hospitalization Medical Expenses

Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

- i. Such Medical Expenses are incurred for the same condition for which the Insured

Person's Hospitalization was required, and

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

26. Post-hospitalization Medical Expenses

Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

- i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
- ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

27. Migration

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.

28. 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.

29. Qualified Nurse

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.

30. Reasonable and Customary Charges

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.

31. Renewal

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 preexisting diseases, time-bound exclusions and for all waiting periods.

32. Room Rent

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

33. Surgery or Surgical Procedure

Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

34. Unproven/Experimental treatment

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.

ii. Specific Definitions (Definitions other than as mentioned under Section 1 (i) above)

1. Age

Means the completed age of the Insured Person on his / her most recent birthday as per the English calendar, regardless of the actual time of birth.

2. Room Category

Room Category shall mean one of the following:

- a. Single Private Room means a hospital room with one patient bed and such room must be the most economical of all accommodations available in that hospital as single occupancy.
- b. Shared Accommodation means a hospital room with two or more patient beds.
- c. Economy Ward means a hospital room with more than three patient beds.

This definition does not apply to ICU or ICCU.

3. **We/Us/Our** means TATA AIG General Insurance Company Limited.
4. **You/Your/Yourself** means the Policy Holder and/or Insured Person(s) who is named in the Policy Schedule.

5. Associated Medical Expenses

Associated Medical Expenses shall include Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/ anesthetist/ Specialist conducted within the same Hospital where the Insured Person has been admitted.

6. Policyholder

The Policyholder shall be the Employer who has taken the group insurance policy as a service benefit to his Employees or a Group Manager of a homogeneous group of persons who assemble together for a commonality of purpose and there is a clearly evident relationship between the member and group manager for services other than insurance.

Section 2: Benefits (Base Covers)

The following benefits are payable subject to Terms and Conditions of the policy:

B1. In-Patient Treatment

We will cover for expenses for hospitalization due to disease/illness/Injury during the policy period that requires an Insured Person's admission in a hospital as an inpatient.

Medical expenses directly related to the hospitalization would be payable provided:

i. Limit on Room Rent/Room Category:

We will, limit Room Rent up to the amount/percentage of Sum Insured or room category as specified in the Policy Schedule/ Certificate of Insurance.

ii. Associated Medical Expenses:

- a. If the Insured Person is admitted in a room where the Room Rent expenses incurred is higher than limit specified in the Policy Schedule/ Certificate of Insurance, then the Insured Person shall bear a rateable proportion of the total Associated Medical Expenses (including surcharge or taxes thereon), except pharmacy charges, diagnostic costs, costs of implants & medical devices and consumables expenses, in the proportion of the difference between the eligible Room Rent expenses to the Room Rent expenses actually incurred. Proportionate Expenses is applied in respect of the Hospital which follow differential billing or for those expenses in respect of which differential billing is adopted based on the Room Category.
- b. If the Insured Person is admitted in a hospital room where the room category opted is higher than the category specified in the Policy Schedule/Certificate of Insurance, then the Insured Person shall bear 10% of admissible claim amount

In case of unavailability of specified room category, the Insured Person is eligible for next immediate available hospital room provided that necessary

documented proof for unavailability of such hospital room is furnished to us.

iii. Limit on Treatment / Illness/ Surgery/ Medical Condition

We will cover the Medical Expenses incurred towards claim for a specified treatment of an Illness/procedure upto the amount of Sub-Limit applicable per claim during the Policy Year as specified in the Policy Schedule/ Certificate of Insurance.

B2. Pre-Hospitalization expenses

We will cover the Pre-Hospitalization expenses for consultations, investigations and medicines incurred upto the number of days as specified in your policy schedule/ Certificate of Insurance.

The benefit is payable if We have admitted a claim under In-patient Treatment/Day Care Procedures/Domiciliary treatment.

B3. Post-Hospitalization expenses

We will cover the Post-Hospitalization expenses for consultations, investigations and medicines incurred upto the number of days, as specified in your policy schedule/ Certificate of Insurance.

The benefit is payable if We have admitted a claim under In-patient Treatment/Day Care Procedures /Domiciliary treatment.

B4. Day Care Procedures

We will cover expenses for listed Day Care treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. The list of such day care procedures covered is available on our website (www.tataaig.com).

This benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance. Treatment normally taken on out-patient basis is not included in the scope of this cover.

B5. Domiciliary Treatment

We will cover for expenses related to

Domiciliary Hospitalization of the insured person if the treatment exceeds beyond three days. The treatment must be for management of an illness and not for enteral feedings or end of life care.

At the time of claiming under this benefit, we shall require certification from the treating doctor fulfilling the conditions as mentioned under the general definitions (Section 1-10) of this policy.

This benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance.

B6. Organ Donor

We will cover for Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient provided that:

- i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs Act (Amended), 1994 and other applicable laws and rules and the organ donated is for the use of the Insured Person, and
- ii. We have accepted an inpatient Hospitalization claim for the insured member under In-Patient Hospitalization Treatment (section B1).

This benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance.

B7. Ambulance Cover

We will cover for expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency or from one hospital to another hospital for better medical facilities and treatment, subject to amount as specified on the policy schedule/Certificate of Insurance.

For this claim to be paid, the claim must be admissible under section In-patient Treatment or Day Care Procedures of this policy.

B8. Maternity Cover

We will cover for Maternity Expenses for the delivery of a child and/or Maternity Expenses related to a Medically Necessary Treatment and lawful medical termination of pregnancy, during the Policy Year, subject to the Sub-Limits and maternity waiting period as specified in the Policy Schedule/ Certificate of Insurance. Medical expenses incurred for resuscitation of newborn baby shall form part of the maternity sub limit.

We will not cover ectopic pregnancy under this benefit (although it shall be covered under section In-patient Treatment).

Expenses incurred for pre/post natal care shall be excluded from the scope of this coverage.

B9. Pre/Post Natal Cover

We will cover for Medical Expenses incurred during the Policy Year on outpatient basis, in respect of pre-natal checkups, since confirmation of pregnancy, post-natal check-ups for a period up to six weeks from date of loss, prescribed pre- natal medicines and diagnostic tests up to the limit specified in the Policy Schedule/ Certificate of Insurance provided that:

- i. This Benefit is opted,
- ii. The maternity claim is admissible by Us under B8, and
- iii. Date of delivery is within policy period

The sum insured applicable for pre/post natal cover on out-patient basis shall be part of Maternity limit.

We will not be liable to make any payment in respect of any Pre-hospitalization Expenses or Post – hospitalization Expenses paid under the Base Cover.

B10. Baby day one Cover

We will cover for Medical Expenses incurred during the Policy Year, towards the Treatment of the New Born Baby from the date of birth of baby up to the Sub Limit, as specified in the Policy Schedule/ Certificate of Insurance, provided that You have paid requisite

premium for inclusion of the newborn baby in to the policy.

New Born Baby older than 90 days can be covered under the Policy as an Insured Person only by way of an endorsement or at the next Renewal, whichever is earlier, on payment of the requisite premium.

B11. Family Transportation Benefit

If We have accepted a claim under Benefit B1, then We will reimburse the actual expenses incurred in transporting one Immediate Family Member from the Insured Person's residence to the Hospital where the Insured Person is admitted, provided that such Hospital is located at least 200 kms away from the Insured Person's residence up to the limit as specified in the policy schedule/Certificate of Insurance.

For the purpose of this benefit, Immediate Family Member means the Insured Person's legal spouse, children, parents, parents-in-law, legal guardian, ward, step child or adopted child.

Section 3 – Exclusions

i. Standard Exclusions

1. Exclusions with waiting period

- i. Pre-Existing Diseases (Code- Excl 01) shall be waived off
- ii. Specified disease / procedure Waiting period: (Code- Excl 02) shall be waived off
- iii. 30 days waiting (Code- Excl 03) shall be waived off

2. Medical Exclusions

We will neither be liable nor make any payment for any claim in respect of any Insured Person which is caused by, arising from or in any way attributable to any of the following exclusions, unless expressly stated to the contrary in this Policy connection with or in respect of:

1. Investigation & Evaluation (Code- Excl 04)

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

2. Rest Cure, rehabilitation and respite care (Code- Excl 05)

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.

3. Obesity/ Weight Control (Code- Excl 06)

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

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

III. Severe Sleep Apnea

IV. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: (Code- Excl 07)

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

5. Cosmetic or plastic Surgery: (Code- Excl 08)

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

6. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code- Excl 12)
7. 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- Excl 13)
8. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code- Excl 14)

9. Refractive Error: (Code- Excl 15)

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

10. Unproven Treatments: (Code- Excl 16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or

supplies that lack significant medical documentation to support their effectiveness.

11. Sterility and Infertility: (Code- Excl 17)

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

12. Maternity (Code - Excl 18):

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

3. Non-Medical Exclusions

- i. 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
- ii. 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.
 - iii. Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its

website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim (Code – Excl11)

ii. Specific Exclusions (Exclusions other than as mentioned under Section 3 (i) above)

1. Exclusions with waiting periods

- i. Nine months maternity waiting period shall be waived off

2. Medical Exclusions

- i. Congenital External Diseases, defects or anomalies.
- ii. Stem cell therapy, however Hematopoietic stem cells for bone marrow transplant for haematological conditions will be covered under Benefit B1 and B4 of this Policy.
- iii. Growth hormone therapy.
- iv. Sleep-apnoea.
- v. Admission primarily for administration of Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid.
- vi. Venereal disease, sexually transmitted disease or illness.
- vii. All preventive care, vaccination including inoculation and immunisations (except in case of post- bite treatment and other vaccines explicitly covered).
- viii. Dental treatment or surgery of any kind unless as a result of Illness/Accidental Bodily Injury to natural teeth and also requiring hospitalization.

- ix. Any non-allopathic treatment.
- 3. Non-Medical Exclusions**
- i. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country),, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.
 - ii. Any Insured Person's participation or involvement in naval, military or air force operation.
 - iii. Intentional self-injury or attempted suicide while sane or insane.
 - iv. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service.
 - v. Treatment rendered by a Medical Practitioner which is outside his discipline
 - vi. Doctor's fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family.
 - vii. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy unless explicitly stated and covered in the policy.
 - viii. Any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

- ix. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.
- x. Crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively and explicitly stated and covered in the policy.
- xi. Any claim incurred after date of proposal/enrolment form and before issuance of policy/Certificate of Insurance where there is change in health status of the member and the same is not communicated to us.

Section 4 – General Terms and Clauses

i. Standard General Terms & Clauses

1. 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.

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. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to

obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

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

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

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

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

4. Multiple Policies

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.
- iii. If the amount to be claimed exceeds the sum insured under a single Policy, the Insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount and **We** will assist the Insured person in facilitating the same.
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen Policy.

5. Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or, misrepresentation by the insured person.

- i. The Company shall give notice for renewal within timelines as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof.
- ii. Renewal shall not be denied on the ground that the insured 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. Single premium payment mode Policy 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 after the end of the policy period. If not renewed under the Grace Period, the Policy shall terminate at the end of the Grace period.

- v. The grace period for payment of the premium during the Policy Period, for instalment premium shall be 15 days where premium payment mode is monthly and 30 days for all other cases (Quarterly/Half yearly)
 - a. if the premium is paid in instalments during the policy period, coverage will be available for the grace period also. Within the policy period - coverage will be available from the due date of instalment premium till the date of receipt of premium by Company within the grace period.
 - b. 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 after the end of the policy period.
- vi. The insured person will get the accrued continuity benefit in respect of the Waiting For Detailed Guidelines on Migration, kindly refer Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and subsequent amendments thereof.

Periods in the event of payment of premium within the stipulated Grace Period.

- vii. No loading shall apply on renewals based on individual claims experience.

6. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

7. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company policy by applying for migration of the policy atleast 30 days before the policy renewal date. 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

8. Portability

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

For Detailed Guidelines on Portability, kindly refer Insurance Regulatory and Development Authority of India (Insurance Products) Regulations, 2024 F. No. IRDAI/Reg/8/202/2024 dated 20th March, 2024 and Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29th May 2024 and their subsequent amendments thereof.

9. Withdrawal of Policy

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

9. Cancellation

- ii. i. You may cancel this Policy by giving 7 days written notice and in such an event, We shall refund proportionate premium for unexpired policy period, provided no claim been reported up to the date of cancellation if otherwise there

shall be no refund of premium. The Company may cancel the Policy at any time on grounds of mis-representation, nondisclosure of material facts, established fraud by the Insured Person by giving 15 days written notice. The policy shall stand cancelled ab-initio and there would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or established fraud.

10. Free look period

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

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document, whether received electronically or otherwise to review the terms and conditions of the policy, and to return the same if not acceptable.

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

- i. a refund of the proportionate premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges.

11. Nomination:

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of

death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule/ Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

12. Claim settlement (provision of Penal Interest)

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

("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)

13. 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.

14. Redressal of Grievance

In case of any grievance the Insured Person may contact through Website: www.tataaig.com

Call us 24x7 toll free helpline 1800 266 7780 or 022-66939500>> (toll free) or You may Email us at customersupport@tataaig.com

Courier: Customer Support, Tata AIG General Insurance Company Limited, 7th and 8th Floor, Romell Tech Park, Cama Industrial Estate, Western Express Highway, Goregaon(E), Mumbai, Maharashtra 400063

Visit the Servicing Branch mentioned in the policy document

The insured person may also approach the grievance cell at any of the Company's branches with 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 manager.customersupport@tataaig.com. For updated details of grievance officer, kindly refer the link (<https://www.tataaig.com/grievance-redressal-policy>)

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. Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/> and Bima Bharosa Portal - <https://bimabharosa.irdai.gov.in/>

Escalation Level 1

For lack of a response or if the resolution still does not meet Your expectations, You can write to manager.customersupport@tataaig.com. After investigating the matter internally and subsequent closure, We will send Our response within a period of 8 days from the date of receipt at this email id.

Escalation Level 2

For lack of a response or if the resolution still does not meet Your expectations, You can write to the Head – Customer Services at head.customerservices@tataaig.com Within 30 days of lodging a complaint with Us, if You do not get a satisfactory response from Us and You wish to pursue other avenues for redressal of grievances, You may approach Insurance Ombudsman appointed by IRDAI under the Insurance Ombudsman Scheme.

15. Moratorium Period

After completion of five continuous years 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 continuous period of five years 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 five continuous years would be applicable from the date of enhancement of sums insured only on the enhanced limits. ii. Specific terms and clauses (terms and clauses other than those mentioned under Section 4 (i) above)

16. Condition Precedent

- i. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.

- ii. No change in this Policy shall be valid unless a valid endorsement is passed in the policy.
- iii. In case of master policy, the policy period would be 1 year however the period of certificate of insurance would be from 1 year to 5 years (in case of credit linked). Details of the policy term applicable to individual certificate of insurance would be clearly stated in Your certificate of insurance.

17. Insured Person

- i. Only those persons named as an Insured Person in the Policy Schedule/Certificate of insurance shall be covered under this Policy.
- ii. Mid-term addition of Primary Insured and Dependents:

Mid-term addition of Primary insured and dependents shall be allowed in the event of following:

1. Intimation is given to Us by a defined & agreed date and shall be subject to Regulations/Guidelines issued by Insurance Regulatory and Development Authority of India and any subsequent amendments as published from time to time
2. Requisite premium has been paid to Us.
3. All existing dependents must be covered along with the Primary Insured and the addition of Dependents shall be allowed only in the event of:
 - Children in the event of childbirth

- Spouse in the event of marriage

If any of the conditions (1) & (2) above are not met, coverage will commence only from the date of intimation to Us or premium remittance whichever is later.

iii. Mid-term deletion of Primary Insured and Dependents:

a. In case of Employer-Employee Policies:

- The coverage for existing Primary Insured and his dependents will automatically expire from date of cessation of employment.
- Proportionate refund of premium would be made on intimation provided such intimation is made by a defined date and no claim is made by the Primary Insured or his dependents.

b. In case of non Employer- Employee Policies, the coverage shall automatically expire from the date the insured person exits the scheme.

c. In case of refund of premium being generated on the Policy due to deletion of Insured Persons, the same will be refunded or adjusted accordingly against the future premium installments due on the Policy.

18. Entire Contract

- This Policy, its Schedule, endorsement(s), proposal/enrolment form constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by Us and such approval be endorsed hereon.
- This Policy and the Policy Schedule/ Certificate of insurance shall be read together as one contract and any word or

expression to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear such meaning wherever it may appear.

19. Notices

i. Any notice, direction or instruction under this Policy shall be in writing and if it is to:

- Any Insured Person, then it shall be sent to You at Your address specified in the Schedule to this Policy and You shall act for all Insured Person(s) for these purposes.
- Us, it shall be delivered to Our address specified in the Schedule to this Policy. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

20. Termination

- You may terminate this Policy / Certificate of Insurance at any time by giving 7 days written notice to Us, and the Policy/Certificate of Insurance shall terminate when such written notice is received.

In case of master policy, each Certificate of Insurance will get terminated on the earliest of the following dates:

- The date You or We cancel the Certificate of Insurance
- The member opts out of the scheme

- c. Foreclosure/closure of loan availed (wherever applicable)

21. Assignment Clause

The Benefits under this Policy are assignable subject to applicable Laws

Section 5 – Claims Procedure and Claims Payment

This section explains about the procedures involved to file a valid claim by the insured member and processes related in managing the claim by TPA or Us. All the procedures and processes such as notification of claim, availing cashless service, supporting claim documents and related claim terms of payment are explained in this section.

1. Notification of Claim

	Treatment, Consultation or Procedure:	We or Our TPA* must be informed:
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1	If any treatment for which a claim may be made and that treatment requires planned Hospitalisation:	At least 48 hours prior to the Insured Person’s admission.
2	If any treatment for which a claim may be made and that treatment requires emergency Hospitalisation	Within 24 hours of the Insured Person’s admission to Hospital.

Failure to furnish such intimation within the time required shall not invalidate nor reduce any claim if You can satisfy us that it was not reasonably possible for You to give proof of such delay within such time. The Company may relax these timelines only in special circumstances and for the reasons beyond the control of the insured.

**TPA as mentioned in the policy schedule*

3. Procedure for Cashless Service

- i. Cashless Service is only available at Network Hospitals.
- ii. In order to avail cashless treatment, the following procedure must be followed by You:

2. Cashless Service

Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned t r e a t m e n t o r Hospitalisation
If any treatment, consultation or procedure for which a claim may be made, requiring emergency hospitalisation	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

- a. Prior to taking treatment and/ or incurring Medical Expenses at a Network Hospital, You must call our designated TPA/Us and request pre-authorization.
- b. For any emergency Hospitalization, our designated TPA/We must be informed no later than 24 hours of the start of Your hospitalization/ treatment.
- c. For any planned hospitalization, our designated TPA/We must be informed atleast 48 hours prior to the start of your hospitalization/treatment
- d. Our designated TPA/We will check your coverage as per the eligibility and send an authorization letter to the provider. You have to provide the ID card issued to You along with any other information or documentation that is requested by the TPA/Us to the Network Hospital
- e. In case of deficiency in the documents sent to TPA/Us for cashless authorization or the ailment /treatment is not covered under the policy, the same shall be communicated to the hospital/You by TPA/Us..
- f. We/TPA will respond within timeline as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof .
- g. Rejection of cashless in no way indicates rejection of the claim. You are required to submit the claim along with required documents for us to decide on the admissibility of the claim

- h. If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.
- i. Pre-authorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

4. Supporting Documentation & Examination

- i. You or someone claiming on Your behalf shall provide Us with documentation, medical records and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days or earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment.
- ii. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if you can satisfy us that it was not reasonably possible for you to give proof within such time.
- iii. We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

Your claim will be processed including cashless and final bill authorization as prescribed by the Regulator under the Master Circular on IRDAI (Insurance Products) Regulations 2024- Health Insurance Ref: IRDAI/HLT/CIR/PRO/84/5/ 2024 and its subsequent amendments thereof.

iv. Such documentation will include the following:

- a. Our claim form, duly completed and signed for on behalf of the Insured Person. We, upon receipt of a notice of claim, will furnish Your representative with such forms as We may require for filing proofs of loss or you may download the claim form from our Web site.
- b. Original Bills (pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
- c. All medical reports, case histories, investigation reports, indoor case papers/ treatment papers (in reimbursement cases, if available), discharge summaries.
- d. A precise diagnosis of the treatment for which a claim is made.
- e. A detailed list of the individual medical services and treatments provided and a unit price for each in case not available in the submitted hospital bill.
- f. Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. In case of pre/post hospitalization claim Prescriptions must be submitted with the corresponding Doctor/ hospital invoice.
- g. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made, if and where applicable.
- h. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident, if available
- i. Copy of settlement letter from other insurance company or TPA
- j. Stickers and invoice of implants used during surgery

- k. Copy of MLC (Medico legal case) records, if carried out and FIR (First information report) if registered, in case of claims arising out of an accident and available with the claimant.
 - ii.
- l. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
- m. Legal heir/succession certificate, if required
- n. PM report (wherever applicable and conducted)
- v. Note: In case You are claiming for the same event under an indemnity based policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

We at our own expense, shall have the right and opportunity to examine Insured Person(s) through Our Authorised Medical Practitioner whose details will be notified to Insured Person when and as often as We may reasonably require during the pendency of a claim hereunder.

5. Claims Payment

- i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full and on time and We have been provided with the documentation and information We or Our TPA has requested to establish the circumstances of the claim, its quantum or Our liability for it, and

unless the Insured Person has complied with his obligations under this Policy.

All claims will be settled in accordance with the applicable regulatory Notifications. Section 6 - Dispute Resolution

1. Dispute Resolution Clause

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

2. 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.

List of Insurance Ombudsman

Sr.No.	Centre	Address & Contact	Jurisdiction of Office Union Territory, District
1	AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
2	BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
3	BHOPAL	Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh
4	BHUBHANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
5	CHANDIGARH	Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu &

			Kashmir, Ladakh & Chandigarh.
6	CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)
7	DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh
8	GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
9	HYDERABAD	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	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry

10	JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
11	KOCHI	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry
12	KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
13	LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar,

			Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
14	MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolititan Region (excluding Navi Mumbai & Thane)
15	NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	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 Buddha nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal,

			Amroha, Hathras, Kanshiramnagar, Saharanpur.
16	PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand
17	PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)

For updated list and details of Insurance Ombudsman Offices, please visit website <http://www.cioins.co.in/ombudsman.html>

Prohibition of Rebates - Section 41 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015.

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in

accordance with the published prospectuses or tables of the insurer.

2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Insurance is the subject matter of the solicitation". Please read the Policy wordings carefully before concluding the sale.