Ref: IRDAI/HLT/REG/CIR/164/06/2020

26th June, 2020

Guidelines on COVID Standard benefit based Health Policy

INDEX

To

All Insurers,

Guidelines on COVID Standard benefit based health policy

A. Preamble:

1. In view of the global pandemic COVID-19, to help the public to protect themselves all insurers (life, general and health insurers) are encouraged to offer an individual COVID specific Standard benefit based health policy with the following objective:

    - To have a COVID specific benefit based product addressing health insurance needs of insuring public related to COVID.

2. The COVID Standard benefit based health policy shall have the basic cover as specified in these Guidelines which shall be uniform across all Insurers.

3. The insurer may determine the price keeping in view the cover proposed to be offered subject to complying with the norms specified in the IRDAI (Health Insurance) Regulations, 2016 and Guidelines notified there under.

4. The COVID- Standard benefit-based health policy shall offer a policy tenure of three and half months (3 ½ months), six and half months (6 ½ months) and nine and half months (9 ½ months) i.e, 105 days, 195 days and 285 days respectively.

5. The COVID Standard benefit based health policy shall comply with all the provisions of IRDAI (Health Insurance) Regulations, 2016, all other applicable Regulations, Guidelines on Standardization in Health Insurance (Ref: IRDA/HLT/REG/CIR/146/07/2016) dated 29th July, 2016, Guidelines on Product Filing in Health Insurance Business (Ref: IRDA/HLT/REG/CIR/150/07/2016) dated 29th July, 2016 and other applicable Guidelines as amended from time to time.

6. All Insurers (General, Health and Life) transacting Health Insurance business may endeavor offering this product preferably by 10th July,2020.

B. Construct of COVID Standard benefit based health policy: The COVID Standard benefit based health policy shall offer the following:

Covid Cover:

Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of COVID shall be from a government authorized diagnostic centre.

C. Other Norms applicable:

Sl.No	Particulars	Norms Applicable
1.	Plan Variants	No plan variants are allowed.
2.	Distributions Channels	COVID Standard benefit based health policy may be distributed across all distribution channels including Micro Insurance Agents, Point of sale persons and Common Public Service Centres. Distribution of COVID Standard benefit based health policy shall be governed by the regulations of concerned distribution channels.
3.	Individual Basis	COVID Standard benefit based health policy shall be offered on individual basis only.
4.	Category of Cover	The cover shall be made available on benefit basis
5.	Minimum and Maximum Sum Insured	The minimum sum insured under COVID Standard benefit based health policy shall be Rs. 50,000/- (Fifty Thousand only) Maximum limit shall be Rs.2,50,000(Two lakhs and Fifty Thousand only) (in the multiples of fifty thousand)
5.	Policy Period	COVID Standard benefit based health policy shall be offered with a policy term of three and half months (3 ½ months), six and half months (6 ½ months) and nine and half months (9 ½ months) i.e, 105 days, 195 days and 285 days respectively.
6.	Modes of premium payment	Single premium payment mode shall only be allowed.
7.	Entry age	Minimum entry age shall be 18 years and maximum age at entry shall not be less than 65 years for the persons covered complying to Regulation 12(i) of HIR 2016.
8.	Benefit Structure	The benefit pay out should be explicitly disclosed in the format of application (Form – IRDAI-UNF-SCHP) along with other relevant documents.

		On payment of 100% of sum insured the policy shall be terminated.
9.	Underwriting	The insurer shall specify the non-medical limit and relevant details explicitly in the format specified.
10.	Renewal, migration and portability	Lifelong renewability, migration and portability stipulated under Regulation 13 and 17 of IRDAI (Health Insurance) Regulations, 2016 respectively are not applicable to this product.
11.	Pricing	The premium under this product shall be pan India basis and no geographic location / zone based pricing is allowed.

D: Construct of Terms and Conditions for COVID Standard benefit based health policy

7. The Policy Terms and Conditions of the COVID Standard benefit based health policy shall be in the format specified in Annexure – 1. Insurer may suitably modify the definitions and other clauses of the policy contract prospectively based on the Regulations or Guidelines that may be issued by the Authority from time to time.

E: Other Norms:

8. The nomenclature of the product shall be Corona Rakshak Policy, succeeded by name of insurance company, (Corona Rakshak Policy, <name of insurer>). No other name is allowed in any of the documents.

9. The Proposal Form used for the product shall be subject to the norms specified under the Guidelines on Product Filing in Health Insurance.

10. Insurers shall issue Customer Information Sheet as per the format specified in Annexure-2

11. The COVID Standard benefit based health policy may be offered as MICRO Insurance Product subject to Sum Insured limits specified in IRDAI (Micro Insurance) Regulations, 2015, and other circulars / guidelines issued in this regard by the Authority from time to time.

12. The COVID Standard benefit based health policy may be launched under use and file without prior approval of the Authority subject to complying with the following conditions.
    a. The product shall be approved by the Product Management Committee (as may be applicable).

b. Insurers shall obtain UIN from the Authority for the COVID Standard benefit based health policy by filing the relevant particulars in Form – IRDAI-UNF-SCHP (as specified in Annexure – 3 of these Guidelines) along with a certificate from Chief Compliance Officer that the product filed is in compliance with the norms specified under these guidelines.
c. On review of the application, the Authority may call for such further information as may be required and may issue suitable directions which shall be retrospectively effected in respect of all contracts issued under this product.

13. In terms of the provisions of Regulation 4(iii) of IRDAI (Issuance of e-Insurance Policies) Regulations, 2016 providing policy document in physical form is mandatory when policies are issued in electronic form directly to the policyholders. Since features of COVID Standard benefit based health policy are common across the industry and as the terms and conditions of the policy are already specified by the Authority, with the objective of reducing the oprearating costs and to pass on this benefit of reduced operational cost to the policyholders by way of affordable premiums, insurers are allowed to issue the policy contract of COVID Standard benefit based health policy in electronic / digital format. The digital form of the policy contract may be forwaded through email or a link shall be provided in the certificate of insurance.However, where policyholder specifically seeks the physical form of the policy contract, the same shall be provided by the insurer.

14. Insurers offering COVID Standard benefit based health policy shall provide a certificate of insurance to the policyholder indicating the availability of health insuarnce coverage.The certificate shall have a reference to access detailed terms and conditions of the policy contract. Insurers shall also clearly mention policy period (Policy Start Date to Policy End Date), effective policy period (from end of waiting period to end of policy period), waiting period (policy start date to end of policy period) in the Certificate of Insurance.

15. In terms of Clause 5 of Guidelines on short term health insurance policies Ref: IRDAI/HLT/REG/CIR/156/05/2020 dated 23rd June, 2020, the guidelines will remain valid till 31st March, 2021 for issue of short term policies in respect of standard COVID product as specified in these guidelines.

16. This has approval of the Competent Authority.

(DVS Ramesh)
General Manager

Annexure-1

Corona Rakshak Policy, [Company Name]

1. PREAMBLE

This Policy is a contract of insurance issued by *[name of the Company]* (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person named in the schedule (hereinafter called the 'Insured Person'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period the e Insured Person is diagnosed with COVID and hospitalized for more than seventy-two hours following Medical Advice of a duly qualified Medical Practitioner as per the norms specified by Ministry of Health and Family Welfare, Government of India, the Company shall pay the agreed sum insured 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 exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during the Policy period shall be the Sum Insured) opted and specified in the Schedule.

3. 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.

3.1. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

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

3.3. **COVID**: For the purpose of this Policy, Corona virus Disease means COVID-19 as defined by the World Health Organization (WHO) and caused by the virus SARS-CoV2

3.4. **Diagnosis** means diagnosis by a registered medical practitioner, supported by clinical, radiological, histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable.

3.5. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policy holder.

3.6. **Hospital mea**ns any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
vi. For the purpose of this policy any other set-up designated by the government as hospital for the treatment of Covid-19 shall also be considered as hospital.

3.7. **Hospitalisation** means admission in a hospital designated for COVID-19 treatment by Government, for a minimum period of seventy-two (72) consecutive 'In-patient care' hours.

3.8. **In-Patient Care** means treatment for which the insured person has to stay in a hospital continuously for more than 72 hours for treatment of COVID.

3.9. **Insured Person** means person(s) named in the schedule of the Policy.

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

3.11. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

3.12. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

3.13. **Non- Network Provider** means any hospital that is not part of the network.

3.14. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

3.15. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

3.16. **Policy period** means period of three and half months (3 ½ months), six and half months (6 ½ months) and nine and half months (9 ½ months) i.e, 105 days, 195 days and 285 days respectively as specified in the policy schedule.

3.17. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy

3.18. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum liability for any and all claims made under the Policy, in respect of that Insured Person during the Policy period.

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

3.20. **Waiting Period** means a period from the inception of this Policy during which specified disease is not covered. On completion of the period, specified disease shall be covered provided the Policy has been continuously renewed without any break.

4. Coverage:

The cover listed below is in-built Policy benefit and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1. COVID Cover

Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of COVID shall be from a government authorized diagnostic centre.

Note:

i. Payment will be made only on Hospitalisation for a minimum continuous period of 72 hours following positive diagnosis for COVID.

ii. This is onetime benefit applicable for the entire tenure of the Policy and shall terminate upon payment of this benefit.

5. Waiting Period:

The Company shall not be liable for any claim arising for COVID within 15 days from the first policy commencement date.

6. EXCLUSIONS

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

6.1Investigation & Evaluation (Code- Excl04)

i.Expenses related to any admission primarily for diagnostics and evaluation purposes.

ii.Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

6.2Any diagnosis which is not related and not incidental to COVID is not covered in this Policy

6.3. Testing done at a Diagnostic centre which is not authorized by the Government shall not be recognized under this Policy

6.4. Any claim with respect to COVID manifested prior to commencement date of this policy or during the waiting period.

6.5. Cover under this Policy shall cease if the Insured Person travels to any country placed under travel restriction by the Government of India.

7. CLAIM PROCEDURE

7.1 Notification of claim:

Upon the happening of the covered event, which may give rise to a claim under this policy, notice with full particulars shall be sent to the Company within 15 days from the date of occurrence of the event / diagnosis of COVID.

7.2 Procedure: The insured person may submit the necessary documents to TPA(if applicable)/Company within the prescribed time limit as specified hereunder.

Sl	Type of Claim	Prescribed Time limit

No		
1.	COVID Cover	Within thirty days of date of discharge from hospital following positive diagnosis for COVID.

7.3 Documents to be submitted:

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

Benefits	Claims Documents Required
1. Covid-19 Cover	i. Duly filled and signed Claim Form ii. Copy of Insured Person's passport, if available (All pages) iii. Photo Identity proof of the patient (if insured person does not own a passport) Medical practitioner's prescription advising admission iv. Medical practitioner's prescription advising admission v. Discharge summary including complete medical history of the patient along with other details. vi. Investigation reports including Insured Person's Test Reports from Authorized diagnostic centre for COVID. vii. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque viii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines ix. Legal heir/succession certificate, wherever applicable x. Any other relevant document required by Company/TPA for assessment of the claim.

[Note: Insurer may specify the documents required in original and waive off any of above required as per their claim procedure]

Note:

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
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

7.4 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest 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 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 at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

7.5 Payment of Claim
All claims under the policy shall be payable in Indian currency only. On payment of 100% of sum insured the policy will be terminated.

8. GENERAL TERMS &CONDITIONS

8.1. Disclosure of Information

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

8.2. Condition Precedent to Admission of Liability

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

8.3. Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

8.4. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

8.5. 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.

8.6. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

8.7. Territorial Limit

The company's liability to make any payment under the policy will be within India only.

8.8. 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 shall be forfeited.

Any amount already paid against claims made under the policy which are found fraudulent later under this policy 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.

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, with intent to deceive the insurer or to induce the insurer to issue a 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 policy 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.

8.9. Cancellation: The Company may cancel the Policy at any time on grounds of mis-represenation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-represenation, non-disclosure of material facts or fraud.

8.10. Automatic termination:
This policy shall terminate for the Insured immediately on the earlier of the following events irrespective of the expiry date mentioned in the policy schedule
• Upon the demise of the covered person.
• Upon payment of an admissible claim and settlement of 100% of Sum Insured specified in the Policy Schedule.

8.11. 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.

8.12. Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

8.13. Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

8.14 Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

8.15 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.

9. REDRESSAL OF GRIEVANCE

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

Website:
Toll free:
E-mail:
Fax :
Courier:

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 .....

For updated details of grievance officer, kindly refer the link.....
(Link having details of grievance officer on website to be provided)

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

Insurance Ombudsman –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. The contact details of the Insurance Ombudsman offices have been provided as Annexure-A.[1][Insurers are advised to note the revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html and ensure that updated details are prospectively incorporated in the policy documents for the information of the policyholders.]

10.TABLE OF BENEFITS

Name	Corona Rakshak Policy,[Company Name]
Product Type	Individual
Category of Cover	Benefit based
Sum insured	Rs 50,000/- (Fifty Thousand) to 2,50,000 (Two and half Lakh) (in the multiples of fifty thousand)
Policy Period	Three and half months (3 ½ months), six and half months (6 ½ months) and nine and half months (9 ½ months) i.e, 105 days, 195 days and 285 days respectively
Eligibility	Policy can be availed by persons between the age of 18 years and _____ years .(To be filled by the insurers). Proposer with higher age can obtain policy for adult members of the family, without covering self.
Coverage	**COVID Cover** Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of COVID shall be from a government authorized diagnostic centre.

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad @ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road,JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi .co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar @ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam-682015. Tel.: 0484 - 2358759/2359338 Fax: 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, 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, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052

	Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in

[Note to Insurers: Insurers are advised to mention the correct address, e mail Id, phone number etc. of insurance ombudsmen while issuing policy contracts]

Annexure-2

Customer Information Sheet (Description is illustrative and not exhaustive)

<table>
<tr><th>No.</th><th>TITLE</th><th>DESCRIPTION</th><th>Refer to policy clause number</th></tr>
<tr><td>1.</td><td>Product Name</td><td>Corona Rakshak Policy ,<name of the Insurer>.</td><td rowspan="2"></td></tr>
<tr><td>2.</td><td>What am I covered for</td><td>COVID Cover:
Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of72 hours. The positive diagnosis of COVID shall be from a government authorized diagnostic centre.</td><td>4.1</td></tr>
<tr><td rowspan="3">3.</td><td rowspan="3">What are the Major exclusions in the policy</td><td>Following is a partial list of the policy exclusions. Please refer to the policy document for the complete list of exclusions:
a. Admission primarily for investigation & evaluation</td><td>6.1</td></tr>
<tr><td>b. Any diagnosis which is not related and not incidental to COVID is not covered in this Policy</td><td>6.2</td></tr>
<tr><td>c. Testing done at a Diagnostic center which is not authorized by the Government shall not be recognized under this Policy</td><td>6.3</td></tr>
<tr><td>4.</td><td>Waiting period</td><td>The Company shall not be liable for any claim arising under the policy within 15 days from the first policy commencement date with Us.</td><td>5</td></tr>
<tr><td>5.</td><td>Payment basis</td><td>Benefit basis</td><td></td></tr>
<tr><td>6.</td><td>Claims</td><td>The insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.
<table>
<tr><th>Sl No</th><th>Type of Claim</th><th>Prescribed Time limit</th></tr>
<tr><td>1.</td><td>COVID Cover</td><td>Within thirty days of date of discharge from hospital following positive diagnosis for COVID</td></tr>
</table></td><td>7.2</td></tr>
<tr><td>7</td><td>Policy Servicing</td><td>Insurer to provide the details of company officials.</td><td></td></tr>
</table>

	Grievances/ Complaints	a. Details of Grievance redressal officer (Insurer to provide the link) b. IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/ c. Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.	9
8.	***Insured's Obligations***	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	8.1
Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.			

Annexure-3

Form IRDAI-UNF-SCHP

[All the items should be filled in properly and carefully. No item must be left blank.]

S No		Item	Particulars (to be filled in by insurer)
	Section I: General Information		
1.1		Name of Health / General/ Life Insurer	
1.2		Registration No. allotted by IRDAI	
1.3		Name of Appointed Actuary [Please note that his/her appointment should be in force as on the date of this application]	
1.4		Brand Name [Give the name of the product which will be printed in Sales Literature and known in the market. This name should not be altered/modified in any form after launching in the market. This name shall appear in all returns etc. which would be submitted to IRDAI	Corona Rakshak Policy, <Name of the insurer>
1.5		Date of approval by PMC (as applicable)	
	Section II: Underwriting		
2.		Underwriting –Selection of Risks [This section should discuss how the different segments of the population will be dealt with for the purpose of underwriting (to the extent they are relevant and a brief detail of procedure adopted for assessment of various risk classes may be given.)	
2.1		Specify Non-medical Limit [Where no pre-medical examination is asked for]	
2.2		Specify when and what classes of lives would be subject to medical examination	
2.3		Whether any loading based on the health status are applicable	Yes / No
2.4		Whether any loading based on the occupation are applicable	Yes / No

2.5		Specify, any other underwriting criteria	
2.6		Whether Underwriting of the product aligned to the Board Approved Underwriting policy of the Company	Yes / No
2.7		Whether full costs of pre policy medical check up are borne by the Insurer	Yes / No
2.8		If no, specify the percentage proposed to be borne by the Insurer.	

Section III - Distribution Channels

3		Distribution channels:		
	3.1	Specify the various distribution channels to be used for distributing the product- [reply shall be specific and can not refer to the replies like "as approved by IRDAI]		
	3.1	Commission scales to distribution channels—specify the rates which are to be paid-[reply shall be specific]		

3.2		Expected proportions of business to be procured by each channel shall be indicated.	Distribution Channel	FY 20-21					
			1.Individual Agents						
			2. Corporate Agents						
			3. Insurance Brokers						
			4.Web Aggregators						
			5.Micro Insurance Agents						
			6.CSC						
			7.PoS						
			8.Direct – Only Online						

			9.Direct Marketing - Others					
			(Incorporate separate line for each distribution channel) 10. Others-specify					
			11. Total					

	Section IV - Reinsurance arrangements			
4.1		Retention limit		
4.2		Name of the reinsurer (s)		
4.3		Terms of reinsurance(type of reinsurance, commissions, etc.).		
4.4		Any recapture provisions shall be described.		
4.5		Reinsurance rates provided		
4.6		Whether a copy of the reinsurance program and a copy of the Treaty is submitted to the Authority.		Yes/No
	4.6.1		Whether reinsurance program and a copy of the treaty enclosed (required only if these are not filed with the Authority previously)	Yes/No
	4.6.2		Whether the reinsurance proposed for the product is in line with the Board approved reinsurance program filed with the Authority	Yes / No
	4.6.3		If no, furnish the particulars	
	Section V: Pricing			
5		*Premium Loadings & Discounts*		

		(Please provide objective and transparent criteria to offer discounts/rebate/Loadings And complete financial justifications by AA to every item referred hereunder. *In case of General and Health Insurers to be also furnished separately in the Technical Note)*		
	5.1		Sum insured rebates/discounts offered, if any	
	5.2		Rebates/charges for different modes offered:	
	5.3		Premium rebates/discounts	
	5.4		Staff rebates	
	5.5		Any other discounts offered	
	5.6		Maximum cap on all Discounts for all variables taken together	
	5.7		Any loadings proposed	
	5.8		Maximum Cap on all Loading for all variables taken together	
	5.9		Subrogation (Not applicable to Health Insurance)	
5.10		**Pricing Assumptions and Methodology:** The pricing assumptions and the methodology may vary depending on the nature of product. Give details of the following		
5.11		Give the actuarial formulae, if any, used; if not, state how premiums are arrived at briefly explaining the methodology and details:		
5.12		Source of data (internal/industry/ reinsurance)		
5.13		Rate of morbidity [The tables whereever relevant shall be the prescribed one.]		
5.14		Rates of policy terminations. [The rates used must be in		

		accordance with insurer's experience. If such experience is not available, this can be from the industry/reinsurer's experience .]	
5.15		Rate of interest, if any. [The rate or rates must be consistent with the investment policy of the insurer.]	
5.16		Commission scales [Give rates of commission. These are explicit items.]	
5.17		Expenses - Split into First Year, Renewal and Claim related:- [Expense assumptions must be company specific. If such experience is not available, the Appointed Actuary might consider industry experience or make reasonable assumptions.](**As may be applicable.)**	
	5.17 .1	First Year expenses by: sum assured related, premium related, per policy related	

First Year Expenses	sum assured related	premium related	per policy related

5.17 .2	Renewal expenses where relevant (including overhead expenses) by : sum assured related, premium related, per policy related	

Renewal Expenses	sum assured related	premium related	per policy related

	5.17 .3	Claim expenses	
	5.17 .4	Future inflationary increases, if any	
5.18		Allowance for transfers to shareholder, if any: [Please see section 49 of the Insurance Act, 1938]	
5.19		Taxation. [Please see the relevant sections of the Income Tax Act, 1961 applicable for payment of taxes by the Insurer]	
5.20		Any other parameter relevant to pricing of product –specify	
5.21		Reserving assumptions (please specify all the relevant	

		details)			
5.22		Base rate (risk premium)-furnish the rate table, if any			
5.23		Gross premium- furnish the rate table, if any			
5.24		Annualised Premium			
		5.24.1 Minimum			
		5.24.2 Maximum			
5.25		Expected loss ratio (for the product) -			
5.26		Age-wise loss ratio-	S.No	Age	Loss ratio
5.27		Sum insured-wise- loss ratio	S.No	SA	Loss ratio
5.28		Age and sum insured wise loss ratio -	Table given below (SI band and age bands shall be increased. The format given below is indicative.)		

S.NO	SI/Age bands	50,000	100000	150000	200000	250000	
1	>=0<=2						
2	>=3<=15						
3	>=16<=25						
4	>=26<=30						
5	>=31<=35						
6	>=36<=40						
7	>=41<=45						
8	>=46<=50						
9	>=51<=55						
10	>=56<=60						
11	>=61<=65						
12	>=66						

5.29		Expected combined ratio	
5.30		Age-wise combined ratio-	
5.31		Sum insured-wise- combined ratio	
5.32		Age and sum insured wise combined ratio - to be furnished for each option or plan separately	Table given below (SI band and age bands shall be increased. The format given below is indicative.)

S.NO	SI/Age bands	50,000	100000	150000	200000	250000	
1	>=0<=2						
2	>=3<=15						
3	>=16<=25						
4	>=26<=30						
5	>=31<=35						
6	>=36<=40						
7	>=41<=45						
8	>=46<=50						
9	>=51<=55						
10	>=56<=60						
11	>=61<=65						
12	>=66						

5.33		Expected cross-subsidy between age/sum insured	
5.34		Experience of similar products, if any for the preceding Five Financial Years	

S.No	Exposure	Premium – Rs.		Number of claims	Incurred claims -Rs.	Claim frequency	Average cost per claim	Burning cost-Rs.	Loss ratio	Combined ratio
FY										
FY-1										
FY-2										

	FY-3										
	FY-4										

		1. Exposure: earned life year (no of life earned during a particular financial year); 2. Premium: premium earned during the financial year; 3.Number of claims: claims occurred during the financial year; 4. Incurred claims: Incurred amount as of today for claims mentioned in "3"; 5. Claim frequency: No. of claims/ Exposure; 6. Average cost per claim: Incurred claims / No. of claims; 7. Burning cost: Claims frequency* Average cost per claim; 8. Loss ratio: Incurred claims/ Premium; 9. Combined ratio: Loss ratio + Expense ratio;			
5.35		**Results of Financial Projections/Sensitivity Analysis:** [The profit margins should be shown for various model points for base, optimistic and pessimistic scenarios in a tabular format below. The definition of profit margin should be taken as the present value of net profits to the p.v of premiums. Please specify assumptions made in each scenario. For terms less than or equal to one year loss ratio may be used and for terms more than one year, profit margin may be used.]			
5.36		Risk discount rate used in the profit margin			
5.37		Average Sum Insured Assumed			
5.38		Assumptions made under pessimistic scenario			
5.39		Assumptions made under optimistic scenario			
5.40		Age [PM: Profit Margin/Loss Ratio] [Age Band may be revisted based on the product design paratmeters]	*PM (base scenario)*	*PM (pessimistic scenario)*	*PM (optimistic scenario)*
		>=0<=2			
		>=3<=15			
		>=16<=25			
		>=26<=30			
		>=31<=35			

		>=36<=40			
		>=41<=45			
		>=46<=50			
		>=51<=55			
		>=56<=60			
		>=61<=65			
		>=66			
	Section VI: Enclosures to the Application: The following specimen documents should be enclosed:				
6.1		Technical Note on Pricing			
6.2		Proposal form, wherever necessary			
6.3		Premium Table			
6.4		Certificates by Appointed Actuary and Chief Compliance Officer			

Soft ware used for product design and monitoring --- (for information of the Authority)

The Insurer shall enclose a certificate from the Chief Compliance Officer, Appointed Actuary, countersigned by the principal officer of the insurer, as per specimen given below:(The language of this should not be altered)

Certification by Chief Compliance Officer:

I------- (Name of Chief Compliance Officer) the undersigned, on behalf of the Insurer named below, hereby affirm and declare as follows:

1. That the details of the (Name of product) filled in above are true and correct and reflect what the policy and other documents indicate.
2. That the product complies with the various provisions of the IRDAI Health Insurance Regulations, 2016, Guidelines on Standardization of Health Insurance, Product Filing,Guidelines on Standard Individual Health Insurance Product, issued thereon and the applicable provisions of extant IRDAI Regulations and all circulars issued by IRDAI from time to time.
3. That this application and all other documents are complete and have been verified for correctness and consistency not only in respect of each item of each document but also vis-a-vis one another.
4. I certify that the policy wordings and Customer Information sheet filed along with this application is in compliance with IRDAI (Health Insurance) Regulations, 2016, Product Filing Guidelines, Guidelines on Standardization of Health Insurance, Guidelines on Standard Individual Health Insurance Product issued thereon.

5. I further certify that the Prospectus submitted is in compliance with the applicable provisions of Rules, IRDAI Regulations and Guidelines on Product Filing and Insurance Advertisements.

Date: (Chief Compliance Officer)
Name of Insurer

Certification by Appointed Actuary:

" I, (**name of the appointed actuary**), the appointed actuary, hereby solemnly declare that the information furnished in this Application Form is true. I also certify that, in my opinion, the premium rates, advantages, terms and conditions of the above product are workable and sound, the assumptions are reasonable and premium rates are fair."

I have carefully studied the requirements of the Product Filing Procedure in relation to the design and rating of insurance products.

The rates, terms and conditions of the above mentioned product are determined on technically sound basis and are sustainable on the basis of the information and claims experience available in the records of the insurer.

An adequate system has been put in place for collection of data on premiums and claims based on every rating factor that will enable review of the rates and terms of the cover from time to time. It is planned to review the rates, terms and conditions of cover (--- mention periodicity of review) based on emerging experience.

It is further certified that the underwriting of the product now filed shall be within the Board approved underwriting philosophy of the Company.

The requirements of the Product Filing Procedure have been fully complied with in respect of this product or revision or modification of the product.

I further declare that except the Sections mentioned in S.No., no other feature/benefit/clause is modified in the product (applicable only for revision or modification of the product)

Place Signature of the Appointed Actuary

Date:

Certification by Principal Officer or CEO

I (name of the Principal Officer or CEO), (mention designation) hereby confirm that:

1. The rates, terms and conditions of the above-mentioned product filed with this certificate have been determined in compliance with the IRDA Act, 1999, Insurance Act, 1938, and the Regulations and guidelines issued there under, including the File and Use / Product Filing guidelines.

2. The prospectus, sales literature, policy and endorsement documents, and the rates, terms and conditions of the product have been prepared on a technically sound basis and on terms that are fair between the insurer and the client and are set out in language that is clear and unambiguous.

3. These documents are also fully in compliance with the underwriting and rating policy approved by the Board of Directors of the insurer.

4. The statements made in the filing Form -IRDAI-UNF-SCHP are true and correct.

5. The requirements of the Product Filing Guidelines have been fully complied with in respect of this product.

Date: Signature of Principal Officer or Designated Officer

Place: Name and designation along with Company's seal