Policy Wordings
Club Foot Insurance (Group)

Preamble & Operative Clause

Bharti AXA General Insurance Company Limited will provide insurance cover to the person(s) named in the Schedule based on the material facts recorded in the proposal and declaration made and only after agreed premium has been paid and realized by us in full.

We will pay the insured person(s) in respect of an insured event occurring during the policy period and subject to the Conditions, Sum Insured, Scope of Coverage, Territorial Limits, Endorsement, Deductible and Exclusions in the manner and to the extent set forth in this policy.

Definitions

Any words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy Schedule/Certificate of Insurance. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

- **"Accident"** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

- **"Clubfoot or Congenital Talipes Equinovarus"** is a condition in which one or both feet of a new born are twisted into an abnormal position at birth. The condition must be present in live births and must be confirmed by a pediatric orthopedist or by a specialist medical practitioner.

- **"Company/We/Our/Ours"** means Bharti AXA General Insurance Company Limited.

- **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

- **"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

- **"Dependent Child"** means a natural or legally adopted child, financially dependent on the Primary Insured.

- **"Disclosure to information norm"** means the policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of mis-representation, mis-description or non-disclosure of any material fact.

- **"Emergency care"** means management for an injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

- **"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:

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

- **"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
     V. it recurs or is likely to recur

- **"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.

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

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- **"Insured Person(s)/You/Your"** means the person(s) who named in the Schedule/Certificate of Insurance.

- **"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.

- **"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.

  The registered practitioner should not be the insured or close member of the family.

- **"Newborn baby"** means baby born during the Policy Period.

- **"Notification of claim"** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

- **"Policyholder"** means an Individual/Organisation/Association in whose name the policy has been issued and should have an insurable interest to cover the insured person(s) under the policy.

- **"Policy Period"** means the period between the inception date and the expiry date specified in the Schedule.

- **"Policy Schedule"** means the document attached to and forming part of this Policy mentioning the details of the Insured Person(s), the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

- **"Pre-Existing Condition"** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice/treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

- **"Renewal"** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

- **"Schedule"** means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

- **"Senior citizen"** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

- **"Subrogation"** means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

- **"Sum Insured"** means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

- **"Surgery or Surgical Procedure"** means manual and/or operative procedure (s) required for treatment of an 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.

- **"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.

Scope of Cover

- **Accidental Death Benefit -** If any Insured Person sustains Injury during the policy period which directly and independently of all other causes result in death within 12 Months from the date of accident, the company agrees to pay to the Insured Person's Nominee, Beneficiary or legal representative, the Sum Insured specified in the Schedule/Certificate of Insurance.

  Once this benefit is paid, this coverage would cease for the respective Insured Person.

- **Club-Foot impairment (Newborn baby). -** If any Insured Person gives birth to a newborn baby and the baby is diagnosed with Club-Foot impairment during the policy period, the Company agrees to pay to the policyholder, the fixed sum insured specified in the Schedule/Certificate of Insurance towards the treatment of the newborn baby covered under the policy.

  This benefit is payable once during the lifetime of the newborn baby covered under the policy. Once this benefit is paid against any newborn baby covered under the policy, this coverage would cease for the newborn baby covered under the policy.

- **Transportation Charges (Newborn baby). -** If any newborn baby covered under the policy is diagnosed with Club-Foot impairment during the policy period, the Company agrees to pay to the policyholder, the fixed sum insured specified in the Schedule/Certificate of Insurance towards expenses incurred whilst travelling from the place of residence to the Hospital/ Nursing Home for treatment of Club-Foot.

  The liability of the Company arises only if there is admissible claim under Club-Foot impairment (Newborn baby) Section.

- **Club-Foot impairment (Primary Insured) -** If any Insured Person who is covered under the policy and suffering from an external congenital disorder present by birth and has been diagnosed for the first time during the policy period as Club-Foot or taking follow-up treatment for Club-Foot during the policy period,

the Company agrees to pay to the policyholder, the fixed sum insured specified in the Schedule/Certificate of Insurance towards the treatment of the Insured Person covered under the policy.

This benefit is payable once during the lifetime of Insured Person covered under the policy. Once this benefit is paid against Insured Person covered under the policy, this coverage would cease for the Insured Person covered under the policy.

Benefit under the Club-Foot impairment (Primary Insured) is payable upon satisfying the following conditions:-

- Nature of the abnormality should be external congenital in nature that has been confirmed by a pediatric orthopedist or by a specialist medical practitioner as "Club-Foot impairment"

- If the Club-Foot impairment is curable in nature i.e., age at the beginning of treatment influences the rate of successful correction that is confirmed by a pediatric orthopedist or by a specialist medical practitioner. This shall also include the Primary Insured who have Pre-existing Club-Foot and undergoing treatment for correction of the impairment

Specific Exclusion:
If the nature & extent of Club-Foot impairment is such that no medical treatment can be successfully performed to correct the deformity after a certain age or other health conditions that shall adversely affect the treatment of Club-Foot impairment.

- **Transportation Charges (Primary Insured) -** If any Insured Person who is covered under the policy and suffering from an external congenital disorder present by birth and has been diagnosed for the first time during the policy period as Club-Foot or taking follow-up treatment for Club-Foot during the policy period, the Company agrees to pay to the policyholder, the fixed sum insured specified in the Schedule/Certificate of Insurance towards expenses incurred whilst travelling from the place of residence to the Hospital/ Nursing Home for treatment of Club-Foot.

The liability of the Company arises only if there is admissible claim under Club-Foot impairment (Primary Insured) Section.

General Exclusions

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

- Through suicide, attempted suicide (whether sane and insane) or intentionally self-inflicted injury or illness, including abstinent from a normal behavior of having food.
- Mental or nervous disorder, anxiety, stress or depression,
- Whilst engaging in Adventure Sports. .The list of adventurous sports are Water Rafting, Wildlife/Jeep Safaris, Trekking, Camping, Boat safaris, Parasailing, Paragliding, Elephant/Camel/Horse/Yak Safaris, Cycling, House Boat stays, Motor Bike tours, Kayaking, Rock Climbing, Artificial Wall Climbing, Bungee Jumping, Paintball, Suba Diving, Hot Air Ballooning, Canoeing, Mountain Biking, Rappelling, Snorkeling, Zip wires & high Rope course, Abseiling, Surfing, Water Skiing, Skiing, Caving, Self-Drive tours,

Mountaineering/Hiking, All Terrain Vehicle, Hang Gliding, Snowboarding, Ultra-Light flying, Heli-skiing, Sky Diving.

- While under the influence of liquor or drugs , alcohol or other intoxicants,
- Through deliberate or intentional, unlawful or criminal act, error, or omission, participation in an actual or attempted felony, riot, crime, misdemeanor, civil commotion,
- Whilst engaging in aviation, whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world,
- Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs,
- As a result of any alternative forms of medicines like chiropractic treatments etc.
- Arising out of your participation in any police ,naval, military or air force operations whether peace or in war in the form of military exercises or war games or actual engagement with the enemy, Whether foreign or domestic,
- Your consequential losses of any kind or your actual or alleged legal liability.
- Venereal or sexually transmitted diseases,
- HIV (Human Immunodeficiency Virus) and/or any HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and/or mutant derivatives or variations thereof however caused,
- Any claims arising out of pregnancy, resulting childbirth, miscarriage, abortion, or complications arising out of any of these, except where the Insured Person gives birth to a baby who is born with clubfoot
- War (whether declared or not), civil war, invasion, act of foreign enemies, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraint or detainment, confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority, or
- Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from burning nuclear fuel,
- The radioactive, toxic, explosive or other dangerous properties of any explosive nuclear equipment or any part of that equipment,
- Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft; or Scheduled Airlines
- No benefit under Club-Foot impairment & Transportation Charges would be paid under this policy, unless the nature & extent of Club- Foot impairment is established medically with appropriate investigation reports & certified by the pediatric orthopedist or by a specialist medical practitioner.
- While engaged in hazardous activity unless specifically covered under the policy
- Expenses incurred on any external aid /devices, unless specifically required for the treatment of Club-Foot impairment.
- Any medical expenses on indemnity basis including but not limited to Maternity expenses**.**

General Conditions:

I. Duty of Disclosure:

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material facts in the Proposal/Enrolment Form,

personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or device being used by the Policyholder/Insured Person or any one acting on their behalf to obtain a benefit under this Policy.

II. Consideration :

The Frequency of Premium payable under the policy and or each Certificate of the Insurance issued under this Policy shall be made annually or on installment basis.

- Annual Premium - premium is payable before the beginning of each 12 month period when the annual premium is due.

  Installment Premium – premium is payable and realized in full by the Company in equated installments (as the case may be) before the installment due date. There shall be no installment grace period and policy shall terminate and no claim shall be payable in the event of premium not being paid within the installment due date.

III. Observance of terms and conditions:

The due observance and fulfillment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Policyholder/Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

IV. Material Change:

The Policyholder/ Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Policyholder's/Insured person's own expense. The Company may, adjust the scope of cover and/or the premium, if necessary, accordingly.

V. Fraudulent Claims:

If any claim 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 Policyholder/Insured Person or anyone acting on their behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this condition as well as Duty of Disclosure condition of this Policy.

VI. No Constructive Notice:

The Company shall not take notice of any information relating to the Policyholder/Insured person unless such information is submitted in writing by the Policyholder/Insured person, even if such information was available with the Company.

VII. Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Insured Person or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

VIII. Special Provisions:

Any special provisions subject to which this Policy has been entered into and endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

IX. Electronic Transaction:

The Policyholder/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDAI regulations for protection of Policy holder's interests.

X. Duty of the Insured on occurrence of loss/event leading to claim

On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Policyholder/Insured Person shall:

- Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
- Allow the Medical Practitioner or any representative of the Company to inspect the medical and hospitalization records and to examine the Insured Person
- Assist and not hinder or prevent the Company or any of its representatives in pursuance of their duties

In case the Policyholder/Insured Person does not comply with the provisions of this clause or other obligations cast upon the Policyholder/Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

XI. Right to Investigate:

If required by the Company, an agent/representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured Person, be permitted at all reasonable times to investigate into the circumstances of such loss/event leading to claim. The Insured Person or his representatives shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of

them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of investigation required under this section.

XII. Multiple policies:

If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder 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 who has issued the chosen policy 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.
- Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy/policies.
- If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

The points mentioned above shall not apply for claims payable on Benefit basis.

XIII. Forfeiture of claims:

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

XIV. Free Look Period:

Insured/ Policyholder has a period of 15 days from the date of receipt of the Policy document/Certificate of Insurance to review the terms and conditions of this Policy/Certificate of Insurance. If the Insured/ Policyholder has any objections to any of the terms and conditions, he/she have the option of cancelling the Policy/Certificate of Insurance stating the reasons for cancellation and in such a case, the Company will refund premium subject to ;

- A deduction of the expenses incurred on stamp duty charges, if the risk has not commenced.
- A deduction of the expenses incurred on stamp duty charges and proportionate risk premium for period on cover, if the risk has commenced.
- A deduction of such proportionate risk premium in commensuration with the risk covered during such period, where only a part of risk has commenced.

The Policy can be cancelled only if there is no claim under the Policy.

Free look provision is not applicable and/or available at the time of renewal of the Policy.

XV. Cancellation:

Single Policy/Master Policy

The Company may cancel this Policy, by giving 15 days' notice in writing/e-mail registered with us acknowledgment due to the Policyholder at his / their last known address. The Company shall exercise its right to cancel only on grounds of mis-representation, fraud, non-disclosure of material facts, in which case the policy shall be void and all premium paid thereon shall be forfeited to the Company as per the disclosure to information norm. In case of non-cooperation of the Policyholder in implementing the terms and conditions of this Policy the policy shall be cancelled and premium shall be refunded on ratable proportion provided that no claim has/is occurred/reported up to the date of cancellation of this Policy.

The Policyholder may also give 15 days' notice in writing/ e-mail registered with us, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice, cancel the Policy and retain the premium for the period this Policy has been in force as opted for by the Policyholder and mentioned in the Renewal & Refund section of this Policy. Provided that, refund on cancellation of Policy by the Insured shall be made only if no claim has/is occurred/reported up to the date of cancellation of this Policy.

The Policy will terminate at the expiration of the period for which premium has been paid or on Expiration Date shown in the Policy Schedule, whichever is earlier.

Certificate of Insurance

Each Certificate of Insurance will terminate on the earliest of the following dates:

1. The date the master Policy is terminated,
2. The date when the insured person or Company cancels the Certificate of Insurance.
3. The date the Insured person ceases to be part of the group unless specified otherwise.
4. The date of Expiry of the Certificate
5. Instalment premium is not received within the installment due date.

The Company may cancel this Certificate of Insurance, by giving 15 days' notice in writing/ e-mail acknowledgment due to the Insured at his / their last known address. The Company shall exercise its right to cancel only on grounds of mis-representation, fraud, non-disclosure of material facts of the Insured/ Insured Person in which case the Certificate of Insurance shall be void and all premium paid thereon shall be forfeited to the Company as per the disclosure to information norm.

In case of non-cooperation of the Insured/Insured Person(s) in implementing the terms and conditions of this Policy the policy shall be cancelled and premium shall be refunded on ratable proportion provided that no claim has/is occurred/reported up to the date of cancellation of this Policy

The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this Certificate of Insurance, in which case the Company shall from the date of receipt of notice, cancel the Certificate of Insurance

and retain the premium for the period this Certificate of Insurance has been in force, as opted for by the Policyholder and mentioned in the Renewal & Refund section of this Policy. Provided that, refund on cancellation of Certificate of Insurance by the Insured shall be made only if no claim has/is occurred/reported up to the date of cancellation of this Certificate of Insurance

XVI. Territorial Limits/Currency of payment:

The coverage shall be restricted to the Territorial limits of India. All claims shall be payable in India in Indian Rupees only.

XVII. Policy Disputes:

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Policyholder and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

XVIII. Renewal & Refund:

The premium for renewal will be applicable as per the premium quote issued by the company based on Sum Insured; Change in group size, past policy claims history and any other relevant factors affecting the risk of the group.

In the likelihood of this Policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the Policy. Insured will have the option to migrate to other plan under similar health insurance Policy at the time of renewal, provided the Policy is maintained without a break.

The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDAI) and inform the same to the Insured at least 3 months prior to the effective date of revision and/ or modification or renewal

All applications for renewal of the Policy must be received by us before the expiry of current Policy.

Refund: As opted for by the Policyholder and indicated in the Master Policy refund will be done in the following proportion:

Annual Policy

Period on risk	**% Return Premium**
Upto 1 month	3/4th of the annual rate
Upto 3 months	½ of the annual rate
Upto 6 months	1/4th of annual rate
Exceeding 6 months	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured Person where any claim has been admitted by the Company or has been lodged with the Company.

XIX. Inclusion of members under the Policy:

New Person can be added to this Policy, either by way of endorsement/ Certificate of Insurance in case of mid-term inclusion or at the time of renewal subject to acceptance by the Company.

XX. Renewal Notice:

The Company shall not be bound to accept any renewal premium or to give notice that such is due.

XXI. Entry Age There is no restriction on minimum entry age. The Maximum entry age is restricted to 85 Years.

XXII. Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to;

- In case of the Policyholder/Insured Person, at the address given in the Schedule to the Policy/Certificate of Insurance.
- In case of the Company, to the Policy issuing office/nearest office of the Company.

SECTION 5- GRIEVANCES REDRESSAL PROCEDURE

The Company is committed to extend the best possible services to its customers. However, If Policyholder/Insured Person have a grievance that he/she wish us to redress, he/she may contact the Company with the details of their grievance via:

- Website : www.bharti-axagi.co.in
- Email : customer.service@bharti-axagi.co.in
- Phone : 080-49123900
- Courier : Any of the Company's Branch office or corporate office

Policyholder/Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Escalation Level 1

For lack of a response or if the resolution still does not meet the expectations through one of the above methods, Policy holder/Insured/ Insured Person may contact the Company's Head of Customer Service at.

Bharti AXA General Insurance Co. Ltd.,

First Floor, The Ferns Icon,

Survey No. 28 Next to Akme Ballet, Doddanekundi,

Off Outer Ring Road, Bangalore – 560037

Escalation Level 2

In case the Policy holder/Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, If Policy holder/Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, they may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below. Policy holder/Insured/Insured Persons may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.

- Website : www.bharti-axagi.co.in
- Email : customer.service@bharti-axagi.co.in
- Phone : 080-49123900
- Courier : Any of the Company's Branch office or corporate office

Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

List of Ombudsmen

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@GBIC.CO.IN	**OFFICE OF THE INSURANCE OMBUDSMAN,** JEEVAN SOUDHA BUILDING, PID NO. 57-27-N-19 GROUND FLOOR, 19/19, 24TH MAIN ROAD, JP NAGAR, IST PHASE, **BENGALURU – 560 078.** **TEL:** 080 - 26652048 / 26652049 **EMAIL:** BIMALOKPAL.BENGALURU@GBIC.CO.IN
OFFICE OF THE INSURANCE OMBUDSMAN, JANAK VIHAR COMPLEX, 2ND FLOOR, 6, MALVIYA NAGAR, OPP. AIRTEL OFFICE, NEAR NEW MARKET, **BHOPAL – 462 003.** **TEL:** 0755 - 2769201 / 2769202	**OFFICE OF THE INSURANCE OMBUDSMAN,** 62, FOREST PARK, **BHUBNESHWAR – 751 009.** **TEL:** 0674 - 2596461 /2596455 **FAX:** 0674 - 2596429 **EMAIL:**

FAX: 0755 - 2769203 **EMAIL:** BIMALOKPAL.BHOPAL@GBIC.CO.IN	BIMALOKPAL.BHUBANESWAR@GBIC.CO.IN
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@GBIC.CO.IN	**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@GBIC.CO.IN
OFFICE OF THE INSURANCE OMBUDSMAN, 2/2 A, UNIVERSAL INSURANCE BUILDING, ASAF ALI ROAD, **NEW DELHI – 110 002.** **TEL:** 011 - 23239633 / 23237532 **FAX:** 011 - 23230858 **EMAIL:** BIMALOKPAL.DELHI@GBIC.CO.IN	**OFFICE OF THE INSURANCE OMBUDSMAN,** JEEVAN NIVESH, 5TH FLOOR, NR. PANBAZAR OVER BRIDGE, S.S. ROAD, **GUWAHATI – 781001(ASSAM).** **TEL:** 0361 - 2132204 / 2132205 **FAX:** 0361 - 2732937 **EMAIL:** BIMALOKPAL.GUWAHATI@GBIC.CO.IN
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 - 65504123 / 23312122 **FAX:** 040 - 23376599 **EMAIL:** BIMALOKPAL.HYDERABAD@GBIC.CO.IN	**OFFICE OF THE INSURANCE OMBUDSMAN,** JEEVAN NIDHI – II BLDG., GR. FLOOR, BHAWANI SINGH MARG, **JAIPUR - 302 005.** **TEL:** 0141 - 2740363 **EMAIL:** BIMALOKPAL.JAIPUR@GBIC.CO.IN
OFFICE OF THE INSURANCE OMBUDSMAN, 2ND FLOOR, PULINAT BLDG., OPP. COCHIN SHIPYARD, M. G. ROAD, **ERNAKULAM - 682 015.** **TEL:** 0484 - 2358759 / 2359338 **FAX:** 0484 - 2359336 **EMAIL:** BIMALOKPAL.ERNAKULAM@GBIC.CO.IN	**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@GBIC.CO.IN
OFFICE OF THE INSURANCE OMBUDSMAN, 6TH FLOOR, JEEVAN BHAWAN, PHASE-II, NAWAL KISHORE ROAD, HAZRATGANJ, **LUCKNOW - 226 001.** **TEL:** 0522 - 2231330 / 2231331 **FAX:** 0522 - 2231310 **EMAIL:** BIMALOKPAL.LUCKNOW@GBIC.CO.IN	**OFFICE OF THE INSURANCE OMBUDSMAN,** 3RD FLOOR, JEEVAN SEVA ANNEXE, S. V. ROAD, SANTACRUZ (W), **MUMBAI - 400 054.** **TEL:** 022 - 26106552 / 26106960 **FAX:** 022 - 26106052 **EMAIL:** BIMALOKPAL.MUMBAI@GBIC.CO.IN
OFFICE OF THE INSURANCE OMBUDSMAN, JEEVAN DARSHAN BLDG., 3RD FLOOR, C.T.S. NO.S. 195 TO 198, N.C. KELKAR ROAD, NARAYAN PETH, **PUNE – 411 030.** **TEL:** 020-41312555 **EMAIL:** BIMALOKPAL.PUNE@GBIC.CO.IN	**OFFICE OF THE INSURANCE OMBUDSMAN,** 1ST FLOOR,KALPANA ARCADE BUILDING,, BAZAR SAMITI ROAD, BAHADURPUR, **PATNA 800 006.** **TEL:** 0612-2680952 **EMAIL:** BIMALOKPAL.PATNA@GBIC.CO.IN

OFFICE OF THE INSURANCE OMBUDSMAN, BHAGWAN SAHAI PALACE 4TH FLOOR, MAIN ROAD, NAYA BANS, SECTOR 15, DISTT: GAUTAM BUDDH NAGAR, **U.P-201301.** **TEL:** 0120-2514250 / 2514252 / 2514253 **EMAIL:** BIMALOKPAL.NOIDA@GBIC.CO.IN	

SECTION 6: CLAIM SERVICING:

I. Claim Notification - Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured Person/Insured Person's representative to intimate the claim to the Company. The intimation can be given in following ways:

- Toll Free call Centre of the Insurance Company (24x7) – 1800-103-2292
- Login to the Company's website and intimate the claim – http://www.bharti-axagi.co.in/contact-us
- Send an email to the Company- claims@bharti-axagi.co.in or BAGIClaims.Commercial@Bharti-axagi.co.in
- Post/courier to the Company - Bharti AXA General Insurance Company Limited, 1st Floor, 102 - Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063
- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 1st Floor, 102 - Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063

In all the above, the intimations are directed to a central team for prompt and immediate action.

II. Information Details

- Insured Person/Insured Person's representative should intimate the claims within 7 working days upon occurrence of the event. The Notification of Claim should be ideally provided by the Insured Person or his representative.

However, if there is a genuine reason for delay in intimation, the Company shall not enforce any penalty if the admissibility of the claims is not contested upon.

When the Insured Person/Insured Person's representative intimates a claim as mentioned above the following information should be given for prompt services.

- Aadhar Card No. (if available)
- Master Policy number
- Certificate number
- Name of the Policyholder
- Name of Insured Person making the claim

- Contact details
- Nature of the Claim
- Name and address, phone number of the attending medical practitioner/hospital.

For Accidental Death Claim

- Police Report
- Post Mortem report (if applicable)
- Inquest and Spot Panchnama
- Death Certificate
- Viscera Report (if any)

For Club-Foot impairment Claim

- Date of Hospitalization
- Date of Child delivery
- Certificate from the treating doctor
- Medical & diagnostic reports

III. Claim Form

Upon the notification of the claim, The Company shall assist the Insured person/ Insured Person's nominee/ legal heir to access the claim form electronically through web download, email or visit to the nearest branch of the Company.

Alternatively, the Company will dispatch the claim form to the Insured person/ Insured Person's nominee/ legal heir.

IV. Claim Procedure

- The Company shall be under no obligation to make any payment under this Policy unless all the premium payments are received in full and all payments have been realized.
- The Company will only make payment as per the Policyholder's direction. In case of Insured Person's unfortunate demise, the Company will only make payment to the Assignee or Nominee (as named in the Policy Schedule/Certificate of Insurance).
- When there is an Instalment facility - if Insured Person makes a claim under the policy (applicable for both annual and multi-year policy), Insured Person will be liable to pay the premium for the entire policy period in full and premium shall be realized by the Company in full, before the claim is paid or Insured Person authorizes us to deduct from claim amount due any outstanding premiums due.
- The Company will process the claims and make claim payments.
- If there is any deficiency in the documents/ information submitted by Insured person, the Company will send the deficiency letter within 7 days of receipt of the claim documents.
- On receipt of the complete set of claim documents to the Company's satisfaction, the Company will send offer of settlement, along with a settlement statement within 30 days to the insured. Payment will be made within 7 days of receipt of acceptance of such settlement offer.

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, the offer of settlement /Rejection of claim with reasons will be made to the Insured in any case not later than 30 days maximum. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid, The period of 7 days mentioned above is included in the maximum period of claim settlement (30 days) stated above.

V. Documents

It is the Policy of the Company to seek documents in a single request. Based on documents submitted, if any further documentation is required then it will be sought promptly, at the earliest.

In cases where investigation is deemed necessary, the same will be conducted in all promptitudes. Every attempt will be made to keep the process transparent.