CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai – 600 001.
Toll free: 1800 208 5544, T: +91 (0) 44 4044 5400, F: +91 (0) 44 4044 5550
E: customercare@cholams.murugappa.com; website: www.cholainsurance.com
IRDA Regn. No.123**; PAN** AABCC6633K **CIN** U66030TN2001PLC047977

Chola Hospital Cash Healthline (Revision)
CHOHLIP21301V022021
Policy Wordings

CHOLA HOSPITAL CASH HEALTHLINE (REVISION)

Sections

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
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Chola Hospital Cash Healthline (Revision)

CHOHLIP21301V022021

Section 1 – Customer Information Sheet			
S No	Title	Description	Policy Clause Number
1	Product Name	Approved Brand Name	Chola Hospital Cash Healthline (Revision)
2	What am I covered for:	Hospital admission longer than 24 hrs	Section 3 Coverages 3.1
		Hospital Admission in ICU longer than 24 hrs	Section 3 Coverages 3.1
		Lumpsum benefit for Hospitalisation more than 20 continuous days	Section 3 Coverages 3.1
3	What are the Major exclusions in the policy:	War or any act of war, invasion, acts of foreign enemies, hostilities whether are be declared or not, civil war, revolution, insurrection, mutiny, martial law	Section 5 Exclusions 5.2.13
		Breach of law: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. **Code – Excl 10**	Section 5 Exclusions 5.2.6
		Vaccination or inoculation unless forming a part of post-animal bite treatment **Refer policy wordings for detailed list of exclusions**	Section 5 Exclusions 5.2.17
4	Waiting period	Initial Waiting period: 30 days for all illness (not applicable on renewal and for accidents)	Section 5 Exclusions 5.1.3
		Specific Waiting period: - 24 months for 17 diseases (clauses (i) to (xvii))	Section 5 Exclusions 5.1.2
		Pre-existing diseases: covered after 48 months	Section 5 Exclusions 5.1.1
5	Payment basis	Cashless Basis Reimbursement Basis Reimbursement of 50% of the cost of pre policy health checkup	Not Applicable Benefit basis Coverage 3.1.1 and 3.1.2 6 General Conditions – 6.5
6	Loss sharing	In case of a claim, this policy requires you to share the following costs: - Expenses exceeding the following sub-limits	Not applicable
7	Renewal Conditions	The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person, Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years	Section 6 General condition 6.21
8	Renewal Benefits	Not Applicable	Not applicable
9	Cancellation	The Policy shall be cancelled by us for misrepresentation, fraud, non-disclosure of material facts of insured by giving 15 days written notice	Section 6 General condition 6.26

Chola Hospital Cash Healthline (Revision)
CHOHLIP21301V022021
Policy Wordings

		The Policy Holder may also cancel the policy at any time during the currency of the policy in which case the refund shall be on short period rates as per Policy condition	
10	Claims	Claim Documents as listed in the Policy Terms have to be submitted at the earliest possible opportunity not exceeding 30 days from date of discharge.	Section 6 General condition 6.17
11	Policy Servicing/ Grievances/ Complaints	In case of any grievance the insured person may contact the company through Website :www.cholainsurance.com Toll free: 1800 208 5544 E-Mail: customercare@cholams.murugappa.com Fax : 044 -4044 5550 Courier: **Cholamandalam MS General Insurance Company Limited, Customer services,** Head Office, **Dare House** 2nd floor, No 2 N.S.C. Bose Road, Chennai 600 001 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 GRO@cholams.murugappa.com If Insured Person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management system https://igms.irda.gov.in/	Section 7 Grievance Redressal Mechanism
12	Insured's Rights	• Free Look: Insured will have a free look period of 15 days from the date of receipt of this policy to review the terms and conditions of the policy and to return the same if not acceptable. • The policy will be renewed so long as the Insurer receives the premium unless on grounds of misrepresentation, fraud by the Insured. • Migration: Proposer should approach the insurer atleast 30 days before the premium	Section 6 General Conditions 6.4,6.21,6.27,6.25,6.24,6.17

		renewal date of his/her existing policy for the purpose of migration Portability: The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability • Sum Insured can be enhanced at the time of renewal subject to reported claim status and health condition of the Insured. • Insured has to send us written request for the above service requests to our customer services at the email id customercare@cholams.murugappa.com or to the Company address as mentioned in the Policy Schedule • Claim Settlement: We shall settle claims, including its rejection, within thirty days of the receipt of last `necessary' document.	
13	Insured's Obligations	• Insured is at obligation to disclose all pre-existing diseases or condition in the Proposal form. In the event of misrepresentation, mis-description or non-disclosure of any material fact by the Insured, the Policy shall be void and all premium paid hereon shall be forfeited to the Company and no claims shall be payable. • Insured can contact our Customer Services over phone at the toll free no. 1800 208 5544 or write to us at customercare@cholams. murugappa.com to intimate any change to the material information affecting the policy.	Section 6 –General Conditions 6.2

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.

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We issue this insurance policy to You and/or Your Family based on the information provided by You / Proposer in the proposal form and premium paid by You/ Proposer. This insurance is subject to the following terms and conditions. This policy covers you and Your Family on Individual Sum Insured basis. The term **You/ Your / Insured Person /Insured/ Policyholder/ Proposer** in this document refers to **You and all the Insured persons** covered under this policy. The term **Insurer/ Us/ our/ Company** in this document refers to **Cholamandalam MS General Insurance Company Limited.**

Section 1 : SCHEDULE OF BENEFITS

Benefits in the table below should be read in conjunction with Section 3 Coverages and Section 4 Definitions

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Hospitalization Cash Benefit - Illness / Accident. (more than 24 hrs hospitalisation)	Rs 1000 per day upto 20 days	Rs 2000 per day upto 20 days	Rs 3000 per day upto 20 days	Rs 1000 per day upto 25 days	Rs 2000 per day upto 25 days	Rs 3000 per day upto 25 days
Hospitalisation Cash Benefit - Intensive Care unit (more than 24 hrs hospitalisation in ICU)	Twice the limit of Daily Cash Benefit shown above per day upto 20 days	Twice the limit of Daily Cash Benefit shown above per day upto 20 days	Twice the limit of Daily Cash Benefit shown above per day upto 20 days	Twice the limit of Daily Cash Benefit shown above per day upto 25 days	Twice the limit of Daily Cash Benefit shown above per day upto 25 days	Twice the limit of Daily Cash Benefit shown above per day upto 25 days
Convalescence Benefit (Lump sum payment on continuous 20 days of hospitalisation)	Rs 10000	Rs 15000	Rs 20000	Rs 10000	Rs 15000	Rs 20000

Benefits under Hospitalisation Cash or Hospitalisation cash –ICU put together will be paid for a maximum of 20 days per person in a policy year for Plans A / B / C and for a Maximum period of 25 days per person in a policy year for plans D/E/F

Section 2 : COVERAGES

Upon the happening of the events under sections 3.1 below during the policy period, we will pay the policyholder a daily benefit in respect of medically necessary costs as mentioned in the schedule of benefits and as per the General Conditions in Section 6 of this policy.

3.1 Benefits under this policy

3.1.1 Hospital Cash Benefit:

In the event of hospitalization in India of the Insured Person due to any illness or due to accidental injuries for a consecutive period of more than 24 hrs, a daily benefit based on the plan opted as mentioned in the Schedule of the Policy is payable for a maximum of 20 /25 days as shown in the schedule of benefits during a policy year.

In case the hospital confinement is in an Intensive Care Unit for a period of more than 24 hours, the Daily Benefit payable as above shall stand doubled for the period of ICU confinement.

Only one daily benefit is payable for any one day of hospital confinement, regardless of number of the number of sicknesses, or diseases for which the confinement is required.

3.1.2 Convalescence Benefit:
For Hospital Confinement in India beyond 20 consecutive days a fixed amount based on the Plan opted as mentioned in the schedule is payable towards convalescence, in addition to the Hospital Confinement benefit. This benefit is payable only once per illness / accident / policy. This benefit is payable in addition to 3.1.1 only if there is an admissible claim under Hospital Confinement Cash benefit as per benefit 3.1.1 above.

Section 3 : D E F I N I T I O N S

To help **You** understand **Your Policy** the following words and phrases used anywhere within **Your Policy** have specific meanings, which are set out in this section.

1. **Accident means** a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Acquired Immune Deficiency Syndrome (AIDS)** means the meaning assigned to it by the World Health Organization and shall include Human Immune deficiency Virus (HIV), Encephalopathy (dementia) HIV Wasting Syndrome and ARC (AIDS Related Condition)
3. **Age** means completed years on Your last birthday as per the English Calendar regardless of the actual time of birth, at the time of commencement of Policy Period
4. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context
5. **Annual Period** refers to a continuous period of insurance of 12 months within the contract period.
6. **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.
7. **Claims Team** means the Claims administration team within Chola MS General Insurance Company
8. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
9. **Congenital Anomaly** means a condition which is present since birth, 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.
10. **Day care Procedure/ treatment** refers to medical treatment and/or surgical procedure which is
    a. undertaken under general or local anesthesia in a hospital / day care centre in less than 24 hours because of technological advancement and
    b. which would have otherwise required hospitalization of more than 24 hours

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
11. **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery
12. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/ her independent sources of income.
13. **Dependents** refer to family members listed below, who is financially dependent on the Primary Insured or proposer and does not have his / her independent sources of income. Spouse, dependent children, Parents, Parents-in-law, siblings.
14. **Diagnosis** means the identification of a disease/illness/medical condition made by a Medical Practitioner supported by clinical, radiological and histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to us
15. **Diagnostic Test** means investigations such as X-ray or blood tests to find the cause of Your symptoms and medical condition
16. **Disclosure to information norm:** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
17. **Emergency Care** means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.
18. **Endorsement** means written evidence of change to the insurance Policy including but not limited to increase or decrease in the policy period, extent and nature of the cover agreed by the Company in writing
19. **Excluded hospital** means any hospital which is excluded from the hospital list of the company, due to fraud or moral hazard or misrepresentation indulged by the hospital.

Chola Hospital Cash Healthline (Revision)
CHOHLIP21301V022021
Policy Wordings

20. **Grace period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of *preexisting diseases*. Coverage is not available for the period for which no premium is received
21. **Hospital** means any institution established for inpatient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    - has qualified nursing staff under its employment round the clock;
    - has at least 10 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;
    - has qualified medical practitioner(s) in charge round the clock;
    - has a fully equipped operation theatre of its own where surgical procedures are carried out;
    - maintains daily records of patients and makes these accessible to the insurance company's authorized personnel
22. **Hospitalisation** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours
23. **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** 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** is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires rehabilitation for the patient or for the patient to be specially trained to cope with it—it continues indefinitely—it recurs or is likely to recur.
24. **Inception Date** means the commencement date of the coverage under this Policy as specified in the Policy Schedule
25. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner
26. **In Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event
27. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards
28. **Long Term** means the continuous period of insurance more than 12 months with in the Policy period.
29. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
30. **Maternity Expenses** shall include
    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
31. **Medical Practitioner/Doctor** means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.
    The registered practitioner should not be the insured or close family members.
32. **Medical Practitioner** is 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 family members of the insured.

33. **Medically necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    a. is required for the medical management of the illness or injury suffered by Insured;
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a medical practitioner;
    d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
34. **Migration** means the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
35. **Network Provider/ Hospital** mean Hospitals or health care providers enlisted by the insurer to provide medical services to an insured on payment by a cashless facility. The list is available with the insurer and subject to amendment from time to time.
36. **Non- Network** means any hospital, day care centre or other provider that is not part of the network.
37. **Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
38. **Policy** means the policy schedule (including endorsements if any), the terms and conditions in this document, any annexure thereto (as amended from time to time) and your statements in the Proposal form.
39. **Policy period** means the period between the inception date and earlier of
    a. The Expiry Date specified in the Schedule
    b. The date of cancellation of this Policy by either Policyholder or Insurer in accordance with General Condition (6.26) below.
    c. In a multi Tenure Policy, a policy year would be reckoned from the date of inception to 12 months of continuous cover.
40. **Policy Schedule** means that portion of the Policy which sets out Your personal details, the type and plan of insurance cover in force, the Policy duration and sum insured etc. Any Annexure or Endorsement to the Schedule shall also be a part of the Schedule.
41. **Pre-existing Disease means any condition, ailment, injury or disease:**
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement or
    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
42. **Portability** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
43. **Proposal Form:** The form in which the details of the insured person are obtained for a Health Insurance Policy. This also includes information obtained over phone or on the internet and stored on any electronic media and forms basis of issuance of the policy
44. **Proposer** means the person who has signed in the proposal form and named in the Schedule. He may or may not be insured under the policy
45. **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
46. **Schedule of Benefits** means the table of benefits, with the limit of Sum Insured under each benefit, that will be paid by us as per the plan opted by you.
47. **Hospitalisation cash benefit** means the amount shown in the policy schedule which shall be our maximum liability per day of admissible normal Hospitalisation for each Insured Person during the Annual Period (i.e per annum for multi year tenure) within the policy period
48. **Hospitalisation cash benefit – ICU** means the amount shown in the policy schedule which shall be our maximum liability per day of admissible ICU Hospitalisation for each Insured Person during the Annual Period (i.e per annum for multi year tenure) within the policy period.

49. **Surgery** or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner
50. **Unproven/Experimental treatment** is treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven.
51. **Waiting period** refers to the period during which we shall not be liable to make any payment for any claim for treatment. This is not applicable if caused directly due to an accident during the policy period.

Section 4 : E X C L U S I O N S

5.1.1 Pre-Existing Diseases – Code – Excl01:

a) Expenses related to the treatment of a Pre-Existing Disease(PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

5.1.2. Specified disease/procedure waiting period – Code – Excl02:

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of first 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures are as below
    1. Congenital Internal Diseases,
    2. Varicose veins and Varicose Ulcers
    3. Rheumatism and arthritis of any kind
    4. Treatment of diseases on ears/ tonsils /adenoids /paranasal sinuses / Deviated Nasal Septum
    5. Stones in the Urinary and Biliary systems
    6. Gastric or Duodenal Ulcer
    7. Any type of benign Cyst/ Nodules/ Polpys/ Tumours/ Breast Lumps
    8. Intervertebral Disc Prolapse, and Degenerative Disc / vertebral Disorders
    9. Cataract
    10. Benign Prostatic Hypertrophy
    11. Myomectomy, Hysterectomy unless because of malignancy
    12. Dilatation and curettage (D&C)
    13. Anal Fistula, Fissure and Piles
    14. All types of Hernia
    15. Hydrocele
    16. Chronic Renal Failure

17. Joint replacement Surgery unless because of accident

5.1.3. 30-day waiting period – Code – Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

5.2 General Exclusions

5.2.1 Investigation & Evaluation – Code – Excl04:

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded

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

5.2.2 **Obesity/Weight Control: Code – Excl06**: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) Greater than or equal to 40 or
   b) Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe sleep Apnea
      iv. Uncontrolled Type2 Diabetes

5.2.3 **Change-of-Gender treatments:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. **Code – Excl07**

5.2.4 **Cosmetic or plastic Surgery:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner. **Code – Excl08**

5.2.5 **Hazardous or Adventure sports:** Expenses related to any treatment, necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving. **Code – Excl09**

5.2.6 **Breach of law:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent. **Code – Excl 10**

5.2.7 Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Excl12**

5.2.8 Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim or day care procedure. **Code – Excl14**

5.2.9 **Refractive Error:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **Code – Excl15**

5.2.10 **Unproven Treatments**: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness. **Code – Excl16**

5.2.11 **Sterility and Infertility: Code – Excl17**: Expenses related to Sterility and infertility. This includes:

(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

5.2.12 Maternity: Code – Excl18:

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

5.2.13 War or any act of war, invasion, acts of foreign enemies, hostilities whether are be declared or not, civil war, revolution, insurrection, mutiny, martial law

5.2.14 All hospitalisation caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel

5.2.15 Hospitalisation, if applicable for the following treatments:

5.2.16 Circumcisions (unless necessitated by illness or injury and forming part of treatment)

5.2.17 Vaccination or inoculation unless forming a part of post-animal bite treatment

5.2.18 Sexually transmitted disease or illness

5.2.19 Any external congenital diseases, defects or anomalies

5.2.20 Fitting of hearing aids, eyeglasses or contact lenses

5.2.21 Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who shares the same residence as an Insured Person or who is a member of the Insured Person's family like, spouse, daughter, son, father, mother, father-in-law, mother-in-law & siblings

5.2.22 Naturopathy Treatments.

Section 6 : GENERAL CONDITIONS

I. CONDITIONS PRECEDENT TO THE CONTRACT

6.1 Condition Precedent to Admission of Liability

The terms and Conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

6.2 Disclosure of Information

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

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

6.3 Change of Address / Contact details

It is in the Insured person's interest to intimate us if there is any change in residential address and phone numbers.

6.4 Free Look Period

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

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

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

i. A refund of premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

6.5 Cost of Pre Insurance Health Check up

Based on acceptance of the proposal and issuance of policy, we would reimburse to the insured 50% to 100% of the cost of examinations as per the plan selected. This will be provided as refund of expenses for pre-policy health check-up to the proposer after policy issuance.

Original receipt for medical tests undergone is required to be submitted to us for reimbursement. This has to be claimed within 30 days of approval of policy. Any claim beyond 30 days shall be considered, if the delay is because of any genuine reason.

6.6 Specific and Permanent Exclusions

a. A specific exclusion with waiting period may be applied on a medical condition/disease depending on the medical test done based on the Proposed Insured person's medical history and declarations as part of special conditions on the Policy with due consent from the policyholder.

b. Permanent exclusions may be applied for diseases disclosed by the person to be insured at the time of underwriting with due consent of the proposer or person to be insured, where underwriting policy of the Company does not enable Us to offer the Health Insurance Coverage for the given disease disclosed.

6.7 Moratorium Period

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sublimits, co-payments, deductibles as per the policy contract.

II. CONDITIONS APPLICABLE DURING THE CONTRACT

6.8 Excluded Providers: Code –Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses upto the stage of stabilization are payable but not the complete claim.

6.9 Notification

i. Any and all notices and declarations for the attention of the Insurer shall be in writing and shall be delivered to the Insurer's address as specified in the Schedule.
ii. Any and all notices and declarations for the attention of any or all of the insured Persons shall be in writing and shall be sent to the Policyholder's address as specified in the Schedule.

6.10Transfer

Transferring of interest in this Policy to anyone else is not allowed

6.11Nomination
The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

6.12Fraud
If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

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

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

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

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

6.13Governing Law
The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are descriptive only and do not form part of this Policy for the purpose of its construction or interpretation.

6.14Entire Contract
The Policy constitutes the complete contract of insurance. Only the Insurer may alter the terms and conditions of this Policy. Any alteration that may be made by the Insurer shall be evidenced by a duly signed and sealed endorsement on the Policy.

6.15Territorial Limits
The Insurer's liability to make any payment towards illness or accidental injury shall be to make payment within India and in Indian Rupees only for medical services or procedures rendered in or undertaken within India.

6.16Assignment
The Policy can be assigned subject to applicable laws

III. CONDITIONS WHEN A CLAIM ARISES

6.17 Claim Procedure

Chola Hospital Cash Healthline (Revision)
CHOHLIP21301V022021
Policy Wordings

If the Insured Person happens to suffer Accidental Bodily Injury or is diagnosed with an Illness which gives rise to or may give rise to a claim, then it is a condition precedent to our liability that the insured Person shall immediately:

a. Give us notice of the claim at the earliest irrespective of notice provided to any other insurer for the same illness in case you are holding multiple insurance policies
b. Expeditiously give or arrange for us to be provided with any and all information and documentation in respect of the claim and/or our liability for it that may be requested by the us
c. Upon Hospitalisation, the insured Person or his/her dependents shall provide us with fully particularised details of the quantum of any claim and any and all other information and documentation in respect of the claim and/or our liability for it sought by our In-House Claims team at the earliest possible opportunity not exceeding 30 days from date of discharge.
d. The Insurer shall be under no obligation to pay or arrange to make payment for any claim until and unless it is satisfied as to the validity of the Insured Person's claim, and may for these purposes require the Insured Person to be examined by a medical advisor nominated by the Insurer as often as and to the extent that either considers to be reasonably necessary.
e. The Insurer shall only make payment to the insured person or nominee whose name is mentioned in the policy schedule.
f. The Insured Person acknowledges and agrees that the payment of any claim by or on behalf of the Insurer shall not constitute on the part of the Insurer any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the Insured Person, it being agreed and recognised by the Policyholder that the Insurer is not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution.
g. Claim submission should be made irrespective of the same being intimated to any indemnity insurer. However the company shall consider the claim as valid if the documents so required are submitted in original or in any of the following mentioned manner.
    1. Duly filled & signed claim form.
    2. Detailed discharge summary specifying the DOA, DOD, ailment & treatment details (The insured may collect back originals after the same has been verified by the company).
    3. All investigation reports including radiology reports supporting the diagnosis.
    4. FIR / MLC copy in case of RTA's cases.
    5. AML documents (Proof of Identity with photo, Address proof) for above 1 lac claims.
    6. All previous consultation papers pertaining to the present ailment

6.17.1 Claim Settlement(Provision for penal interest)

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

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the Financial Year in which claim has fallen due)

16.17.2 TPA

There is no TPA tie –up envisaged for this product. Any arrangement in future will be disclosed in the Policy to the Policyholders.

Chola MS customer support operates 24/7 basis and the contact details are as followed for any queries / grievances:

- Toll Free Phone No: **1800-208-5544**
- Toll Free FAX No: **1800-425-2200** (For Cashless Request)
- E-Mail: help@cholams.murugappa.com

Address of Chola MS Health Claims Office:

Chola MS HELP – Health Claims Department
New No.319, Old No.154, Shaw Wallace Building,
2nd Floor, Thambu Chetty Street, Parry's Corner,
Chennai - 600001
Customer Care Toll Free No: 1800-208-5544
E-Mail: help@cholams.murugappa.com

6.17.3 **Complete Discharge**
Any payment to the policyholder, insured person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim

6.18 Delay in intimation of claim
It is essential and imperative that any loss or claim under the policy has to be intimated to us strictly as per the policy conditions to enable us to appoint investigator for loss assessment. This will enable us to render prompt service by way of quick and fair settlement of claim, which is our primary motto. Any genuine delay, beyond Your control will definitely not be a sole cause for rejection of the claim. However any undue delay which could have otherwise been avoided at Your end and especially if the delay has hindered conducting investigation on time to make proper assessment, to mitigate further loss, if any may not only delay the claim settlement but also may result in claim getting rejected on merits.

6.19 Authority to Obtain Records
The insured must procure and cooperate with us in procuring any medical records and information from the hospital relating to the treatment for which claim has been lodged. If required, the Insured Person should give consent to us to obtain Medical records / opinion from the Hospital directly relating to the treatment for which claim has been made.
If required the Insured / Insured Person must agree to be examined by a Medical Practitioner of Company's choice at our expense

6.20 Any one illness / relapse period
If the hospitalization is continuous and the illness relapses within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken will be treated as same illness

IV.CONDITIONS FOR RENEWAL OF THE CONTRACT

6.21 Renewal of Policy
The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

6.22 Possibility of Revision of Terms of the policy including the Premium Rates:
The company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

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

6.24 Sum Insured Enhancement
Sum Insured can be enhanced only at the time of renewal subject to reported claim status and health condition of the insured. If you decide to increase the sum insured at the time of renewal then the coverage for the increased sum insured shall be as if a new policy is issued for the additional sum insured. The additional Sum Insured will be available subject to 30 day, 2 years and 4 years waiting periods as per exclusion no. 5.1.1, 5.1.2 and 5.1.3.

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

For Detailed guidelines on Portability, kindly refer the link: www.cholainsurance.com

6.26 Cancellation of cover
i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

Short Period Scales					
1 Yr Policy Term		2 Yrs Policy Term		3 Yrs Policy Term	
No of Months	% of Premium to be retained	No of Months	% of Premium to be retained	No of Months	% of Premium to be retained
0 to 1	25%	0 to 1	15%	0 to 1	10%
1 to 2	50%	1 to 3	20%	1 to 3	15%
2 to 3	50%	4 to 6	30%	4 to 5	25%
3 to 4	75%	7 to 8	40%	6 to 7	30%
4 to 5	75%	9 to 11	50%	8 to 10	40%
5 to 6	75%	12 to 13	60%	11 to 15	50%

6 to 7	100%	14 to 16	75%	16 to 18	60%
7 to 8	100%	17 to 18	80%	19 to 21	70%
8 to 9	100%	19 to 20	90%	22 to 24	80%
9 to 10	100%	21 to 22	95%	25 to 30	90%
10 to 11	100%	22 to 23	100%	31 to 32	95%
>11	100%	>23	100%	>32	100%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the insured person by giving 15 days written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

6.27 Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed guidelines on migration, kindly refer the link: www.cholainsurance.com

6.28 Arbitration

a. Any dispute or difference between the Insurer and the Insured Person or the Policyholder will be resolved in accordance with Arbitration & Conciliation Act 1996 or any modification or amendment of it. The arbitration proceedings shall be conducted in the English language.
b. It is agreed as a condition precedent to any right of action or suit on this Policy that a final arbitration award shall be first obtained.
c. If this arbitration clause is held to be invalid in whole or in part, then all disputes shall be referred to the exclusive jurisdiction of Chennai Courts.

6.29 Disclaimer

It is also hereby further expressly agreed and declared that if we shall disclaim liability to You for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a Court of law or pending reference before Ombudsman, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

Section 7 : GRIEVANCES

Mechanism for Grievance Redressal:-

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

Website : www.cholainsurance.com
Toll free : 1800 208 5544
E-Mail : customercare@cholams.murugappa.com
Fax : 044 -4044 5550
Courier : **Cholamandalam MS General Insurance Company Limited, Customer services,** Head Office **Dare House** 2nd floor, No 2 N.S.C. Bose Road, Chennai 600 001

Chola Hospital Cash Healthline (Revision)
CHOHLIP21301V022021
Policy Wordings

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 GRO@cholams.murugappa.com

For details of grievance officer, kindly refer the link www.cholainsurance.com

If any Grievances / issues on Health insurance related claims pertaining to Senior Citizens, Insured can register the complaint / grievance in 'Senior Citizen Channel' which shall be processed on Fast Track Basis by dedicated personnel.

If Insured Person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380014 Tel.: 079-27546150/27546139, Fax: 079-27546142, Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevansoudha Building, PID No.57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru 560078. 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 – 462003. Tel.: 0755-2769201/2769202, Fax.: 0755-2769203, Email.: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Foresh Partk, Bhubhaneshwar – 750009. Tel.: 0674-2596461/2586455. 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 – 160017. Tel.: 0172-2706196/2706468. Fax.: 0172-2708274, Email.: bimalokpal.chandigarh@ecoi.co.in
Tamilnadu, 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 – 110002. Tel. 011-23239633/23237532, Fax.011-23230858, 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.: 0361-2132204/2132205, Fax.: 0361-2732937, 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-

Chola Hospital Cash Healthline (Revision)
CHOHLIP21301V022021
Policy Wordings

	Pool, Hyderabad – 500004. Tel.: 040-65504123/23312122, Fax.: 040-23376599, Email.: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman,JeevanNidhi – II Bldg, Gr. Fllor, Bhawani Singh Marg, Jaipur – 302005. 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. Cohin 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 – 700072. 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 – 226001. Tel.: 0522-2231330/2231331. Fax.: 0522-2331310. Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevanseva Annexe, S.V. Road, Santacruz (W), Mumbai – 400054. 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, Baudam, 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: gautambhuddh Nagar, U.P – 201301. Tel.: 0120-2514250/2514251/2514253. Email.: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 1st Fllor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800006, 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 to198, N.C. Kelkar Road, Narayan Peth, Pune-411030 Tel: 020-32341320, Email: bimalokpal.pune@ecoi.co.in