Group Care- Certificate of Insurance

(Applicable in case of Non Employer- Employee Group)

Issued At: **Issue Date:**

Name of Unit (if applicable)

Primary Member ID

Insured Member/ Dependent Name

Gender

Age/Date of Birth

Relationship with Primary Member

Grade

Date of joining (DD/MM/YY)

Cover Start Date

Sum Insured for Benefit

Sum Insured for Optional Extensions (if applicable)

Date of separation

Cover End Date

Nominee

Premium

Portability Details of the Insured Members

Name of the Previous Insurer

First Policy Number

Date of first enrollment

For detail, Please refer attached Policy terms and conditions.

Coverage Summary

Details of Benefit :

Details of Optional Extensions opted :

Claims servicing team / Third Party Administrator (TPA) details

Name of TPA/In-house :
Address :
Name of contact person :
Phone :
Fax :
Email id :
Website :

Premium Payment by **: Insured Member */ Policyholder**

For Religare Health Insurance Company Limited

Authorized Signatory

Service Tax Reg. No. : <xxxxxxxxxxxx>

Stamp duty of ….. Paise paid in cash or by demand draft or by pay order, vide Receipt/Challan no. <Challan No.> dated <Challan Date>.

*In case premium is paid (partly/fully) by the Insured Member, the same shall be eligible for deduction u/s 80D of Income Tax Act as per the provisions of the Act and premium deduction certificate shall be issued.

UIN: xxx

Policy Terms & Conditions

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, Regulations notified by the Authority and Circulars and Guidelines issued by the Authority shall carry the meanings explained therein. The judicial pronouncements of the highest courts in India will have the effect on the definitions and the language used in this product. The terms and conditions, coverage's and exclusions, benefits, various procedures and concepts which have been built in to the product also carry the specified meaning assigned to them in the said language.

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

1. Definitions

1.1. **Accidental / Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means;

1.2. **Age** means the completed age of the Insured Member as on his last birthday;

1.3. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

1.4. **Ambulance** means a road vehicle operated by a licensed/ authorized service provider and equipped for the transport and paramedical treatment of persons requiring medical attention;

1.5. **Annexure** means the document attached and marked as Annexure to this Policy;

1.6. **Any One Illness** means a continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where the treatment may have been taken;

1.7. **Break in Policy** occurs at the end of the existing Policy term, when the premium due date for Renewal on a given policy is not paid on or before the premium Renewal date or within 30 days thereof.

1.8. **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization approved;

1.9. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of Medical Expenses or Optional Extensions in respect of the Insured Member as covered under the Policy;

1.10. **Condition Precedent** shall mean a policy term or condition upon which the Our liability under the policy is conditional upon;

1.11. **Congenital Anomaly**

refers to a condition(s) 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

1.12. **Contribution** is essentially Our right to call upon other insurers, liable to the same Insured Member, to share the cost of an indemnity Claim on a ratable proportion of Sum Insured.

1.13. **Co-payment** means a co-payment is a cost-sharing requirement under a health insurance policy that provides that the Insured Member will bear a specified percentage of the admissible costs. A co-payment does not reduce the sum insured.

1.14. **Cover End Date** means the date specified in Annexure 'A' for the respective Insured Member on which the Insured Member's cover under the Policy expires;

1.15. **Cover Period** means the period commencing from the Cover Start Date and ending on the Cover End Date for each Insured Member as specified in Annexure 'A';

1.16. **Cover Start Date:** means the date specified in Annexure 'A' for the respective Insured Member on which the Insured Member's cover under the Policy commences;

1.17. **Day Care Centre** means any institution established for Day Care Treatment of Illness and / or Injuries or a medical set up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under :

(a) has qualified nursing staff under its employment;
(b) has qualified Medical Practitioner(s) in-charge;
(c) has a fully equipped operation theatre of its own, where Surgical Procedures are carried out;
(d) maintains daily records of patients and will make these accessible to Our authorized personnel.

1.18. **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is listed in Annexure "B" and 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 a Hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

1.19. **Dependent** means a person who is a member of the Primary Insured Member's family who is legally wedded spouse, Dependent Child, parents and parents in law and who is named in Annexure "A" to the Policy as an Insured Member;

1.20. **Deductible** means a cost-sharing requirement under a health insurance policy that provides that We will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by Us. A Deductible does not reduce the Sum Insured.
The Deductible may be applicable on per year, per life or per event basis as specified in Policy Certificate.

1.21. **Dental Treatment (Dental Care)** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

1.22. **Disclosure to information norm** means 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.

1.23. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care or treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

b. The patient takes treatment at home on account of non-availability of a room in a Hospital.

1.24. **Emergency** means a medical condition arising out of any Illness or Injury contracted by the Insured Member and declared and certified by the Medical Practitioner, attending to the Insured Member, that immediate treatment is required to save the life of the Insured Member;

1.25. **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 Member's health.

1.26. **Grace Period** means the specified period of time immediately following the premium due date during which payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

1.27. **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 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:

(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.

1.28. **Hospitalization** means admission in a Hospital for a minimum period of 24 In-patient Care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours;

1.29. **Illness** means a sickness or a disease or a pathological condition leading to the impairment of normal physiological function which manifests itself during the Cover Period and requires medical treatment.;

1.30. **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;

1.31. **In-patient Care** means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for a covered event;

1.32. **Insured Member** means the Primary Insured Member named in the Policy Certificate and those of his Dependents named as Insured Members in the Policy Certificate;

1.33. **Intensive / Critical Care Unit (ICU)** 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;

1.34. **Maternity Expense / Treatment** 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.

1.35. **Medical Advice** means any consultation or advice from a Medical Practitioner including issue of any prescription or repeat prescription;

1.36. **Medical Expenses** means those expenses that an Insured Member has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Member had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment;

1.37. **Medically necessary** means a treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

(i) Is required for the medical management of the illness or injury suffered by the insured;

(ii) Must not exceed the level of care necessary to provide safe, adequate and appropriate

(iii) Medical care in scope, duration, or intensity;

(iv) Must have been prescribed by a medical practitioner;

(v) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India

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

1.39. **Network Provider** means the Hospitals or health providers enlisted by Us or by Our TPA and by Us to provide medical services to an Insured Member on payment by a Cashless Facility;

1.40. **Non-Network means** any hospital, Day Care Centre or other provider that is not part of the network;

1.41. **Notification of Claim (Intimation)** is the process of notifying a Claim to Us or Our TPA by specifying the timelines as well as the address / telephone number to which it should be notified;

1.42. **Out-Patient Treatment (OPD Treatment)** OPD treatment is one in which the Insured Member visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice o f a Medical Practitioner. The Insured Member is not admitted as a day care or in-patient.

1.43. **Policy** means these Policy Terms & Conditions, Optional Extensions (if any), the Proposal Form / data sheet, Policy Certificate and Annexures which form part of the policy contract and shall be read together;

1.44. **Policy Certificate** is a certificate attached to and forming part of this Policy;

1.45. **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.

1.46. **Policyholder** means the person or the entity named in the Policy Certificate as the Policyholder;

1.47. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Certificate;

1.48. **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Certificate;

1.49. **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Certificate;

1.50. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for Pre-Existing Conditions and time bound exclusions if he/she chooses to switch from one insurer to another.

1.51. **Pre-existing Diseases** means any condition, ailment or Injury or related condition(s) for which the Insured Member had signs or symptoms, and / or were diagnosed, and / or received Medical Advice / treatment within 48 months prior to the first Policy issued by Us;

1.52. **Primary Insured Member** means Your employee or a member of Your group who satisfies and continues to satisfy the eligibility criteria specified in the Policy Certificate and who is named in Annexure "A" to the Policy as an Insured Member;

1.53. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India;

1.54. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved;

1.55. **Rehabilitation** means assisting an Insured Member who, following a medical condition, requires assistance in physical, vocational, independent living and educational pursuits to restore him to the position in which he was in, prior to such medical condition occurring;

1.56. **Renewal** defines 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 all waiting periods.

1.57. **Room Rent** shall mean the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

1.58. **Subrogation** shall mean Our right to assume the rights of the Insured Member to recover expenses paid out under the Policy that may be recovered from any other source.

1.59. **Sum Insured** means the amount specified against each Insured Member in the Policy Certificate which represents Our maximum, total and cumulative liability for that Insured Member for any and all Claims incurred in respect of that Insured Member during the Cover Period;

1.60. **Surgery/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 a Day Care Centre by a Medical Practitioner;

1.61. **TPA** or Third Party Administrator, means any person who is licensed under the IRDA (Third Party Administrators-Health Services) Regulations,2001 by the Authority, and engaged, for a fee or remuneration by Us for the purposes of providing health services;

1.62. **Unproven/Experimental Treatment** means a treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

1.63. **Variable Medical Expenses** means those Medical Expenses as listed below which vary in accordance with the Room Rent or room category or ICU charges in a Hospital.

(a) Room, boarding, nursing and Operation theatre expenses as charged by the Hospital where the Insured Member availed medical treatment

(b) Intensive Care Unit (ICU) charges

(c) Fees charged by surgeon, anesthetist, Medical Practitioner

1.64. **We / Our / Us** means Religare Health Insurance Company Limited;

1.65. **You/Your** means the Policyholder.

2. Scope of Cover

Benefit - Hospitalization Expenses

If an Insured Member is diagnosed with an Illness or suffers an Injury during the Cover Period and while the Policy is in force that requires:

2.1. In-patient Care

(a) The Insured Member's Hospitalization, then We will indemnify the Medical Expenses incurred on Hospitalization, provided that the Hospitalization was on the written advice of a Medical Practitioner.

2.2. Day Care Treatment

(a) The Insured Member to undergo Day Care Treatment at a Day Care Centre or Hospital, We will indemnify the Medical Expenses incurred on that Day Care Treatment, provided that the treatment was taken on the written advice of a Medical Practitioner.

Our maximum, total and cumulative liability for an Insured Member for any and all Claims incurring under this Policy during the Cover Period in relation to that Insured Member shall not exceed the Sum Insured for that Insured Member. All Claims shall be payable subject to the terms, conditions and exclusions of the Policy and subject to availability of the Sum Insured.

2.3. Sub-limit on Room Rent

(a) If the Insured Member is admitted in a Hospital room where the Room Rent incurred is higher than the eligible limit, as specified below then the Insured Member shall bear the ratable proportion of the Medical Expenses (including surcharge or taxes thereon) as specified in the Policy Certificate in the proportion of the Room Rent actually incurred less Room Rent limit and divided by Room Rent actually incurred, provided that We have admitted a Claim under Clause 2.1(a).

(b) Room Rent Limit = one (1%) percent of the Sum Insured per day subject to maximum amount specified in the Policy Certificate.

2.4. Sub-limit on ICU charges

(a) If the Insured Member is admitted in an ICU where the ICU charges incurred are higher than the ICU charges Limit specified below, then the Insured Member shall bear the ratable proportion of the Medical Expenses (including surcharge or taxes thereon) as specified in the Policy Certificate in the proportion of the ICU charges actually incurred less ICU charges limit and divided by the ICU charges actually incurred, provided that We have admitted a Claim under Clause 2.1(a).

(b) ICU charges Limit = two (2%) percent of the Sum Insured per day subject to maximum amount specified in the Policy Certificate.

3. Exclusions

3.1. Waiting Period

(a) **30-Day waiting period**

Claim for any Medical Expenses incurred for treatment of any Illness during the first 30 days of the Cover Start Date shall not be admissible, except those Medical Expenses incurred as a result of an Injury.

(b) **Specific waiting period**

(i) Any Claim for or arising out of any of the following Illnesses or Surgical Procedures shall not be admissible during the first 24 consecutive months from the Cover Start date:

I Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism and Spinal disorders, Joint replacement Surgery;

II Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty), nasal septum deviation, Sinusitis and related disorders;

III Benign Prostatic Hypertrophy;

IV Cataract;

V Dilatation and Curettage;

VI Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers;

VII Surgery of Genito urinary system unless necessitated by malignancy;

VIII All types of Hernia, Hydrocele;

IX Hysterectomy for menorrhagia or fibromyoma or prolapse of uterus unless necessitated by malignancy;

X Internal tumors, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant;

XI Kidney Stone/ Ureteric Stone/ Lithotripsy/ Gall bladder Stone;

XII Myomectomy for fibroids;

XIII Varicose veins and varicose ulcers.

(ii) If an Insured Member is suffering from any of the above Illnesses, conditions or Pre-existing Diseases at the time of commencement of the first Cover Start Date, that Insured Member shall not be covered for any Claim in respect of or related to that Illnesses, condition or Pre-existing Disease until the completion of the period specified in the Policy Certificate but not exceeding 48 months of continuous insurance coverage with Us from the first Cover Start Date under the first Policy with Us.

(c) **Pre-existing Disease:**

Any Claims for Medical Expenses incurred for diagnosis or treatment of any Pre-existing Disease shall not be admissible until the completion of first 48 months of continuous insurance coverage from the first Cover Start Date under the first Policy with Us.

(d) The Waiting Periods as defined in Clauses 3.1.(a), 3.1.(b) and 3.1.(c) shall be applicable individually for each Insured Member and Claims shall be assessed accordingly.

3.2. Permanent Exclusions:

Any Claim in respect of any Insured Member for, arising out of or directly or indirectly due to any of the following shall not be admissible, unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Any condition or treatment as specified in Annexure-C

(ii) Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

(iii) Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy provided that it is proved by diagnostic means and a qualified gynecologist certifies in writing that it is life threatening.

(iv) Any treatment arising from or traceable to any fertility sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.

(v) Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self -medication.

(vi) Charges incurred in connection with cost of routine eye and ear examinations, dentures, and artificial teeth and all other similar external appliances and/or devices whether for diagnosis or treatment.

(vii) Unproven/Experimental Treatment or investigation treatment. Any Illness or treatment which is a result or a consequence of undergoing such Unproven/Experimental treatment or investigational treatment.

(viii) Any diagnosis or treatment of an Illness or Injury which does not require Hospitalization.

(ix) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear,

glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition, cost of cochlear implants.

(x) Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, Rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital.

(xi) Treatment of all external Congenital Anomaly or Illness or defects or anomalies or treatments relating to birth defects..

(xii) Treatment of mental illness, stress or psychological disorders.

(xiii) Aesthetic treatment, Cosmetic Surgery and plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury, cancer or burns

(xiv) Any treatment or surgery for change of sex or gender reassignments including any complication arising from these treatments.

(xv) Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

(xvi) All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment), vitamins and tonics

(xvii) Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health

(xviii) Any travel or transportation expenses including Ambulance charges.

(xix) All expenses related to donor treatment, including surgery to remove organs from the donor, in case of transplant surgery.

(xx) Non-allopathic treatment.

(xxi) Out-Patient Treatment.

(xxii) Treatment received outside India.

(xxiii) Domiciliary Hospitalization or treatment.

(xxiv) Charges incurred at a Hospital primarily for X-ray or laboratory examinations not consistent with or incidental to the diagnosis and

treatment of the positive existence or presence of any Illness or Injury, for which In-patient Care/Day Care Treatment is required.

(xxv) War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

(xxvi) Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Member with any criminal intent.

(xxvii) Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol.

(xxviii) Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.

(xxix) Personal comfort & convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs (except patient's diet), cosmetics, hygiene articles, body/baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

(xxx) Expenses related to any kind of RMO charges, service charge, surcharge, night charges levied by the Hospital under whatever head.

(xxxi) Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

I Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any illness, incapacitating disablement or death.

II Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any illness, incapacitating disablement or death.

III Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.

(xxxii) Impairment of an Insured Member's intellectual faculties by abuse of stimulants or depressants.

(xxxiii) Alopecia, wigs and/or toupee and all hair or hair fall treatment and products.

(xxxiv) Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Certificate.

(xxxv) Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification Centre, sanatorium, home for the aged, mentally disturbed, remodeling clinic or similar institutions, unless specifically provided for.

4. Claims Intimation, Assessment and Management

4.1. Upon occurrence of any Illness or Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the You or the Insured Member shall undertake all of the following:

(a) **Claims Intimation**

(i) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, You or the Insured Member, shall notify Us either at Our call Centre or in writing immediately.

(ii) If the Insured Member is to undergo planned Hospitalization, You or the Insured Member shall give written intimation to Us of the proposed Hospitalization at least 48 hours prior to the planned date of admission to Hospital.

(iii) It is agreed and understood that the following details are to be provided to Us at the time of intimation of Claim:

I Policy Number ;
II Name of Primary Insured Member;
III Name of the Insured Member in whose relation the Claim is being made;
IV Nature of Illness or Injury;
V Name and address of the attending Medical Practitioner and Hospital;
VI Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
VII Any other information, documentation or details as requested by Us.

4.2. Claims Procedure

(a) **Cashless :**
Cashless Facility is available only at Network Providers. The Insured Members can avail Cashless Facility at the time of admission into a Network Provider, by presenting the health card as provided by Us under this Policy, along with a valid photo identification document (like: Voter ID card / Driving License / Passport / PAN Card / any other identification documentation as approved by Us).

(b) In addition to the above, in order to avail Cashless Facility, the following procedure must be followed:

(i) Pre-authorization: You or the Insured Member must call Our call centre (xxx-xxxxxxxxx) or Our TPA and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least 48 hours prior before the commencement of a planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency.

(ii) We will process the request for authorization after having obtained accurate and complete information in respect of the Illness or Injury for which Cashless Facility is sought to be availed. We or Our TPA will confirm in writing authorization or rejection of the request to avail cashless facility for the Insured Member's Hospitalization.

(iii) If the request for availing Cashless Facility is authorized by Us or Our TPA, then payment for the Medical Expenses incurred in respect of the Insured Member shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by Us for availing Cashless Facility. Payment in respect of Co-payments (if applicable) or within Deductible (if applicable) or any other costs and expenses not authorized under the Cashless Facility shall be made directly by You or the Insured Member to the Network Provider. All original bills and evidence of treatment for the Medical Expenses incurred in respect of the Hospitalization of the Insured Member and all other information and documentation specified at Clause 4.4 shall be submitted to the Network Provider immediately and in any event before the Insured Member's discharge from Hospital.

(iv) If We or Our TPA do not authorize the Cashless Facility due to insufficient Sum Insured or if insufficient information is provided to Us or Our TPA to determine the admissibility of the Claim, payment for the treatment will have to be made by You or the Insured Member to the Network Provider, following which a Claim for reimbursement may be made to Us and the same will be considered by Us subject to the Policy.

(c) The list of updated Network Providers is available with Us or Our TPA and is subject to amendment or modification of the Network Providers and/or the extent of cashless facilities available at particular Network Providers from time to time.

(d) Health card issued by Us shall not be used

(i) On termination or cancellation of this Policy
(ii) From Cover End Date
(iii) On death of Insured Member

(e) **Re-imbursement :**

(i) We shall be given intimation of Hospitalization at Our call Centre or in writing at least 48 hours before the commencement of a planned Hospitalization or within 24 hours of admission to Hospital, if the Hospitalization is required in an Emergency.

(ii) It is agreed and understood that in all cases where intimation of a Claim has been provided under this provision, all the information and documentation specified in Clause 4.4. below shall be submitted (at Your or the Insured Member's expense) to Us immediately and in any event within 15 days of Insured Member's discharge from Hospital or completion of treatment..

4.3. The Policyholder and Insured Member's duty at the time of Claim

(a) You or the Insured Member shall check the updated list of Network Providers before submission of a pre-authorization request for cashless facility; and

(b) It is agreed and understood that as a Condition Precedent for a Claim to be considered under this Policy:

(i) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.
(ii) The Insured Member shall follow the directions, advice or guidance provided by a Medical Practitioner and We shall not be obliged to make payment that is brought about or contributed to by the Insured Member failing to follow such directions, advice or guidance.
(iii) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 4 of the Policy.
(iv) The Insured Member will, at Our request submit himself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such medical examination shall be borne by Us.
(v) Our Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Member's medical and Hospitalization records and to investigate the facts and examine the Insured Member.
(vi) We shall be provided with complete documentation and information which We have requested to establish Our liability for the Claim, its circumstances and its quantum.

4.4. Claim Documents

(a) The following information and documentation shall be submitted to Us in accordance with the procedures and within the timeframes specified in Clause 4 of the Policy in respect of all Claims:

(i) Duly completed and signed Claim form, in original;
(ii) Medical Practitioner's referral letter advising Hospitalization;

(iii) Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;
(iv) Original bills, receipts and discharge card from the Hospital / Medical Practitioner;
(v) Original bills from pharmacy / chemists;
(vi) Original pathological / diagnostic test reports and payment receipts;
(vii) Indoor case papers;
(viii) First Information Report/ final police report, if applicable;
(ix) Post mortem report, if conducted;
(x) Any other document as required by Us or Our TPA to assess the Claim;

(b) Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company or to a reimbursement provider We will accept properly verified photocopies of such documents attested by such other insurance company/reimbursement provider along with an original certificate of the extent of payment received from such insurance company/reimbursement provider.

(c) We will only accept bills/invoices which are made in the Insured Member's name.

(d) We shall condone delay on merit for delayed Claims where delay is proved to be for reasons beyond Your / Insured Member's control.

4.5. Claim Assessment for Benefit

(a) All admissible Claims under this Policy shall be assessed by Us in the following progressive order:

(i) If the provisions of the Contribution Clause in Clause 5.10 are applicable, Our liability to make payment under that Claim shall first be apportioned accordingly.
(ii) If a room/ ICU accommodation has been opted for where the rent or category is higher than the eligible limit for that Insured Member under the Policy, then, the Insured Member shall bear the ratable proportion of the Medical Expenses (including surcharge or taxes thereon) as specified in the Policy Certificate in the proportion of the Room Rent actually incurred less Room Rent limit and divided by Room Rent actually incurred.
(iii) If any sub-limits on Medical Expenses are applicable as specified in the Policy Certificate, Our liability to make payment shall be limited to the extent of the applicable sub-limit for that Medical Expense.
(iv) Co-payments and Deductibles, if any, shall be applicable on the amount payable by Us after applying Clause 4.5.(a)(i), (ii) and (iii).

(b) The Claim amount assessed in Clause 4.5(a) above would be deducted from the Sum Insured.

4.6. Payment Terms

(a) This Policy covers only medical treatment taken entirely within India.

(b) All payments under this Policy shall be made in Indian Rupees and within India.

(c) The Sum Insured of the Insured Member shall be reduced by the amount payable or paid under the Policy Terms and Conditions and any Optional Extensions applicable under this Policy and only the balance amount shall be available as the Sum Insured for the unexpired Cover Period.

(d) The Claim amount assessed for any Benefit or for any Optional Extensions would be deducted from the Sum Insured and for the unexpired Policy Period balance Sum Insured shall be available.

(e) We shall have no liability to make payment of a Claim under the Policy in respect of an Insured Member, once the Sum Insured for that Insured Member is exhausted.

(f) If the Insured Member suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.

(g) Under cashless facility, the payment of Claims shall be made to the Network Provider and Our discharge would be complete and final.

(h) For the Reimbursement Claims, We will pay to the Primary Insured Member unless specified otherwise in the Policy Certificate. In the event of death of the Primary Insured Member, unless specified otherwise in the Policy Certificate, We will pay the nominee (as named in Annexure A to the Policy) and in case of no nominee to the legal heir of the Primary Insured Member whose discharge shall be treated as full and final discharge of its liability under the Policy.

(i) We shall settle any claim within 30 days of receipt of all the necessary documents/information as required for settlement of such Claim and sought by Us. In case We accept Our liability under any Claim, We shall make the payment within 7 days from the confirmation by You / Insured Member. In case there is delay in the payment beyond the stipulated timelines, We shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the Claim is reviewed by Us.

5. General Terms and Conditions

5.1. Mid-term Addition/ Deletion of Insured Members

a) Mid-term addition of the Insured Member

Any person may be added as an Insured Member during the Policy Period provided that his application for cover has been accepted by Us, additional premium, on pro rata basis in respect of such Member has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Member.

b) Mid-term deletion of the Insured Member

Name of any Insured Member who is covered under the Policy and whose name specifically appears in Annexure A may be deleted on Your request during the Policy Period. Refund of premium shall be made on pro-rata basis provided that Primary Insured Member or any of his Dependent has not made any Claim during the Cover Period under this Policy.

5.2. Disclosure to Information Norm

If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld or if a Claim is fraudulently made or any fraudulent means or devices are used by You, the Insured Member or any one acting on his / their behalf, We shall have no liability to make payment of any Claims and the premium paid shall be forfeited to Us.

5.3. Observance of Terms and Conditions

The due observance and fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by You or the Insured Member, shall be a Condition Precedent to Our liability under this Policy.

5.4. Reasonable Care

The Insured Member shall take all reasonable steps to safeguard against any Illness or Injury that may give rise to a Claim.

5.5. Material Change

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

5.6. Records to be maintained

You and the Insured Members shall keep an accurate record containing all relevant medical records and shall allow Us or Our representatives to inspect such records. You or the Insured Member shall furnish such information as We may require under this Policy at any time during the Policy Period and up to three years after the Policy Period End Date, or until final adjustment (if any) and resolution of all Claims under this Policy.

5.7. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to You the Insured Members which is in Our possession a other than that information expressly disclosed in the Proposal Form or otherwise in writing to Us, shall not be held to be binding or prejudicially affect Us.

5.8. Complete Discharge

Payment made by Us to You the Insured Member or their legal representatives or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construed as an effectual discharge in favor of Us.

5.9. Subrogation

You and the Insured Members shall at their own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by Us for the purpose of enforcing and / or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which We are or would become entitled upon Us paying for a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after Our payment. Neither You nor the Insured Members shall prejudice these subrogation rights in any manner and shall at their expense provide Us with whatever assistance or cooperation is required to enforce such rights. Any recovery We make pursuant to this clause shall first be applied to the amounts paid or payable by Us under this Policy and Our costs and expenses of effecting a recovery, where after We shall pay any balance remaining to the You or the Insured Member.

This clause shall not apply to any Optional Extension offered on a fixed benefit basis.

5.10. Contribution

(a) In case any Insured Member/Dependent is covered under more than one indemnity insurance policies, with Us or with other insurers, Insured Member/Dependent shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to Sum Insured of such Policy.

(b) In case the Claim amount exceeds the Sum Insured, then Insured Member/Dependent shall have the right to choose the companies with whom the Claim is to be settled. In such cases, the settlement shall be done as under :

  (i) If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then We shall not be liable to pay or contribute more than its ratable proportion of any Claim.

(c) This clause shall not apply to any Benefit offered on a fixed benefit basis.

5.11. Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect of this Policy shall be determined by the Indian Courts and subject to Indian law.

(a) The disputes on quantum on payment of losses or any other dispute explained in the paragraph shall be preferred to be dealt and resolved under the alternative dispute resolutions system including Arbitration and Conciliation Act of India.

5.12. Free Look Period

(a) You may, within 15 days from the receipt of the Policy document, return the Policy, if You disagree with any Policy terms and conditions. If no Claim has been made under the Policy, We will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period.

(b) It is agreed and understood that this clause cannot be exercised on any renewal of this Policy, if the Policy terms and conditions remain unchanged.

5.13. Renewal Notice

(a) This Policy will automatically terminate on the Policy Period End Date. All renewal applications and requisite premium shall be given to Us on or before the Policy Period End Date and in any event before the expiry of the Grace Period. The Policyholder shall give Us written notice along with the renewal application of any material changes to the risk insured under the Policy. If no such written notice is received by Us along with the renewal application, it shall be deemed that there is no material change to the risk.

(b) Any Policy which is due for renewal, and where You have requested for one or more of the following alterations in the expiring Policy, may be subjected to a review by Us:

(i) Increase in Sum Insured
(ii) Change in Terms & Conditions

(c) The general underwriting conditions, where the underwriters review the Proposal Form or any other parameter described above, shall prevail and need be adhered to at the renewal also.

(d) We will ordinarily not refuse to renew the Policy except on grounds of fraud, moral hazard or misrepresentation.

(e) The Policyholder has an option to seek a change of TPA at time of renewal of the Policy. The Policyholder shall give Us written notice for such change 30 days before the renewal.

(f) Renewal premium is subject to change with prior approval from IRDA

(g) This product may be withdrawn by Us after due approval from the IRDA. In case this product is withdrawn by Us, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDA. We shall duly intimate You regarding withdrawal of this product and the options available to You at the time of renewal of this policy.

5.14. Cancellation / Termination

(a) Policy shall automatically terminate in case the total number of Insured Member falls below 25 during the Cover Period and premium paid under the Policy shall be forfeited by Us.

(b) We may at any time, cancel this Policy on grounds as specified in Clause 5.2, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

(c) You may also give 15 days' notice in writing, to Us, for the cancellation of this Policy, in which case We shall from the date of receipt of the notice cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided that no refund shall be made for those Insured Member who has incurred Claim under the Policy.

(d) Refund % to be applied on total premium received as on the date of receipt of the cancellation request

Cancellation period upto (x months) from Policy Period Start Date	Refund %
1 month	75
3 months	50
Beyond 6 months	0

5.15. Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless You or the Insured Member proves to Our satisfaction that the delay in reporting of the Claim was for reasons beyond the Insured Member's control.

5.16. Communication

(a) Any communication meant for Us must be in writing and be delivered to Our address shown in the Policy Certificate. Any communication meant for You or the Insured Member will be sent by Us to Your last known address or the address as shown in the Policy Certificate.

(b) All notifications and declarations for Us must be in writing and sent to the address specified in the Policy Certificate. Intermediaries are not authorized to receive notices and declarations on Our behalf.

(c) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

5.17. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by a written endorsement signed and stamped by Us.

5.18. Overriding effect of Policy Certificate

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Certificate, the information contained in the Policy Certificate shall prevail.

5.19. Electronic Transactions

You and Insured Members agree to adhere to and comply with all such terms and conditions as We may prescribe from time to time, and hereby agree 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 Us, for and in respect of the Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time.

5.20. Portability and Continuity Benefits

We will grant continuity of benefits which were available to the Insured Members under a group insurance policy with any other Indian Non-life insurance company in the immediately preceding policy period provided that:

(a) We shall be liable to provide continuity of only those benefits (for e.g: Wait period of Pre- existing Diseases, wait period of Specific Diseases etc.)which are applicable under the Policy;

(b) The Insured Members to whom continuity benefits will be provided under this Policy were covered under that group insurance policy;

(c) There is no Break in Policy between the previous group insurance policy and this Policy, provided further that the application for this Policy is made within 30 days after the expiry of that group insurance policy;

(d) The benefits which will continue to be applicable under this Policy are specified in the Policy Certificate.

(e) Insured Members covered under this Policy shall have the right to migrate from this Policy to an individual health insurance policy or a family floater policy offered by Us and the credit for wait periods would be given in the opted in individual health insurance policy or a family floater policy offered by Us.

5.21. Obligation in respect to minor

If an Insured Member is less than 18 years of age, the Primary Insured Member shall be responsible for ensuring compliance with all terms and conditions of this Policy on behalf of that Insured Member.

5.22. Nominee

The Primary Insured Member can at the inception or at any time before the expiry of the Policy make the nomination for the purpose of payment of Claims.

Any change of nomination shall be communicated to us in writing and such change shall be effective only when an endorsement to the Policy is made by Us.

In case of any Insured Member other than the Primary Insured Member under the Policy, for the purpose of payment of Claims in the event of death, the default nominee would be the Primary Insured Member.

5.23. Grievances

(a) The Company has developed proper procedures and effective mechanism to address complaints, if any of the customers. The Company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued from time to time in this regard.

(b) If You or the Insured Member or Dependent have a grievance that You or the Insured Member or Dependent wish Us to redress, You or the Insured Member may contact Us with the details of their grievance through:

Website : www.religarehealthinsurance.com
e-mail : xxxxxx
Telephone : xxxxxxx
Fax : xxxxxxx
Post/Courier : Any of Our branch offices or Our correspondence address, during normal business hours

(c) If You or the Insured Member is not satisfied with Our redressal of their grievance through one of the above methods, You or the Insured Member may contact Our Head of Customer Service at:

The Grievance Cell,
Religare Health Insurance Company Limited
A3, A4, A5 GYS Global,
Sector -125,
Noida – 201301

(d) If You or the Insured Member is not satisfied with Our redressal of their grievance through one of the above methods, You or the Insured Member may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below:

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Shri P. Ramamoorthy	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, AHMEDABAD-380 014. Tel.:- 079-27546840 Fax : 079-27546142 Email ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL		Insurance Ombudsman, Office of the Insurance Ombudsman,	Madhya Pradesh & Chhattisgarh

		Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.)-462 023. Tel.:- 0755-2569201 Fax : 0755-2769203 Email bimalokpalbhopal@airtelmail.in	
BHUBANESHWAR	Shri B. P. Parija	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.:- 0674-2596455 Fax : 0674-2596429 Email ioobbsr@dataone.in	Orissa
CHANDIGARH	Shri Manik Sonawane	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel.:- 0172-2706468 Fax : 0172-2708274 Email ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh
CHENNAI		Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.:- 044-24333668 /5284 Fax : 044-24333664 Email chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Shri Surendra Pal Singh	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.:- 011-23239633 Fax : 011-23230858 Email iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Shri D. C. Choudhury	Insurance Ombudsman, Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM).	Assam , Meghalaya, Manipur, Mizoram, Arunachal

		Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email ombudsmanghy@rediffmail.com	Pradesh, Nagaland and Tripura
HYDERABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel : 040-65504123 Fax: 040-23376599 Email insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
KOCHI	Shri R. Jyothindranathan	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel : 0484-2358759 Fax : 0484-2359336 Email iokochi@asianetindia.com	Kerala , UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
KOLKATA	Ms. Manika Datta	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, Kolkatta – 700 072. Tel: 033 22124346/(40) Fax: 033 22124341 Email iombsbpa@bsnl.in	West Bengal , Bihar , Jharkhand and UT of Andeman & Nicobar Islands , Sikkim
LUCKNOW	Shri G. B. Pande	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2231331 Fax : 0522-2231310 Email insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI		Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel : 022-26106928 Fax : 022-26106052 Email ombudsmanmumbai@gmail.com	Maharashtra , Goa

The details of Insurance Ombudsman are available on IRDA website : www.irda.gov.in, on the website of General Insurance Council : www.generalinsurancecouncil.org.in, Our website xxxx. xxxxxxxxxxxx or from any of Our offices.

Address and contact number of Governing Body of Insurance Council –

Shri M.V.V. Chalam, Secretary General
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
MUMBAI – 400 021
Tel:022-26106245
Fax : 022-26106949
Email- inscoun@gmail.com

The Secretary
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz (W),
MUMBAI – 400 021.
Tel : 022 26106980
Fax : 022-26106949