Mosquito Disease Protection Policy - Group

Policy Wordings

Insuring Clause

In consideration of **P**remium paid by **You**, **We** will provide insurance cover to the **Insured Person(s)** under this Policy up to **Sum Insured** and subject to waiting period, Co-payment and deductible/Time Deductible as mentioned on the Schedule of Coverage in the **Policy Schedule/Certificate of Insurance**.

This **Policy** is subject to statements in respect of all the Insured Persons in Proposal Form/Enrollment, declarations, payment of premium and terms and conditions of this **Policy.**

Reference to Definitions

Certain words used in the Coverage description have specific meanings which are mentioned in Definitions and which impacts the Coverage. All such words, where ever mentioned in this document are mentioned in bold to enable you to identify that particular word has a specific meaning for which You need to refer Section D and Section E

Section A – Coverage

1. Vector Borne Diseases – Indemnity

We will pay under below listed covers on Medically Necessary Hospitalization of the Insured Person due to

i) Dengue Fever
ii) Malaria
iii) Other Vector Borne Diseases:
   a. Chikungunya
   b. Japanese Encephalitis
   c. Kala-azar
   d. Lymphatic Filariasis
   e. Zika Virus

which is/are contracted during the Policy Period and as defined and opted under the Policy subject to waiting Period as specified on the Schedule of Coverage.

a) In-Patient Hospitalization Expenses

i. Room rent, boarding and Nursing charges restricted to Single AC Private Room
ii. Intensive Care Unit charges
iii. Consultation fees
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
v. Medicines, drugs and consumables
vi. Diagnostic procedures

Proportionate Deduction

If the Insured Person is admitted in a room where the room rent incurred is greater than Single private AC room, then the Policyholder shall bear the ratable proportion of the total variable medical expenses (including surcharge or taxes thereon) in the proportion of the difference between the room rent actually incurred and single private AC room

Insured Person shall bear specified percentage of admissible Claim amount under each and every admissible Claim if Co-payment under Section 1.1 c) is opted and specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

Health Care at Home

Insured Person has the option to avail Health Care at Home for **Illnesses** including but not limited to **Medically Necessary Treatment** opted for and covered under Section 1, if prescribed by treating **Medical Practitioner**.

This Cover can be availed through **Cashless Facility** only as procedure under Claims Procedure - Section F.

Insured Person shall bear specified percentage of admissible Claim amount under each and every admissible Claim if **Co-payment** under Section 1.1 c) is opted and specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

b) Reinstatement of Sum Insured

We will add to the Sum Insured under Section 1a), an amount equivalent to the admissible Claim amount under Section 1a) of the Policy subject to maximum of Basic Sum Insured subject to following conditions;

a. Sum Insured reinstated under this cover can be used only for subsequent **Hospitalization** of the Insured Person during Policy Year and is not applicable for hospitalization under **Any One Illness**

b. Any unutilized amount of Sum Insured reinstated cannot be carried over to next policy year

c) Pre and Post Hospitalization Cover

We will pay for **Pre Hospitalization Medical Expenses** and **Post Hospitalization Medical Expenses** up to number of days mentioned on Policy Schedule/Certificate of Insured, which are incurred on treatment of diseases for which Claim under Section 1a) is admissible under the Policy.

d) Accidental Death due to Vector Borne Diseases

We will pay the Sum Insured specified against this Benefit in the Policy Schedule/Certificate of Insurance if the Claim is admissible under Section 1a) for a disease that solely and directly results in the Insured Person's death within 7 days from the date of discharge.

1.1) Optional Covers

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that, We will pay the expenses/Sum Insured under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

a) Outpatient Treatment Expenses

We will indemnify the Insured Person towards expenses incurred on;

i. *Outpatient Consultation* with Medical Practitioner
ii. *Diagnostic Tests*
iii. *Pharmacy*

For**Medically Necessary Treatment** of diseases as opted under Section 1a)

Special Conditions applicable to Outpatient Treatment Expenses

If the Claim is payable under this Section and if the Insured Person is subsequently hospitalized within 15 days for the **Medically Necessary** treatment of same illness, entire Claim shall be admissible under Section 1a) and 1d) only and payable upto the Sum Insured under Section 1a) and 1d).

b) Recovery Benefit

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule if period of Hospitalization for Claim admissible under Section 1, exceeds 10 continuous days.

This benefit is not applicable if Medical treatment is taken under Health Care at Home

c) Co-payment

On availing this option, Co-Payment as mentioned on the Schedule of Coverage in the Policy Schedule will be applied on each and every admissible claim under Section 1a).

d) Waiting Period Options

On availing this option, Waiting Period will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applicable for all the Claims under the Policy.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

2. Vector Borne Diseases – Benefit

a) In-patient Hospitalization Benefit

We will pay Sum Insured in the manner as specified in the Schedule of Coverage to an Insured Person due to **Medically Necessary Hospitalization** of an Insured Person due to;

i) Dengue Fever
ii) Malaria
iii) Other Vector Borne Diseases:
   a. Chikungunya
   b. Japanese Encephalitis
   c. Kala-azar
   d. Lymphatic Filariasis
   e. Zika Virus

which is/are contracted during the Policy Period and as defined and opted under the Policy subject to waiting Period as specified on the Schedule of Coverage

b) Reinstatement of Sum Insured

We will add to the Sum Insured under Section 2a), an amount equivalent to the admissible Claim amount under Section 2a) of the Policy subject to maximum of Basic Sum Insured subject to following conditions;

a. Sum Insured reinstated under this cover can be used only for subsequent **Hospitalization** of the Insured Person during Policy Year and is not applicable for Hospitalization under **Any One Illness**
b. Any unutilized amount of Sum Insured reinstated cannot be carried over to next policy year

c) Accidental Death due to Vector Borne Diseases

We will pay the Sum Insured specified against this Benefit in the Policy Schedule/Certificate of Insurance if the Claim is admissible under Section 2 a) for a disease that solely and directly results in the Insured Person's death within 7 days from the date of discharge.

2.2) Optional Covers

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that, We will pay the expenses/Sum Insured under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

a) Outpatient Treatment Expenses

We will pay Sum Insured towards expenses incurred on;

i. *Outpatient Consultation* with Medical Practitioner
ii. *Diagnostic Tests*
iii. *Pharmacy*

For **Medically Necessary Treatment** of diseases as opted under Section 2a)

Special Conditions applicable to Outpatient Treatment Expenses

If the Claim is payable under this Section and if the Insured Person is subsequently hospitalized with in 15 days for the same illness, entire Claim shall be admissible under Section 2a) only and Sum Insured is payable under Section 2a) only.

b) Recovery Benefit

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance if period of Hospitalization for Claim admissible under Section 2 a), exceeds 10 continuous days.

c) Time Deductible

On availing this option, **Time Deductible** as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applied on each and every admissible Claim under the Policy.

d) Waiting Period Options

On availing this option, Waiting Period will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applicable for all the Claims under the Policy.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

e) Annual Aggregate days limit

On availing this option, the no of annual aggregate days limit will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

f) ICU multiplier

On availing this option, the benefit amount will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance, if the Insured Person is hospitalization in ICU.

Section B – my: Health Active

The services listed below are available to all **Insured Person** through **Our Network Provider** on **Our my: health mobile app**only.

i. Health Coach:

An **Insured Person** will have access to Health Coaching services in areas such as:

- Disease management
- Activity and fitness
- Nutrition
- Weight management.

These services will be available through **Our my: health mobile app** as a chat service or as a call back facility.

ii. Wellness services

- **Discounts:** on OPD, Pharmaceuticals, pharmacy, diagnostic centers.
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs:** like stress management, Pregnancy Care, Work life balance management.

Disclaimer applicable to my: health Mobile app and associated services

It is agreed and understood that Our my:health mobile app and Wellness services are not providing and shall not be deemed to be providing any **Medical Advice**, they shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this benefit.

Section C – Waiting Periods and Exclusions applicable to Section 1 & 2

We will not make any payment for any claim in respect of the Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy ;

i) Disease(s) which occurs or manifests itself within 30 days from Coverage Commencement date
ii) Pre-existing Lymphatic Filariasis at the time of taking the policy is excluded for lifetime
iii) Any treatment taken on Outpatient
iv) Hospitalization primarily for purposes diagnostic purposes not related to illness or any purpose which in routine could have been carried out on an out-patient basis and which is not followed by an active treatment or intervention during the period of hospitalization.
v) Experimental or unproven procedures or treatments, devices or pharmacological regimens of any description (not recognized by Indian Medical Council) or hospitalization for treatment under any system other than allopathy.
vi) Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long term nursing care or custodial care and general debility or exhaustion (run down condition)

Following additional exclusions shall apply under Section 1

i) Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to, administration, documentation and filing and non-medical expenses as listed on our website www.hdfcergo.com
ii) Vitamins and tonics unless vitamins and tonics are certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

Section D – Definitions for Vector Borne Diseases

1. Dengue Fever

Diagnosis of Dengue Fever should be confirmed by a Medical Practitioner and Laboratory examination result countersigned by a pathologist/ microbiologist confirms the following:

- Decreasing platelet levels- less than 100,000 cells/mm^3;and

- Immunoglobulins/PCR test showing positive results for Dengue

2. Malaria

Diagnosis of Malaria should be confirmed by a Medical Practitioner with confirmatory tests indicating presence of Plasmodium Falciparum/ Vivax/ Malariae in the patient's blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

3. Other Vector Borne Diseases

a) Chikungunya

Chikungunya is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue and rash.

The diagnosis must be documented by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies.

b) Japanese Encephalitis

Characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis. To confirm Japanese Encephalitis (JE) infection and to rule out other causes of encephalitis, a laboratory testing of serum or preferably cerebrospinal fluid shall be required.

The diagnosis must be confirmed by a Medical Practitioner and positive serological test for JE by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

c) Kala-azar

Visceral leishmaniasis, also known as Kala-azar, is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anaemia.

The diagnosis must be confirmed by a Medical Practitioner and by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for Kala-azar should clearly indicate the presence of this disease.

d) Lymphatic Filariasis

Commonly known as Elephantiasis, must be confirmed by a Medical Practitioner and the laboratory examination countersigned by a pathologist must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria:

- Lymphoedema,
- Elephantiasis,
- Scrotalswelling

Specific condition for this cover:

- Filariasis will be payable once inlifetime

e) Zika Virus

People with Zika virus disease can have symptoms like mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache.

A diagnosis of Zika virus infection should be confirmed by a Medical Practitioner and by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC (Centers for Disease Control and Prevention) or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results.

Section E – Other Definitions

Def. 1. **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def. 2. **Age** or **Aged** means completed years as at the Policy Commencement Date.

Def. 3. **Any one illness** means continuous period of **Illness** and includes relapse within 45 days from the date of last consultation with the **Hospital**/Nursing Home where treatment was taken

Def. 4. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the **Network Provider** by the insurer to the extent pre-authorization is approved.

Def. 5. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule

Def. 6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon

Def. 7. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A Co-Payment does not reduce the Sum Insured

Def. 8. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer 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 the insurer. A **Deductible** does not reduce the sum insured.

Def. 9. **Dependents** means only the family members listed below:

a) **Your** legally married spouse as long as she continues to be married to You

b) **Your** children Aged between 1 day and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households;

c) **Your** natural parents or parents that have legally adopted You, and **Your** parent in laws

Def. 10. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 11. **Emergency Care** means management for an **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.

Def. 12. **Family Floater** means a Policy described as such in the Policy Schedule of Insurance where under You and **Your** Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date. .

Def. 13. **Grace Period m**eans 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 pre – existing diseases. Coverage is not available for the period for which no premium is received.

Def. 14. **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:

- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- 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 will make these accessible to the insurance company's authorized personnel.

Def. 15. **Hospitalization** means admission in a **Hospital** for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 16. **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.

Def. 17. **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.

Def. 18. **Insured Person/You/Your**means the persons named in the Policy Schedule/Certificate of Insurance.

Def. 19. **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.

Def. 20. **ICU (Intensive Care Unit) Charges** means the amount charged by a **Hospital** towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 21. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

Def. 22. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

Def. 23. **Medically Necessary treatment** means any treatment, test, medication, or stay in **Hospital** or part of stay in **Hospital** which

- Is required for the medical management of the **Illness** or **Injury** suffered by the Insured Person;
- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity.
- Must have been prescribed by a Medical Practitioner.
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Def. 24. **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.Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Medical Practitioner (Definition applicable for the treatment taken outside India)
Means a licensed medical practitioner acting within the scope of his license and who holds a degree of a recognized institution and is registered by the Authorized Medical Council of the respective country.

Def. 25. **my: Health App**is proprietary App of HDFC ERGO General Insurance Company. With my: Health App you can:

- Access **Your** Policy Details
  - Now manage **Your** policy, download **Your** Policy Schedule/Certificate of Insurance and access to **Your** e-card will always be at **Your** fingertips, 24 x 7.
- Policy Endorsement made easy
  - By submitting a request to us through my:Health App, you can make any modifications in **Your** policy, for e.g. change in spelling of the name, contact number etc.
- Effortless Claims Management
  - Now you can Submit**Your** claims from the app for faster processing and track the status at **Your** fingertips. You can also intimate a claim using the app. You can also view Network hospitals in **Your** area with directions.
- Stay Active – Short Walks, Big Benefits
  - The App tracks **Your** steps, fitness session and lets you earn incentive on renewal discount on **Your** policy.

Def. 26. **Newborn Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 27. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a **Cashless facility**

Def. 28. **Non Network** means any **Hospital**, **Day Care Centre** or other provider that is not part of the Network

Def. 29. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 30. **OPD Treatment**. OPD treatment means the one in which the Insured visits a clinic / **Hospital** or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient**.**

Def. 31. **Portability** means transfer by an individual health insurance policy holder (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.

Def. 32. **Pre Existing Disease** means any condition, ailment or **Injury** or related condition(s) forwhich there were signs or symptoms, and / or were diagnosed, and / or for which **Medical Advice** / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter

Def. 33. **Policy** means **Your** statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), and the Policy Schedule (as the same may be amended from time to time).

Def. 34. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule

Def. 35. **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 36. **Policy Schedule**/ **Certificate of Insurance** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to (Schedule of coverage), including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 37. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 38. **Pre-hospitalization Medical Expenses** meansMedical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person , provided that:

b. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
c. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company

Def. 39. **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the insured person is discharged from the Hospital provided that:

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

Def. 40. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 41. **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

Def. 42. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated Medical Expenses

Def. 43. **Reasonable and Customary Charges**means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services ,taking into account the nature of Illness/ Injury involved.

Def. 44. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Year, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of **Your** Dependents during the Policy Year

Def. 45. **Time Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer. A Time Deductible does not reduce the sum insured.

Def. 46. **Waiting Period** is the period where we will not be liable for a claim for specified number of days and which will apply before any benefits are payable by Us. The waiting period will be computed from the date of commencement of Policy Period.

Def. 47. **We/Our/Us** means the HDFC ERGO General Insurance Company Limited

Def. 48. **Policyholder** means the person/Organization named in the Policy Schedule who has concluded this Policy with Us.

Section F – Claims Procedure

On the occurrence of any Vetor Borne Diseases that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.

Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website
Claim Intimation Timelines	Within 14 days of the diagnosis of Vector Borne Diseases

Particulars to be provided to Us for Claim notification	1. Policy Number, 2. Name of the Insured Person(s) named in the Policy schedule/Certificate of Insurance availing treatment, 3. Nature of disease/illness/injury, 4. Name and address of the attending Medical Practitioner/Hospital 5. Date and time of event if applicable 6. Date of admission
Claims documents for Vector Borne Diseases	1. Claim Form duly signed by the Insured Person; 2. Copy of Discharge Summary / Discharge Certificate; 3. First consultation letter from treating Medical Practitioner 4. Medical certificate confirming diagnosis, and the treatment of Vector Borne Diseases from Medical Practitioner 5. Certificate from treating Medical Practitioner, specifying the duration and etiology 6. All pathological Investigation Report. We may require the Insured Person to undergo medical examination by Medical Practitioner authorized by Us to obtain an independent medical opinion for the processing of the claim. Any cost towards such a medical examination will be borne by Us. 7. NEFT details & cancelled cheque 8. All original medicine / pharmacy bills along with prescription by Medical Practitioner 9.
Claims documents for Outpatient Treatment due to Vector Borne Diseases	1. All original consultation/diagnostic/pharmacy bills along with prescription by Medical Practitioner
Claims documents for Death due to Vector Borne Diseases	2. Duly Completed Claim Form signed by Nominee/ legal heir of the Insured Person. 3. Copy of address proof (Ration card or electricity bill copy). 4. Attested copy of Death Certificate. 5. Attested copy of Post Mortem Report (if conducted). 6. NEFT details & cancelled cheque of the Insured Person
Conditions for obtaining Cashless facility for Vector Borne Diseases	1. Cashless facility can be availed only at Our Network Provider. The complete list of Network Providers and Empaneled Service Providers is available on Our website and can be obtained by contacting Us. 2. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of Network Providers before applying for Cashless Claim. 3. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital and locations match with the details as per Cashless authorized. 4. We will make payment for the Cashless authorized amount directly to the Network Provider 5. Applicable for Section 2 – In case the hospital bill amount is lower than the payable benefit, We will directly pay You the difference between the benefit payable and the hospital bill amount. However, if the hospital bill amount is higher than the payable benefit, You will be require to settle the balance hospital bill on Your own. Conditions for Health Care at Home On receipt of duly filled pre authorization form with other sufficient details to assess the request, We will inform our Home Healthcare service provider who will follow the following process: i. Meet the treating medical practitioner and verify the requirement along with the prescription/discharge summary (if applicable) and the condition of the patient ii. Verify the past medical history of the patient

	iii. Complete physical examination of the patient iv. Check if the patient requires any equipment, devices etc v. Share the care plan and treatment cost estimation with Us. On receipt of the complete documents We may; i. issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable OR ii. reject the request for pre-authorization specifying reasons for the rejection.
Claims documents submission	In case of any Claim for the Insured Events, the list of documents as mentioned above shall be provided by the Policy Holder/ Insured Person, immediately but not later than 30 days of date of occurrence of an Insured Event, at own expense to avail the Claim
Condonation of delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

Section G – General Conditions

1) Fraudulent claim

i. If any claim made under the policy is found to be fraudulent, or is supported by any fraudulent means or devices or software by **Insured Person** or anyone acting on their behalf to obtain any benefit under this Policy then The policy shall be cancelled ab-initio from the inception date or the renewal date (as the case may be),
ii. All benefits payable, if any, under such Policy shall be forfeited with respect to such claim

2) Geography

This Policy only covers Medical Treatment taken within India however Claims under Section 2a) will be payable if diagnosis of the diseases is in;

- Canada
- Dubai
- Hong Kong
- Japan
- Malaysia
- New Zealand
- Singapore
- Switzerland
- USA
- European Union
- United Kingdom

3) Non Disclosure or Misrepresentation

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, willfully or otherwise, the Policy shall be:

i. cancelled ab initio from the inception date or the **Renewal** date (as the case may be), or the Policy may be modified by Us, at **Our** sole discretion, upon 30 day notice by sending an endorsement to **Your** address shown in the Schedule and
ii. the claim under such Policy if any, shall be rejected/repudiated forthwith.

4) Grace Period

i. A grace period of 30 days for Renewals is permissible and the Policy will be considered as continuous for the purpose of all waiting periods. However, any treatment availed for an Illness contracted during the grace period will not be admissible under the Policy.

ii. For **Renewal** received after completion of 30 days grace period, the policy would be considered as a fresh policy.

5) Renewal

i. The **Company** shall be under no obligation to renew the policy on expiry of the period for which premium has been paid. The **Company** reserves the right to offer revised rates, terms and conditions at renewal based on claim experience and a fresh assessment of the risk. This policy may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. The **Company**, however, shall not be bound to give notice that the policy is due for renewal or to accept any renewal premium. Unless renewed as herein provided, this policy shall automatically terminate at the expiry of the **Policy Period/ Coverage Period.**

ii. The policy is ordinarily renewable for life except on grounds of fraud, moral hazard or non-disclosure of any material facts or misrepresentation or non-cooperation by the insured Person (Subject to policy is renewed annually with us within the Grace period of 30 days from the date of Expiry)

6) Cancellation

i. **Cancellation by Insurer**
We may cancel on grounds of misrepresentation, fraud, non-disclosure of material facts as sought to be in proposal form or non-cooperation by any **Insured Person**. Cancelled ab initio from the inception date or the renewal date (as the case may be), at our sole discretion upon giving 30 days' notice

ii. **Cancellation by Insured**

You may cancel this **Policy** at any time by giving **Us** written notice. The cancellation shall be from the date of receipt of such written notice. In case of any claim made during **Policy Year**, no premium will be refunded.
If no claim has been made under the Policy, We will refund premium in accordance with the table below:

Month	**Refund %**
Up to 1 Month	85.0%
Up to 3 Month	70.0%
Up to 6 Month	45.0%
Above 6 months	0.0%

7) Premium Payment Option

i. **Policy holder/Insured Person** shall have the option to pay policy premium in total at the inception of policy or in instalments as per options as below

Options	**Installment Premium Option**	**Grace Period**
Option 1	Half Yearly	30 days
Option 2	Quarterly	30 days
Option 3	Monthly	15 days

ii. No Additional charges, on the existing premium are applicable irrespective of the Instalment Option selected.

iii. **Grace Period** of 15 days in case of Monthly premium payment option and 30 days for half yearly and Quarterly premium payment option shall be applicable. Any treatment availed for an Illness contracted during the grace period will not be admissible under the Policy.

iv. If case of non-receipt of Instalment Premium on the Instalment due date or before expiry of the grace period, the policy stands cancelled and the Premium for unexpired period will be refund as below
v. In case of Claim under the Policy, unpaid instalment premium will be recovered from the Claim amount payable.
vi. **Cancellation**
   a. Where Instalment option is not opted and premium has been paid in lump sum, cancellation grid as mentioned in clause 6 ii above will be applicable
   b. For all other Premium Payment options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable.
   c. No refund of any premium in case of any claim during policy year

8) Endorsements

The following endorsements are permissible during the **Coverage Period:**

1.1. Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Insured Person (and not the complete name change)
ii. Rectification in gender of the Insured Person (if this does not impact the premium)
iii. Rectification of date of birth of the Insured Person (if this does not impact the premium)
iv. Change in the correspondence address of the Proposer(if this does not impact the premium)
v. Change in Nominee Details
vi. Change in bank details
vii. Any other non-financial endorsement

1.2. Financial Endorsements – which result in alteration in premium

i. Cancellation of Policy
ii. Any other financial endorsement

9) Revision/ Modification of the product

We may revise the **Renewal** premium payable under the Policy or the terms of cover, with the prior approval from Insurance Regulatory and Development Authority of India. We will intimate You/ Policy Holder of any such changes at least 3 months prior to date of such revision or modification

10) Withdrawal of the Product

i. **We** may withdraw this product with the prior approval from Insurance Regulatory and Development Authority of India.
ii. **W**e will intimate **You/ Policy Holder** of any such changes at least 3 months prior to date of such revision or modification.
iii. In such an event of withdrawal of this product, **You/ Policy Holder** can choose to renew this policy under any of Our similar Health insurance products.
iv. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with **Us**

11) Payment of Claim

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i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, **We** will send a maximum of 3 (three) reminders following which **We** will send a closure letter or make a part-payment if **We** have not received the deficiency documents after 45 days from the date of the initial request for such documents
ii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, **We** shall offer within a period of 30 days a settlement of the claim to the Insured person.
iii. Upon acceptance of an offer of settlement by the **Insured person**, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the **Insured Person**. In the cases of delay in the payment **We** shall be liable

to pay 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 it.

iv. However, where the circumstances of a claim warrant an investigation, **We** will 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, **We** will settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

v. If **We**, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents.

vi. If requested by **Us** and at **Our** cost, the **Insured Person** must submit to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary and **We/Our** representatives must be permitted to inspect the medical and Hospitalization records pertaining to the treatment of **Insured Person** and to investigate the circumstances pertaining to the claim.

vii. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim

12) Contact Us

Claim Intimation:	**Toll Free** :1800 2001 999 **Phone (UAN)** :1860 2000 700 (Local charges applicable) **Fax (UAN)** : 1860 2000 600 (Local charges applicable) **Email**:healthclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Sector 62 Noida – 0120 398 8360

13) Grievance Redressal Procedure

i. If You/ Policy Holder have a grievance that You/ Policy Holder wish Us to redress, You/ Policy Holder may contact Us with the details of grievance as given below

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call - 1800-2700-700	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - 1800-2700-700	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - 1800-2700-700
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West). MUMBAI – 400078.	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

ii. If You/ Policy Holder are not satisfied with **Our** redressal of grievance through one of the above methods, You/ Policy Holder may approach the nearest Insurance Ombudsman for resolution of **Your** grievance. The contact details of Ombudsman offices are mentioned below.

List of Ombudsman

GUJARAT,DADRA & NAGAR HAVELI,DAMAN AND DIU
AHMEDABAD - Shri/Smt.....
Office of the Insurance Ombudsman,
JeevanPrakash Building, 6th floor,
TilakMarg,
Relief Road,
Ahmedabad – 380 001.
Tel.: 079 - 25501201/02/05/06
Email: bimalokpal.ahmedabad@ecoi.co.in

KARNATAKA.
BENGALURU - Smt. Neerja Shah
Office of the Insurance Ombudsman,
JeevanSoudhaBuilding,PID No. 57-27-N-19
Ground Floor, 19/19, 24th Main Road,
JP Nagar, Ist Phase,
Bengaluru – 560 078.
Tel.: 080 - 26652048 / 26652049
Email: bimalokpal.bengaluru@ecoi.co.in

MADHYA PRADESH, CHATTISGARH
BHOPAL - Shri Guru Saran Shrivastava
Office of the Insurance Ombudsman,
JanakVihar Complex, 2nd Floor,
6, Malviya Nagar, Opp. Airtel Office,
Near New Market,
Bhopal – 462 003.
Tel.: 0755 - 2769201 / 2769202
Fax: 0755 – 2769203
Email: bimalokpal.bhopal@ecoi.co.in

ORISSA
BHUBANESHWAR - Shri/Smt.....
Office of the Insurance Ombudsman,
62, Forest park,
Bhubneshwar – 751 009.
Tel.: 0674 - 2596461 /2596455
Fax: 0674 – 2596429
Email: bimalokpal.bhubaneswar@ecoi.co.in

PUNJAB,HARYANA,HIMACHAL PRADESH,JAMMU & KASHMIR,CHANDIGARH
CHANDIGARH - Dr. Dinesh Kumar Verma
Office of the Insurance Ombudsman,
S.C.O. No. 101, 102 & 103, 2nd Floor,
Batra Building, Sector 17 – D,
Chandigarh – 160 017.
Tel.: 0172 - 2706196 / 2706468
Fax: 0172 – 2708274
Email: bimalokpal.chandigarh@ecoi.co.in

TAMIL NADU,PONDICHERRY TOWN AND KARAIKAL (WHICH ARE PART OF PONDICHERRY).
CHENNAI - Shri M. Vasantha Krishna
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.
DELHI - Shri/Smt.....
Office of the Insurance Ombudsman,
2/2 A, Universal Insurance Building,
Asaf Ali Road,
New Delhi – 110 002.
Tel.: 011 - 23232481/23213504
Email: bimalokpal.delhi@ecoi.co.in

ASSAM,MEGHALAYA,MANIPUR,MIZORAM, ARUNACHAL PRADESH, NAGALAND AND TRIPURA
GUWAHATI - ShriKiriti .B. Saha
Office of the Insurance Ombudsman,
JeevanNivesh, 5th Floor,
Nr. Panbazar over bridge, S.S. Road,
Guwahati – 781001(ASSAM).
Tel.: 0361 - 2632204 / 2602205
Email: bimalokpal.guwahati@ecoi.co.in

ANDHRA PRADESH,TELANGANA,YANAM AND PART OF TERRITORY OF PONDICHERRY.
HYDERABAD - Shri I. Suresh Babu
Office of the Insurance Ombudsman,
6-2-46, 1st floor, "Moin Court",
Lane Opp. Saleem Function Palace,
A. C. Guards, Lakdi-Ka-Pool,
Hyderabad - 500 004.
Tel.: 040 - 67504123 / 23312122
Fax: 040 – 23376599
Email: bimalokpal.hyderabad@ecoi.co.in

RAJASTHAN.
JAIPUR - Smt. SandhyaBaliga
Office of the Insurance Ombudsman,
JeevanNidhi – II Bldg.,
Ground Floor,
Bhawani Singh Marg,
Jaipur - 302 005.
Tel.: 0141 – 2740363
Email: Bimalokpal.jaipur@ecoi.co.in

KERALA, LAKSHADWEEP,MAHE-A PART OF PONDICHERRY.
ERNAKULAM - Shri/Smt.....
Office of the Insurance Ombudsman,
2nd Floor, Pulinat Bldg.,
Opp. Cochin Shipyard, M. G. Road,
Ernakulam - 682 015.
Tel.: 0484 - 2358759 / 2359338
Fax: 0484 – 2359336
Email: bimalokpal.ernakulam@ecoi.co.in

WEST BENGAL,SIKKIM,ANDAMAN & NICOBAR ISLANDS
KOLKATA - Shri/Smt.....
Office of the Insurance Ombudsman,
Hindustan Bldg. Annexe, 4th Floor,
4, C.R. Avenue,
KOLKATA - 700 072.
Tel.: 033 - 22124339 / 22124340
Fax : 033 – 22124341
Email: bimalokpal.kolkata@ecoi.co.in

LUCKNOW -Shri/Smt.....
Office of the Insurance Ombudsman,
6th Floor, JeevanBhawan, Phase-II,
Nawal Kishore Road,

NOIDA - Shri/Smt.....
Office of the Insurance Ombudsman,
BhagwanSahai Palace
4th Floor, Main Road,

Hazratganj,	Naya Bans, Sector 15,
Lucknow - 226 001.	Distt: GautamBuddh Nagar,
Tel.: 0522 - 2231330 / 2231331	U.P-201301.
Fax: 0522 – 2231310	Tel.: 0120-2514250 / 2514252 / 2514253
Email: bimalokpal.lucknow@ecoi.co.in	Email: bimalokpal.noida@ecoi.co.in
Districts of Uttar Pradesh :	**State of Uttaranchal and the following 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.	Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

GOA, MUMBAI METROPOLITAN REGION, EXCLUDING NAVI MUMBAI & THANE	**BIHAR,JHARKHAND**
MUMBAI - ShriMilind A. Kharat	PATNA
Office of the Insurance Ombudsman,	Office of the Insurance Ombudsman,
3rd Floor, JeevanSeva Annexe,	1st Floor,Kalpana Arcade Building,,
S. V. Road, Santacruz (W),	Bazar Samiti Road,
Mumbai - 400 054.	Bahadurpur,
Tel.: 022 - 26106552 / 26106960	Patna 800 006.
Fax: 022 – 26106052	Tel.: 0612-2680952
Email: bimalokpal.mumbai@ecoi.co.in	Email: bimalokpal.patna@ecoi.co.in

MAHARASHTRA,AREA OF NAVI MUMBAI AND THANE, EXCLUDING MUMBAI METROPOLITAN REGION.
PUNE
Office of the Insurance Ombudsman,
JeevanDarshan Bldg., 3rd Floor,
C.T.S. No.s. 195 to 198,
N.C. Kelkar Road, Narayan Peth,
Pune – 411 030.
Tel.: 020-41312555
Email: bimalokpal.pune@ecoi.co.in