POLICY WORDINGS

1. PREAMBLE

This Policy is a contract of insurance issued by ICICI Lombard GIC Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the Proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period the Insured Person is diagnosed (through laboratory examination and confirmed by the medical practitioner) with any Vector Borne Disease covered in this policy and hospitalized for a minimum period of seventy-two (72) consecutive hours at a Hospital following Medical Advice of a duly qualified Medical Practitioner, the Company shall pay the agreed sum insured as mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage, exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during the Policy Period shall be the Sum Insured (Individual or Floater) opted and specified in the Schedule.

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female, other genders and references to any statutory enactment includes subsequent changes to the same.

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

3.2. Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

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

3.4. Day Care Treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
ii. which would have otherwise required a hospitalization of more than twenty four hours.
iii. treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

3.6. Family means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

i. Legally wedded spouse
ii. Parents and Parents-in-law
iii. Dependent Children (i.e. natural or legally adopted) between the day 1 of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage.

3.7. Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity

benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

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

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

3.9. Hospitalization means admission in a hospital for a minimum period of seventy two (72) consecutive hours of 'In-patient care', provided it will not include procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

3.10. In-Patient Care means treatment for which the insured person has to stay in a hospital for more than 72hours for a covered event.

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

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

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

3.14. Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

i. is required for the medical management of illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.15. "Migration" means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

3.16. Nominee means the person nominated by the insured to receive the insurance benefits under this policy payable on the death of the insured.

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

3.18. Out-Patient (OPD) Treatment means treatment 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.

3.19. Pre-Existing Disease (PED): Pre-Existing disease means any condition, ailment, injury or disease:

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement.

3.20. "Portability" means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

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

3.22. Policy period means period of one policy year as mentioned in the schedule for which the Policy is issued.

3.23. Policy Schedule means the Policy Schedule attached to and forming part of Policy.

3.24. 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.

3.25. Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum and total liability for any claim made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Period.

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

3.27. Unproven/Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India.

3.28. Waiting Period means a period from the inception of this Policy during which specified vector borne disease (s) is/are not covered.

4. SCOPE OF COVER:

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

4.1 Hospitalization Benefit:

Lump sum benefit up to 100% of the Sum Insured (excluding the amount paid under diagnosis cover referred at clause 4.2, if any) shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of any of the following vector borne disease (s) if insured is hospitalized for a minimum period of seventy-two (72) consecutive hours.

i. Dengue fever
ii. Malaria
iii. Filaria (Lymphatic Filariasis)
iv. Kala-azar
v. Chikungunya
vi. Japanese Encephalitis
vii. Zika Virus

4.2 Diagnosis Cover:

2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under "diagnosis cover" for each disease only once in each of the policy year.

Note:

i. The total amount payable in respect of Covers 4.1 and 4.2 shall not exceed 100% of the Sum Insured during a policy period.
ii. Any laboratory test not recognized/ approved in India for diagnosis of the covered vector borne diseases is not covered.
iii. On payment of 100% of sum insured, the policy shall be terminated for the policy year. In case where a policy is issued to a family with individual sum insured for each member, policy will continue for the rest of the insured members.
iv. Once the Sum Insured is paid under the policy for any Insured Beneficiary for Filaria (Lymphatic Filariasis), notwithstanding the terms and conditions, no other claim for this particular condition shall be paid to the Named Insured Beneficiary in his/her entire lifetime.

5. Waiting Period:

5.1 First fifteen-days waiting period

The Company shall not be liable to make any payment under the policy if the covered vector borne disease is diagnosed or hospitalization takes place during first fifteen days (15 days) from the commencement date of this Policy unless insured person is covered under this Policy continuously and without any break in the previous Policy Year.

5.2 Cooling Off Period:

If the Policy is renewed within 30 days from the date of discharge of the previously paid claim for the named insured a 30 days cooling off period shall apply for the same ailment in the renewed Policy. However, there would be no waiting period for other listed vector borne diseases.

6. EXCLUSIONS

6.1 General Exclusions:

The Company shall not be liable to make any payment under the policy in respect of:

i. Claim for any illness/disease other than for vector borne diseases covered under the policy
ii. Diagnosis / Treatment outside the geographical limits of India
iii. Any laboratory test not recognized / approved by the state or central government
iv. **Unproven Treatments:** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

6.2 Exclusions specific to Section 4.1:

i. Domiciliary Hospitalization, Day care OPD treatment.
ii. Investigation & Evaluation
   a. Expenses related to any admission primarily for diagnostics and evaluation purposes
   b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment
iii. Rest Cure, rehabilitation and respite care
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

iv. Excluded Providers

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

v. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

vi. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

vii. Hospitalization for treatment other than allopathy.

viii. Hospitalization for less than a minimum period of seventy-two (72) consecutive hours.

7. CLAIM PROCEDURE

7.1 Notification of claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

7.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable) / Company within the prescribed time limit as specified hereunder.

Sl No	Type of Claim	Prescribed Time limit
1.	Hospitalization Benefit	Within thirty days (30 days) from date of discharge from hospital following positive diagnosis of covered vector borne disease
2.	Diagnosis Cover	Within Fifteen days (15 days) of Diagnosis of the covered vector borne disease

7.3 Documents to be submitted:

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

Benefits	Claims Documents Required
1. Hospitalization Benefit	i. Duly filled and signed Claim Form ii. Photo Identity proof of the patient iii. Medical practitioner's prescription advising admission iv. Discharge summary including complete medical history of the patient along with other details. v. Laboratory report(s) confirming the diagnosis vi. OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable

	vii. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque. viii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs one (1) Lakh or as per extant AML Guidelines. ix. Legal heir/succession certificate, wherever applicable x. Any other relevant document required by Company/TPA for assessment of the claim.
2. Diagnosis Cover	i. Duly filled and signed Claim Form ii. Photo Identity proof of the patient iii. Laboratory report(s) confirming the diagnosis iv. Payment receipt (s) v. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque vi. Legal heir/succession certificate, wherever applicable vii. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

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

7.4 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

7.5 Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim assessment, under this Policy by way of processing of claims, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

7.6 Payment of Claim

All claims under the policy shall be payable in Indian currency only.

8. GENERAL TERMS & CONDITIONS

8.1 Disclosure of Information

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

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

8.2 Condition Precedent to Admission of Liability

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

8.3 Material Change

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

8.4 Records to be maintained

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

8.5 Complete Discharge

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

8.6 Notice & Communication

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

8.7 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

8.8 Fraud

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

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

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

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

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

8.9 Cancellation

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

Refund of Premium (basis Policy Period)	
Risk Period (Policy in force)	**Refund %**
Up to 30 days	77.5%
31 to 90 days	62.5%
3 to 6 months	42.5%
6 to 12 months	0%

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

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

8.10 Renewal of Policy

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.
vi. If the Policy is renewed within 30 days from the date of discharge of the previously paid claim for the named insured a 30 days cooling off period shall apply for the same ailment in the renewed Policy. However, there would be no waiting period for other listed vector borne diseases.

8.11 Withdrawal of Policy

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

8.12 Automatic change in Coverage under the policy is permitted:

i. In the case of Insured Person's demise. However, the cover shall continue for the remaining Insured Person (s) till the end of Policy Period. The other insured person (s) may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of natural guardian or guardian appointed by court for the minor insured person. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.
ii. Upon exhaustion of sum insured for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

8.13 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

8.14 Arbitration

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

8.15 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

8.16 Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

8.17 Endorsements (Changes in Policy)

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

ii. The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any).

8.18 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

8.19 Terms and conditions of the Policy

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

8.20 Nomination

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

9. REDRESSAL OF GRIEVANCE

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

Website: www.icicilombard.com (Customer Support section)
Toll free: 1800 2666 (Senior Citizen included) - In case you are a senior citizen, your call shall be transferred to the Priority Desk and immediate support shall be provided
E-mail: customersupport@icicilombard.com
Fax: +91-40-66789768

Courier: **To the Manager – Service Quality**, ICICI Lombard General Insurance Company Limited, ICICI Lombard House 414, Veer Savarkar Marg, Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance:

Manager- Service Quality,
Corporate Manager- Service Quality,
National Manager- Operations & finally
Director-services and Business development at the following address:
ICICI Lombard General Insurance Company Limited,
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400025

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at Insurance Regulatory and Development Authority of India;

Grievance Call Centre (IGCC) Toll Free No:155255
Email ID: complaints@irda.gov.in.

For updated details of grievance officer, kindly refer the link - https://www.icicilombard.com/grievance-redressal

Insurance Ombudsman – If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.The contact details of the Insurance Ombudsman offices have been provided as Annexure-A.

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

10. TABLE OF BENEFITS

Name	ICICI Lombard Mashak (Mosquito) Rakshak
Product Type	Individual/ Floater
Category of Cover	Benefit
Sum insured	Rs 10,000/- (Ten Thousand) to 2,00,000/- (Two Lakh) (in the multiples of ten thousand) On Individual basis– SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Policy Period	Standard Product shall be offered with a policy tenure of one year (12 Months).
Eligibility	Minimum entry age shall be 18 years for principal insured and maximum age at entry shall not be less than 65 years for all the insured members including principal insured Policy can be availed for Self and the following family members i. legally wedded spouse. ii. Parents and Parents-in-law. iii. Dependent Children (i.e. natural or legally adopted) between the day 1 of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible.

Hospitalization Benefit	Lump sum benefit equal to 100% of the Sum Insured (excluding the amount paid under diagnosis cover, if any) shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of any of the following vector borne disease (s) if insured is hospitalized for a minimum period of seventy-two (72) consecutive hours
Diagnosis Cover	2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under “diagnosis cover” for each disease only once in each of the policy years.
Sub-limits Diagnosis cover	2% of sum insured

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

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - **Shri Kuldip Singh** Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - **Smt. Neerja Shah** Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
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	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
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	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).

DELHI - Shri Sudhir Krishna 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	Delhi.
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
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	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra 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	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri P. K. Rath 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	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar,

	Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.