THE NEW INDIA ASSURANCE CO. LTD,

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai – 400 001

TERTIARY CARE INSURANCE - INDIVIDUAL

(MAJOR ILLNESS / INJURYHOSPITALISATION / DOMICILIARY HOSPITALISATION EXPENSES REIMBURSEMENT INSURANCE POLICY)

1.0 COVERAGES

WHEREAS THE Insured designated in the Schedule hereto has by a Proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to THE NEW INDIA ASSURANCE COMPANY LTD. (Hereinafter called the COMPANY) for the insurance hereinafter set forth in respect of person named in the Schedule hereto (hereinafter called the INSURED PERSON) and has paid premium as consideration for such insurance,

NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any of the below mentioned Major Illness / Injury (herein defined),

A. Nephritis of any Aetiology plus Bacterial renal failure requiring Kidney Transplantation or Dialysis

B. Cerebral or Vascular Strokes

C. Open and Close Heart Surgery (inclusive of C.A.B.G)

D. Malignancy disease which are confirmed on Histopathological report

E. Encephalitis (Viral)

F. Neuro Surgery

G. Total Replacement of joints

H. Liver disorder (Hepatitis B & C) associated with complications like Cirrhosis of liver

I. Grievous Injury including multiple fracture of long bones, head Injury leading to unconsciousness, burns of more than 40%, Injury requiring artificial ventilator support plus Vertebral Column Injury

And if such condition shall require any such Insured Person, upon the advice of a duly qualified Medical Practitioner / Medical Surgeon to incur

a) Hospitalisation expenses for medical/surgical treatment at any Hospital in India as herein defined (herein defined) as an Inpatient OR

b) On Domiciliary treatment in India under Domiciliary Hospitalisation (herein defined), the Company will pay to the Insured Person the amount of such expenses as are Reasonable and Customary, and Medically Necessary incurred in respect thereof by or on behalf of such

Insured Person.

c) In the event of any claim becoming admissible under this scheme, the company will pay to the Insured person the amount of such expenses as would fall under different heads mentioned below, and as are Reasonable and Customary, and Medically Necessary incurred thereof by or on behalf of such Insured Person.

i. Room, Boarding Expenses as provided by the Hospital which includes Registration & Admission Fees.
ii. Nursing Expenses.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees
iv. Anesthesia, Blood, Oxygen, Operation Theater Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses.
v. Reasonable expenses incurred for ambulance within city limits at the time of admission and discharge only.
vi. Pre-Hospitalisation Medical Expenses
vii. Post-Hospitalisation Medical Expenses

N.B. Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured (with Cumulative Bonus) per person per annum to be reckoned from the date of inception of the risk as mentioned in the schedule.

d) This insurance scheme also provides for Cumulative Bonus.

e) Hospitalisation expenses, which are Reasonable and Customary, and Medically Necessarily incurred on person donating the organ to the insured person during the course of organ transplant operation subject to limits available during the policy period.

f) **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).

g) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods.

h) **COVERAGE FOR MODERN TREATMENTS or PROCEDURES:** The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S No	Treatment or Procedure	Limit (Per Policy Period)
h.1	Deep Brain stimulation.	Up to 10% of Sum Insured
h.2	Oral chemotherapy.	Up to 10% of Sum Insured
h.3	Immunotherapy- Monoclonal Antibody to be given as injection.	Up to 10% of Sum Insured
h.4	Robotic surgeries.	Up to 10% of Sum Insured
h.5	Stereotactic radio surgeries.	Up to 10% of Sum Insured
h.6	IONM - (Intra Operative Neuro Monitoring).	Up to 10% of Sum Insured
h.7	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Up to 10% of Sum Insured

Note: For the coverages defined in f & g, waiting period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f 1st October 2020. Coverage for such illness or procedures shall only be available after completion of the said waiting periods.

i) TREATMENT FOR CONGENITAL DISEASES

Congenital Internal Disease or Defects or anomalies shall be covered after **Twenty Four** months of Continuous Coverage.

Congenital External Disease or Defects or anomalies shall be covered after **Forty-Eight** months of Continuous Coverage, but such cover for Congenital External Disease or Defects or anomalies shall be limited to 10% of **the average Sum Insured in the preceding four years.**

2.0 DEFINITIONS:

2.1 AGE means age of the Insured person on last birthday as on date of commencement of the Policy.

2.2 ANY ONE MAJOR ILLNESS means continuous Period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital where treatment may have been taken.

2.3 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.

2.4 CANCELLATION: Cancellation defines the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of fifteen days.

2.5 CASHLESS FACILITY means a facility extended by Us to You where the payments, of the costs of treatment undergone by You in accordance with the policy terms and conditions, are directly made to the Network provider by Us to the extent of pre-authorization approved.

2.6 CONDITION PRECEDENT: Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

2.7 CONGENITAL ANOMALY refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

2.7.1 CONGENITAL INTERNAL ANOMALY means a Congenital Anomaly which is not in the visible and accessible parts of the body.

2.7.2 CONGENITAL EXTERNAL ANOMALY means a Congenital Anomaly which is in the visible and accessible parts of the body.

2.8 CUMULATIVE BONUS: Cumulative Bonus shall mean any increase in the Sum Insured

granted by the insurer without an associated increase in premium.

2.9 DAY CARE TREATMENT: Day Care treatment refers to medical treatment, and/or Surgery which are:

- Undertaken under General or Local Anesthesia in a Hospital/ Day Care Centre in less than twenty four hours because of technological advancement, and
- Which would have otherwise required a Hospitalisation of more than twenty four hours.

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

2.10 DEDUCTIBLE: A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

2.11 DOMICILIARY HOSPITALISATION: Domiciliary Hospitalisation means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- The patient takes treatment at home on account of non-availability of room in a hospital.

2.12 HOSPITAL: A Hospital means any institution established for Inpatient Care and Day Care Treatment of Illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishment (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 Inpatient beds, in those towns having a population of less than 10,00,000 and 15 Inpatient 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 Surgeries are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

2.13 HOSPITALISATION means admission in a Hospital for a minimum period of twenty four In-patient Care consecutive hours except for specified procedures / treatments i.e. Dialysis, Chemotherapy, Radiotherapy; where such admission could be for a period of less than twenty four consecutive hours.

Note: Procedures/treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than twenty four consecutive hours.

2.14 DAY CARE CENTRE: A Day Care Centre means any institution established for day care treatment of Illness and/or Injury or a medical setup within a Hospital and which has been

registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- has qualified nursing staff under its employment;
- has qualified Medical Practitioner/s in charge;
- Has a fully equipped operation theatre of its own where Surgeries are carried out;
- Maintains daily record of patients and will make these accessible to the insurance company's authorized personnel.

2.15 ILLNESS: Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.

ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics

a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

b. it needs ongoing or long-term control or relief of symptoms

c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it

d. it continues indefinitely

e. it recurs or is likely to recur

2.16 INJURY: 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.

2.17 INPATIENT CARE: Inpatient care means treatment for which the insured person has to stay in a Hospital for more than twenty four hours for a covered event.

2.18 MAJOR ILLNESS

2.18.1 CANCER OF SPECIFIED SEVERITY

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

2.18.2 OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:
i. Angioplasty and/or any other intra-arterial procedures

2.18.3 OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart +valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

2.18.4 STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. **The following are excluded:**
i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

2.18.5 PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

2.18.6 ANGIOPLASTY

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

2.18.7 BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are **excluded:**

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

2.18.8 END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is **excluded.**

2.18.9 MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident

must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:
   i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv. Mobility: the ability to move indoors from room to room on level surfaces;
   v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
   i. Spinal cord injury;

2.18.10 THIRD DEGREE BURNS

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

2.19 MEDICAL EXPENSES: Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury 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 Practitioner in the same locality would have charged for the same medical treatment.

2.20 MEDICALLY NECESSARY: Medically Necessary treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- is required for the medical management of the Illness or Injury suffered by the insured;
- 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.

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

Note: The Medical Practitioner should not be the insured or close family members.

2.22 NETWORK HOSPITAL means Hospitals enlisted by Us, TPA or jointly by Us and TPA to provide medical services to an insured by a cashless facility.

2.23 NON-NETWORK HOSPITAL means any hospital that is not part of the network.

2.24 NOTIFICATION OF CLAIM means the process of intimating a claim to Us or TPA through any of the recognized modes of communication.

2.25 PRE-EXISTING DISEASE (PED) means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by Us and its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

2.26 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during 30 days immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

2.27 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred during 60days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

2.28 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.

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

2.30 POLICY SCHEDULE means the Policy Schedule attached to and forming part of Policy.

2.31 POLICY YEAR means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month

period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

2.32 PORTABILITY: 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.

2.33 QUALIFIED NURSE: 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.

2.34 REASONABLE AND CUSTOMARY EXPENSES mean 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.

2.35 RENEWAL: Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of renewing within 30 days from the date of expiry of the policy for treating the renewal continuous for the purpose of all waiting periods.

2.36 ROOM RENT: Room Rent means the amount charged by a Hospital for the occupancy of a bed per day (twenty-four hours) basis and shall include associated medical expenses.

2.37 SUB-LIMIT means a cost sharing requirement under this policy in which We would not be liable to pay any amount in excess of the pre-defined limit

2.38 SUM INSURED is the maximum amount of coverage opted for each Insured Person and shown in the Schedule.

2.39 SURGERY: Surgery means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

2.40 UNPROVEN/EXPERIMENTAL TREATMENT: Treatment including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

2.41 WAITING PERIOD means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

2.42 WE/OUR/US/COMPANY means **The New India Assurance Co. Ltd.**

2.43 YOU/YOUR means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one) in the Schedule.

3.0 EXCLUSIONS:

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

expenses whatsoever incurred by any Insured Person in connection with or in respect of :-

3.1 PRE-EXISTING DISEASES (Code- Excl01)

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

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

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

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

3.2 FIRST THIRTY DAYS WAITING PERIOD (Code- Excl03)

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

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

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

3.3 INVESTIGATION & EVALUATION (Code- Excl04)

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

However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

3.4 COSMETIC OR PLASTIC SURGERY (Code- Excl08)

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

3.5 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

Note: Liver disorders arising out of consumption of drugs/alcohol.

3.6 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

3.7 Bodily Injury or Illness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted Injury and attempted suicide.

However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.

3.8 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:

a. 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.

b. 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.

c. 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.

3.9 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.

3.10 Treatment taken outside the geographical limits of India

3.11 Naturopathy treatment

3.12 Stem cell implantation/Surgery for other than those treatments mentioned in clause h.7

3.13 All other conditions not defined as major Illness / Injury in this policy.

4.0 CONDITIONS

4.1 Every notice or communication to be given or made under this Policy shall be delivered in writing at the address as shown in the Schedule.

4.2 The premium payable under this policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfillment of the terms provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a Condition Precedent to any liability of the Company to make any payment under the Policy. No waiver of any terms, provisions, conditions and endorsement of this policy shall be valid unless made in writing and signed by an

authorized official of the Company.

4.3 Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to the Company within 7 days from the date of Injury, Hospitalisation / Domiciliary Hospitalisation.

4.4 Final claim along with documents as listed below should be submitted to the company within 30 days of discharge from the Hospital:

i. Bill, Receipt and Discharge certificate / card from the Hospital.
ii. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
iii. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.
iv. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.
v. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.
vi. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Note: Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the company that under the circumstances in which insured was placed, it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

4.5 The Insured Person shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company such additional information and assistance as the Company may require in dealing with the claim.

4.6 Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged major Illness / Injury requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the Company.

4.7 **FRAUD, MISREPRESENTATION, CONCEALMENT:** The policy shall be null and void, and no benefits shall be payable in the event of:-

a) Misrepresentation, misdescription or nondisclosure of any material fact/particular.
b) The claim is in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his/her behalf.

4.8 **MULTIPLE POLICIES:**

1. In case of multiple policies taken by You during a period from Us or one or more Insurers to indemnify treatment costs, You shall have the right to require a settlement of Your claim in terms of any of his/her policies. In all such cases We, if chosen by You, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this Policy.
2. Insured having multiple policies shall also have the right to prefer claims under this

policy for the amounts disallowed under any other policy / policies, even if the Sum Insured is not exhausted. Then We shall independently settle the claim subject to the terms and conditions of this Policy.

3. If the amount to be claimed exceeds the Sum Insured under a single policy after, You shall have the right to choose Insurers from whom You wants to claim the balance amount.
4. Where an Insured has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the chosen policy.

Note: The insured Person must disclose such other insurance at the time of making a claim under this Policy. None of the provisions of this Clause shall apply for payments under Clause 4.17 of the Policy.

4.9 CANCELLATION CLAUSE: The Insured may at any time cancel this Policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given below) provided no claim has occurred up to the date of cancellation.

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED
Upto one month	1/4th of the annual rate
Upto three months	1/2 of the annual rate
Upto six months	3/4th of the annual rate
Exceeding six months	Full annual rate

4.10 ARBITRATION:

If We admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration. The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996. No reference to Arbitration shall be made unless We have Admitted Our liability for a claim in writing. If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

4.11 NOTICE OF CLAIM: Preliminary notice of claim with particulars relating to Policy Numbers, Name of insured person in respect of whom claim is made, Nature of major Illness / Injury and Name and Address of the attending Medical Practitioner/Hospital should be given to the Insurance Company/TPA within seven days from the date of Hospitalisation/Injury/Death.

4.12 PAYMENT OF CLAIM:

i. We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last 'necessary' document.
ii. While efforts will be made by Us to not call for any document not listed in Clause 4.4, where any additional document or clarification is necessary to take a decision on the claim, such additional documents will be called for.
iii. All necessary claim documents pertaining to Hospitalisation should be furnished by the Insured Person in original to the TPA (as mentioned in the Schedule), within seven days

from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.

a. In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.

b. In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.

c. The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.

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

v. However, where the circumstances of a claim warrant an investigation in the opinion of the Insurer, We 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, We shall settle the claim within 45 days from the date of receipt of last necessary document.

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

4.13 PRE-MEDICAL HEALTH CHECK-UP: Insured has to submit blood, urine test reports, ECG, Chest X-ray and such other reports along with the Certificate from Medical Practitioners stating that the Insured is free from all the nine major Illness / Injury proposed for Insurance under this policy. The cost of pre-medical check-up at the time of first inception of the policy and when required because of break in renewal for more than thirty days will be borne by the Insured (In case the risk is accepted, 50% of the reasonable cost of Medical Examination would be reimbursed). The family physician's certificate stating the health status of the Insured in a prescribed Performa should also accompany the proposal form.

4.14 CUMULATIVE BONUS: Sum insured under the policy shall be progressively increased by 5% in respect of each claim free Policy Period, subject to maximum accumulation of 10 claim-free years of insurance.

4.15 In case of a claim under the policy in respect of insured person who has earned the cumulative bonus the increased percentage will be reduced by 5%of sum insured at the next period of insurance in case of long-term policies(or renewal in case of annual policies). However, basic sum insured will be maintained and will not be reduced.

Cumulative bonus will be lost if policy is not renewed on or within 30 days from the date of expiry of this policy.

4.16 COST OF HEALTH CHECK-UP: In addition to cumulative bonus, the insured shall be entitled for reimbursement of cost of medical check-up once at the end of block of every four Policy Periods provided there are no claims reported during the block. The

cost so reimbursable shall not exceed the amount equal to 1 % of the average Sum Insured during the block of four continuous claims free Policy Periods.

IMPORTANT
For Cumulative Bonus and Health Check-up Provisions as aforesaid

Both Health Check-up and Cumulative Bonus provisions are applicable only in respect of continuous insurance without break excepting however, where in exceptional circumstances the break in period for a maximum of thirty days is approved as a special case subject to medical examination and exclusion of disease during the break period.

Health Check-up benefit will be accrued after completion of four years continuous claim free insurance.

4.17 RENEWAL CLAUSE:

We shall renew this Policy if You shall remit the requisite Premium to Us prior to expiry of the Period of Insurance stated in the Schedule. We shall be entitled to decline renewal if:

1. Any fraud, misrepresentation or suppression by You or any one acting on Your behalf is found either in obtaining insurance or subsequently in relation thereto, or non-cooperation of the Insured Person; or
2. We have discontinued issue of the Policy, in which event You shall however have the option for renewal under any similar Policy being issued by Us, provided however, benefits payable shall be subject to the terms contained in such other Policy; or
3. You fail to remit Premium for renewal before expiry of the Period of Insurance. We will accept renewal of the Policy if it is effected within thirty days of the expiry of the Period of Insurance. On such acceptance of renewal, We, however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalization commencing in the interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy.

Note: In case of revision or modification or withdrawal of the Policy a notice will be provided to You 90 days before such revision or modification or withdrawal.

4.18 FREE LOOK PERIOD: The free look period shall be applicable at the inception of the policy.

Insured person will be allowed a period of fifteen days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

If the Insured person has not made any claim during the free look period, he/she shall be entitled to:

1. A refund of the premium paid less any expenses incurred by Company on medical examination and the stamp duty charges or;
2. where the risk has already commenced and the option of return of the policy is

exercised by Insured person, a deduction towards the proportionate risk premium for period on cover or;

3. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

4.19 PROTECTION OF POLICY HOLDERS' INTEREST:

This policy is subject to IRDAI (Protection of Policyholders' Interests) Regulation, 2017.

4.20 PORTABILITY AND MIGRATION:

Migration:

You will have the option to migrate the policy to other Health Insurance products/plans offered by the company by applying for migration of the policy at-least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If You are presently covered and has been continuously covered without any lapses under any Health Insurance product/plan offered by the Company, then You will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration. For detailed guidelines on Migration. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

Portability:

You will have the option to port the policy to other Insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at-least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any Health Insurance policy with an India General/Health Insurer, the proposed Insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For detailed guidelines on Portability. Kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_NoYearList.aspx?DF=RL&mid=4.2

4.21 GRIEVANCE REDRESSAL: In the event of Insured person having any grievance relating to the insurance, he/she may contact any of the Grievance Cells at Regional Offices of the Company or Office of the Insurance Ombudsman under the jurisdiction of which the Policy Issuing Office falls. The contact detail of the office of the Insurance Ombudsman is provided in the Annexure II.

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

4.23 The expenses that are not covered in this policy are placed under List-I of Annexure-I. The list of expenses that are to be subsumed into room charges, or procedure charges

or costs of treatment are placed under List-II, List-III and List-IV of Annexure-I respectively.

ENDORSEMENT FOR ADDITIONAL COVER

Endorsement No. extending insurance

under policy No. in the name of

In consideration of the payment of additional premium amounting to Rs.

it is hereby agreed & declared that notwithstanding anything in the within mentioned policy contained to the contrary, the insurance is extended to cover compensation arising out of Hospitalisation of the Insured Person due to covered major Illness / Injury.

In the event of an admissible claim under Hospitalisation section of this policy, expenses not exceeding Rs. 500/- per week shall be reimbursed towards the boarding and lodging expenses in the hospital for one of the family members or next of kin who accompanies the Insured Person during the period of Hospitalisation. The weekly compensation shall not be payable for more than 52 weeks in respect of any one covered major Illness / Injury / policy period. This optional cover is subject to payment of additional premium as mentioned in the premium chart.

This endorsement has been Subject otherwise to the terms, exceptions, conditions, limitations of the original policy.

Duly Constituted Attorney's

ANNEXURE I:

List I – Items for which coverage is not available in the policy

S No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER

52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

S No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES

35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

S No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

S No	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION⁄STERILLIUM
17	Glucometer& Strips
18	URINE BAG

ANNEXURE II: CONTACT DETAILS OF INSURANCE OMBUDSMEN

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**	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**
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**	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**
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 - **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**
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**	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**
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**	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**
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**	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**
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**	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**
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**	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**
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**	