THE ORIENTAL INSURANCE COMPANYLIMITED

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110002

CIN No.U66010DL1947GOI007158

Policy Document

ORIENTAL HAPPY CASH – Nishchint Rahein !

1. WHEREAS the insured named in the Schedule hereto, has by a proposal and declaration, (which shall be the basis of this Contract and is deemed to be incorporated herein) applied to THE ORIENTAL INSURANCE COMPANY LIMITED (hereinafter called the **COMPANY**) for the insurance hereinafter set forth in respect of persons(s) named in the Schedule hereto (hereinafter called the **INSURED PERSON**(S)) and has paid premium to the **Company** as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called the **TPA**) or the **Company** as the case maybe.

   NOW THIS POLICY WITNESSES 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 of insurance stated in the Schedule any **insured** Person shall contract any disease or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require, upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') admission in a Hospital / Nursing home (as defined hereafter) for medical/surgical treatment at any Hospital/Nursing Home in India as herein defined (hereinafter called 'HOSPITAL'), the **Company** shall pay benefits as per the policy terms & conditions. In any case the liability of the **Company** shall be strictly in accordance with the period and amounts stated in the schedule.

2. **COVERAGE:** Subject to terms, conditions and exclusions herein contained or otherwise expressed herein, the policy pays to the insured, the following benefits:

3. **HOSPITALISATION BENEFIT** – In the event of the insured person getting hospitalized, a **Daily Cash Benefit** as mentioned in the schedule shall become payable, limited to the Daily Cash Benefit Period selected by the insured. For the purpose of calculating the number of days for which this benefit becomes payable, each continuous and completed period of 24 hours of hospitalisation shall only be considered. The Policy will pay for any number of hospitalisations, in a policy period, subject to any single hospitalisation not exceeding the Daily Cash Benefit Period selected by the Insured. However, in case of more than one hospitalisation for the same disease / accident, the aggregate number of days of hospitalisation payable in a policy period would be limited to Daily Cash Benefit Period (30/60 days) selected by theInsured.

   NOTE: In case of Ayurveda,Yoga, Naturopathy, Unani, Siddha and Homeopathy systems of medicines, this policy will pay only if Hospitalization is in any **AYUSH** Hospital.

   The term **'Hospital/Nursing Home'** shall not include an establishment which is a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel or a similar place.

   a. CONVALESCENCE BENEFIT – If a single hospitalisation continues for a period exceeding the **Daily Cash Benefit Period** opted for (30/60days), a lump sum amount is payable towards convalescence,

      i. provided that there is an admissible claim under 'a'above.

ii. this benefit is payable only once per insured person during any one policy period.

Our liability shall be as mentioned in the schedule.

The payment under this benefit will be in addition to the payment under 'a' above.

4. **DEFINITIONS:** For the sake of clarity, the following words are put in **Bold** wherever they appear in the body of the policy. The meaning of these words should be taken from the definitions given hereunder.

ACCIDENT is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

AYUSH: AYUSH treatment refers to the Medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy systems.

CONDITION PRECEDENT: means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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

a. **Internal Congenital Anomaly:** which is not in the visible and accessible parts of the body

b. **External Congenital Anomaly:** which is in the visible and accessible parts of the body

BENEFITS: Daily Cash Benefit, Daily Cash Benefit Period **and** Deductible **all together are referred to as Benefits.**

DAILY CASH BENEFIT: means the per day (continuous and completed period of 24 hours of hospitalisation) benefit amount selected by the insured at the time of commencement of policy.

DAILY CASH BENEFIT PERIOD: means the maximum number of days for which the **Daily Cash Benefit** is payable under the policy in respect of any one hospitalisation in a policy period. The policy provides two options of either 30 days or 60 days period depending on insured's selection.

DEDUCTIBLE: A deductible is a cost-sharing arrangement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any Benefits are payable by the Insurer. A deductible does not reduce the Daily Cash Benefit Period.

FAMILY: consists of the proposer and any one or more of the family members as mentioned below:

i. Legally wedded spouse.

ii. Dependent Children (i.e. natural or legally adopted) between the age 3months to 18 years. However male child can be covered up to the age of 25 years if he is a bonafide regular student and financially dependent on proposer. Female child can be covered until she gets married. Divorced and widowed daughters are also eligible for coverage under the policy, irrespective of her age. If the child above 18 years is financially independent or if the girl child is married, he or she shall be ineligible for coverage in the subsequent renewals.

iii. Parents / Parents-in-law (either of them).

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.

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

a) has qualified nursing staff under its employment round the clock;

b) has at least 10 In-patient beds, in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;

c) has qualified Medical Practitioner (s) in charge round the clock;

d) has a fully equipped operation theatre of its own where surgical procedures are carried out

e) Maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

* Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

1. The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002
2. The Bombay Nursing Homes Registration Act, 1949
3. The Delhi Nursing Home Registration Act, 1953
4. The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (Ragistrikaran Tatha Anugyapan) Adhiniyam, 1973.
5. The Manipur Homes and Clinics Registration Act, 1992
6. The Nagaland Health Care Establishments Act, 1997
7. The Orissa Clinical Establishments (Control and Regulations) Act, 1990
8. The Punjab State Nursing Home Registration Act, 1991
9. The West Bengal Clinical Establishment Act, 1950

Hospital Definition for "AYUSH TREATMENT"

We may provide coverage for one or more systems covered under AYUSH treatment "; provided the treatment has been undergone in:

i. A government hospital or in any institute recognized by Government and / or accredited by Quality Council of India or National accreditation Board on Health.

ii. Teaching hospitals of AYUSH colleges recognized by central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)

iii. AYUSH hospital have registered with a Government Authority under appropriate Act in the State/UT and complies with the following as minimum criteria:

a. Has at least five in-patient beds.
b. Has minimum five qualified and registered AYUSH doctors.
c. Has qualified paramedical staff under its employment round the clock.
d. Has dedicated AYUSH therapy sessions.
e. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without inpatient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner (s) in charge.
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

HOSPITALISATION PERIOD: means the period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24hours.

HOSPITALISATION: means admission in a Hospital for a minimum period of twenty four (24) in-patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

INSURED PERSON: means person(s) named in the schedule of the policy

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.

a) **Acute condition -** is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury and leads to full recovery.
b) **Chronic condition -** is a disease, illness, or injury that has one or more of the following characteristics:
    i. It needs on going or long-term monitoring through consultations, examinations, check-ups, and /or tests
    ii. it needs ongoing or long-term control or relief ofsymptoms
    iii. it requires rehabilitation or to be specially trained to cope withit
    iv. it continues indefinitely
    v. it comes back or is likely to comeback.

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.

IN-PATIENT: means an Insured person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

MEDICAL ADVICE: means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

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 oflicense.

NOTIFICATION OF CLAIM: is a process of notifying a claim to the Insurer or TPA by specifying the timelines as well as the address/telephone number, to which it should be notified.

PRE EXISTING DISEASE (PED): Pre existing disease means any condition, ailment, injury or disease:

a. that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer, or its reinstatement.
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.

POLICY PERIOD: means the period of coverage as mentioned in the schedule.

PORTABILITY: "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.

QUALIFIED NURSE: means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

RENEWAL: Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

THIRD PARTY ADMINISTRATOR (TPA): means any person who is licensed under the IRDA (Third Party Administrators – Health Service) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance **Company**, for the purposes of providing health services.

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

5. **Exclusions: Waiting Period**

The Company shall not be liable to make any payment under the policy in connection withor in respect of following expenses till the expiry of waiting period mentioned below:

A. Pre-existing Diseases - code -ExcI0 1

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 the insurer.

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

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

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

B. 30 day waiting period- code – ExcI03

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.

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh policy and clauses 4.A and 4.B shall apply afresh, unless agreed by the Company and suitable endorsement passed on the policy, by the duly authorised official of the Company. Similarly, if the **Daily Cash Benefit** is enhanced subsequent to the inception of the first policy, the exclusion 4.A and 4.B will apply afresh for the enhanced portion of the **Daily CashBenefit**.

5.1 GENERAL EXCLUSIONS: The Company shall not be liable to make any payment under this Policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

C. Investigation & Evaluation – Code – ExcI04

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

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

D. Rest Cure, rehabilitation and respite care – Code -ExcI05

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

b) Custodial care either at home or in a nursing facility for personal care such as help with activities

of daily living such a bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

c) Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

E. Obesity/Weight Control : Code- EscI06

Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

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

F. Change of Gender Treatments : Code – ExcI07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite.

G. Cosmetic or Plastic Surgery- Code- ExcI08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident burns(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.

H. Hazardous or Adventure sports- Code- ExcI09

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

I. Breach of law – Code –ExcI10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

J. Excluded Providers- Code – ExcI11

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 policy

holders are not admissible. However, in case of life threatening situations
OR following an accident, expenses up to the stage of stabilization are payable but not complete claim.

K. Treatment for, Alcoholic drug or substance abuse or any addictive condition and consequences thereof. – Code- ExcI12

L. Treatments received in health 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.- Code- ExcI13

M. **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.- Code- ExcI14

N. Refractive Error- Code- ExcI15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

O. Unproven Treatments- Code – ExcI16

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.

P. Sterility and Infertility- Code- ExcI17

Expenses related to sterility and infertility. This includes:

i) Any type of contraception, sterilization.

ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI.

iii) Gestation Surrogacy.

iv) Reversal of sterilization.

Q. Maternity- Code- ExcI18

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

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

R. 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
S. kinds.

T. 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.

U. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

V. Treatment taken outside the geographical limits of India

5.2 If the proposer is suffering or has suffered from any of the following disease, as per serial no 1-16 of the below table at the time of taking the policy, the specific ICD codes, mentioned therein, will be permanently excluded from the policy coverage:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy

4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083

10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

6. CONDITIONS

6.1 ENTIRE CONTRACT: This policy, along with the proposal form and declaration given by the insured person constitutes the complete contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

6.2 COMMUNICATION: Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator, as the case may be, as shown in the Schedule.

6.3 PAYMENT OF PREMIUM: 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 condition precedent to any liability of the Company in respect of any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorised official of the Company.

6.4 NOTICE OF CLAIM: Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease / injury and Name and Address of the attending medical practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home, by Fax, Email. Such notice should be given within 48 hours of admission but before discharge from **Hospital / Nursing Home**, unless waived in writing.

6.5 CLAIM DOCUMENTS: Documents as listed below, along with duly filled in claim form, should be submitted to the **Company** / **TPA** within 15 days of discharge from the **Hospital** / **Nursing Home**.

a. Discharge certificate / card from the **Hospital**/ **Nursing Home**.

b. Alldocumentspertainingtotheillness,startingfromthedateitwasfirstdetected,i.e Doctor's consultations reports / history

c. Medical history of the patient recorded by the **Hospita**l, if required.

d. Pathological and other test reports from a pathologist /radiologist.

e. Attending Consultants / Anesthetists / Specialist certificates regarding diagnosis.

f. MLC/FIR/Post Mortem Report,(if applicable)

g. Details of previous policies, if the details are already not with **TPA**.

h. Any other information required by Company /**TPA**.

Photocopies of the above documents are accepted in case the hospitalization expenses have been claimed from other sources (e.g. Employer, Insurance Company, etc). However a written confirmation from such source of having received the claim documents is required.

All documents must be duly attested by the insured person/claimant.

NOTE: Waiver of the 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 the insured person was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.

Company shall settle claims including its rejection within 30 days of the receipt of the last 'necessary' document, except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms

& conditions shall be deemed necessary.

6.6 MEDICALRECORDS:

i) The insured person hereby agrees to and authorises the disclosure, to the Company / **TPA** or any other person nominated by the Company, of any and all Medical records and information held by any Institution / **Hospita**l or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by the Company / **TPA** in connection with any claim made under this policy or the Company's liability there under.

ii) The Company / **TPA** agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use it in connection with any claim made under this policy or the Company's liability there under.

iii) Any medical practitioner authorized by the Company / **TPA** shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring **Hospitalisation** when and so often as the same may reasonably be required on behalf of the Company /**TPA**.

6.7 PAYMENT OF CLAIM: All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only. Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In the cases of any delay in the payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed.

6.8 REPUDIATION:

i) The Company shall repudiate the claim if not payable under the policy. The Company / **TPA** shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the Grievance Redressal Cell of the Company at its policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002 or register the complaint on the grievance Portal available at our websitewww.orientalinsurance.org.in.

ii) If the insured is not satisfied with the reply of the Grievance Cell under 5.8 (i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The list of Offices of Ombudsman is available on the Company website (www.orientalinsurance.org.in).The Insurance Ombudsman is empowered to adjudicate on personal line insurance claims up to Rs.30lacs.

6.9 DISCLAIMER OF CLAIM: If the Company shall disclaim liability and communicate in writing (either through the **TPA** or by itself) to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

6.10 ARBITRATION CLAUSE: If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such differenceshallindependentlyofallotherquestionsbereferredtothedecisionofa sole arbitrator to be appointed in writing by the parties; or if they cannot agree upon a single arbitrator within 30 days of any party invoking

arbitration, the same shall be referred to a panel of three arbitrators, comprising of 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.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

6.11 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, 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 policy 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. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6.12 CANCELLATION CLAUSE:

a) The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below:

Period onRisk	**Rate of premium to be charged**
Upto 1Month	1/4th of the annual rate
Upto 3Months	1/2 of the annual rate
Upto 6Months	3/4th of the annual rate
Exceeding6months	Full annual rate

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.

b) 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 30 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation non- disclosure of material facts or fraud.

6.13 BENEFITSAVAILABLE

i. The Policy provides 4 options of **Daily Cash Benefit**- Rs.500 Rs.1000, Rs.2000 and Rs.3000. Different insured persons, under a policy, may opt for different **Daily Cash Benefits**. For females this **Daily Cash Benefit** automatically gets increased by 25% without any extra premium.

ii. The Policy provides 2 options of **Daily Cash Benefit Period**- 30 days and 60 days per **hospitalisation**.

iii. The Policy provides 3 options of **deductible**- no deductible, 1day &2days**deductible**. The deductible is applicable per event.

iv. Itismandatoryforalltheinsuredpersonsunderapolicytohaveanidentical**Daily Cash Benefit Period** and **Deductible** (ii & iii above).

v. Change in Benefit(s): The **Daily Cash Benefit**, the **Daily Cash Benefit period** and **Deductible** under the policy can be changed only at the time of renewal and at the discretion of the Company. For the said enhanced benefits, **pre- existing disease** clause 4.1 and clause 4.2 of the policy, shall apply afresh.

vi. Discounts

a. Family discount of 5% on premium is available if two members are covered and7.5% if more than 2 members are covered.

b. Loyalty Discount of 10% in premium is available for the persons who at the inception of this policy are covered under Oriental's health insurance policy (retail or bank-tie-up). To be eligible for this discount at renewals, such Health policy from Oriental has to be in force at the time of such renewal also.

c. Staff Discount of 33% on premium is available to the employees of Oriental Insurance Company Ltd.

6.14 FREE LOOK PERIOD: This policy shall have a free look period. The free look period shall be applicable at the inception of the fresh policy and the insured will be allowed a period of 15 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 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 insurer on medical examination of the insured persons 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 policyholder, a deduction towards the proportionate risk premium for period on cover or

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

The free look period is not applicable in case of renewal of the policy.

6.15 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 notice for renewal

ii. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.

iv. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

6.16 GRACE PERIOD:

In the event of delay in renewal of the policy, a **grace period** of 30 days is allowed. However, no coverage shall be available during the **grace period** and any disease/injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

6.17 Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall be a valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6.18 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 waiver of waiting period. As per IRDAI guidelines, provided the policy has been maintained without a break.

6.19 POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THEPREMIUMRATES

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.

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

For Detailed Guidelines on Portability, kindly refer the link:

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

6.21 CHANGE OF ADDRESS: Insured must inform the Company immediately in writing of any change in the address.

6.22 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. For Claim settlement under reimbursement, the Company will pay the policyholder. Ill the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

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

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

6.24 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 bank rate from the date of receipt of last necessary document to the date of payment of claim.

("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).

6.25 GRIEVANCE REDRESSAL:

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

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:
Customer Service Department
4th Floor, Agarwal House
Asaf Ali Road,

New Delhi-110002

For updated details of grievance officer, kindly refer the link https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac-c613-ffc05d578a3e

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. The contact details of the Insurance Ombudsman offices have been provided as Annexure-III & revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html.

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

6.26 IRDA REGULATION: This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations 2016 and Guidelines on Standardization in health insurance, as amended from time to time.

6.27 JURISDICTION: All disputes or differences under or in relation to the policy shall be determined by the Indian Courts and according to the Indian laws.

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation.

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ANNEXURE I: CONTACT DETAILS OF INSURANCE OMBUDSMEN

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU Office of the Insurance Ombudsman, JeevanSoudha 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 Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh

BHUBANESHWAR 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 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, Chandigar
CHENNAI 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 Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002 Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD 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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
JAIPUR Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005 Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM 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 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 Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, 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 Office of the Insurance Ombudsman, 3rd Floor, JeevanSeva 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 Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh 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 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 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	Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region