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Shriram General insurance Co. Ltd.

IN PARTNERSHIP WITH THE **Sanlam** GROUP
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Shri Vector Care Group Insurance Policy – Policy Wording

1. PREAMBLE

SHRIRAM General Insurance Company Limited (We, Our or Us) will provide the insurance described in this Policy and any endorsements thereto for the Insured Period as defined in this Policy, to the Insured Persons detailed in the Policy Schedule and in reliance upon the statements contained in the Proposal and Declaration Form filled and signed by the Policyholder, which shall be the basis of this Policy and are deemed to be incorporated herein in return for the payment of the required premium when due and compliance with all applicable provisions of this Policy.
The insurance provided under this Policy is only with respect to such and so many of the benefits as are indicated by a specific amount set opposite in the Policy Schedule.

2. OPERATIVE CLAUSE

If the Insured or the Insured Person(s), as the case may be diagnosed as suffering from any of covered Vector Borne disease during the Policy Period and Hospital admission longer than 24 continuous hours, the Company shall pay a lump sum payment of 100%, as specified under the Policy Schedule, subject to Sum assured limits, terms, conditions, definitions and exclusions contained or otherwise expressed in the Policy Schedule.

3. DEFINITIONS

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

1. **We, Us, Our/Ours** means the Shriram General Insurance Company Limited.

2. **You, Your, Yourself means** the Insured Person shown in the Schedule.

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

4. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

6. **AYUSH Treatment** refers to hospitalization treatments given Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

7. **An AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment and procedure carried out by AYUSH Medical Practitioner(s) comprising of any of the following.
   a. Central and State Government AYUSH Hospital, or
   b. Teaching hospitals attached to AYUSH Colleges recognized by Central Government/Council of Indian Medicine/Central Council of Homeopathy, or
   c. AYUSH Hospitals standalone or co-locted with in-patient healthcare facility of recognized system of medicine, registered with local authority where applicable, and is under the supervision of qualified registered AYUSH Medical Practitioner and must comply with all the following creation:
      i. Having at least 5 in-patient beds
      ii. Having qualified AYUSH Medical Practitioner in charge round the clock
      iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theater where operation procedure are to be carried out.
      iv. Maintains daily records of patients and makes these accessible to the Company's authorized representative.

8. **AYUSH Day Care Centre** means and include Community Health Center(CHC), Primary Health Center(PHC),

   Dispensary, Clinic, Policlinic or any such health center which is registered with local authorities where applicable and having facility for carrying out treatment procedure and medical or surgical/para- surgical interventions or both the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient service must comply with all the following criterion.

   i. Having qualified AYUSH Medical Practitioner in charge round the clock
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theater where operation procedure are to be carried out .
   iii. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized representative.

9. **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

10. **Certificate of Insurance** means the document issued by the Company to the Insured Beneficiary as per these terms and conditions detailing the Insured Beneficiary(s) name, address, age, commencement date and expiry date of the cover, coverage, sums insured, condition(s), exclusions and or endorsement(s).

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

12. **Congenital Anomaly** means Congenital Anomaly means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
    a. Internal Congenital Anomaly
    Congenital anomaly which is not in the visible and accessible parts of the body.
    b. External Congenital Anomaly
    Congenital anomaly which is in the visible and accessible parts of the body.

13. **Cover Period** means period for which the Insured Person/Insured Beneficiary is covered under the Certificate of Insurance.

14. **Cooling off period** means no claim period of 60 days will be applicable from the date of admission of a claim against a covered condition in case of restoration or immediate renewal of the policy.

15. **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

16. **Day** means a continuous period of 24 hours.

17. **Day Care Centre** means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
    i. has qualified nursing staff under its employment;
    ii. has qualified medical practitioner (s) in charge;
    iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
    iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
18. **Deductible:** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours

in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

19. **Disclosure to information norm:** The policy shall be void and all premiums paid thereon shall be forfeited to the Insurer in the event of misrepresentation, mis-description or non-disclosure of any material fact.

20. **Domiciliary Hospitalization**: 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:
    i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii. the patient takes treatment at home on account of non-availability of room in a hospital.

21. **Emergency Care:** Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.

22. **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:
    i. Self
    ii. Spouse
    iii. Children (including unmarried children, step children or legally adopted children, who are financially dependent and aged between 91 days and 18 years).
    iv. Parents/parents-in-law

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

24. **Hospital:** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
    i. Has qualified nursing staff under its employment round the clock;
    ii. Has at least ten inpatient beds, in those towns having a population of less than ten lacs and fifteen inpatient
    iii. beds in all other places;
    iv. Has qualified medical practitioner (s) in charge round the clock;
    v. Has a fully equipped operation theatre of its own where surgical procedures are carried out
    vi. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

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

26. **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 response 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

27. **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.

28. **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

30. **Intensive Care Unit (ICU)** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

32. **Master Policy/Group Policy** shall mean the Proposal, Group Policy Schedule/Shriram Shri Vector Care Group Insurance Policy Schedule, along with these Terms and Conditions, issued to the Policy Holder containing these terms and conditions of the insurance coverage and under which Certificates of Insurance will be issued to the respective Insured Beneficiary/ies and any endorsements attaching to or forming part thereof either on the commencement date or during the Cover Period**.**

33. **Master Policy Period** means period for which the Master Policy is valid in the name of Group Manager.

34. **Master Policy Schedule/Group Policy Schedule**- Group Policy Schedule means the Shriram Shri Vector Care Group Insurance Policy Schedule and any annexure to it read with respective Certificate of Insurance.

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

36. **Medical Expenses** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

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

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

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

ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. Must have been prescribed by a medical practitioner;
iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

39. **Migration** means**,** the right accord to health insurance policyholder (including all the member under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

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

41. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility

42. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.

43. **Out-Patient (OPD) Treatment** means treatment in which the insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a medical practitioner. The insured is not admitted as a day care or in-patient.

44. **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 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.

45. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during of 30 days preceding the hospitalisation of the Insured Person, provided that:

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

46. **Post-hospitalisation Medical Expenses** means medical expenses incurred during 60 days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
    ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

47. **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.

48. **Policy year** means a period of twelve months beginning from the date of commencement of the policperiod 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

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

50. **Proposal form** means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

51. **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.

52. **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

53. **Sum assured** means the amount specified in the Policy Schedule, which We will pay for claims made by You under the Policy Year in respect of the Insured Person(s).

54. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

56. **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.

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

4. Scope of Coverage

If the Insured or the Insured Person(s), as the case may be, is diagnosed as suffering from any of covered Vector Borne disease during the Policy Period and Hospital admission longer than 24 continuous hours, the Company shall pay a lump sum payment of 100%, as specified under the Policy Schedule, subject to Sum assured limits, terms, conditions, definitions and exclusions contained or otherwise expressed in the Policy Schedule.

Following are the vector borne disease covered under the policy

Disease Covered	Cover Details
1. Malaria	A registered medical practitioner should confirm diagnosis of Malaria with confirmatory tests indicating presence of Plasmodium falciparum/ vivax/ malariae in the patient's blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test). Continuous Hospitalization of 24 hrs should be necessary along with high fever and shaking chills. Please note Indoor case papers should be obtained for each claim wherever necessary and the diagnosis of admission should be malaria and its complications, if any. Below are the specific exclusions for this condition: • Any Treatment other than for malaria and its complications • Hospitalization less than 24 hours
2. Dengue	The applicant will be eligible for the benefit pay out in case of being diagnosed with Dengue confirmed by a registered medical practitioner (RMP). Hospitalization must be necessary as advised by the RMP and the Laboratory examination result countersigned by a pathologist/microbiologist must confirm the Immunoglobulins/PCR test showing positive results for Dengue. Indoor case papers should be obtained, if available and the diagnosis of admission should be Dengue in addition to the above. Below are the specific exclusions for this condition: • Any Treatment other than for Dengue (as defined above) • Hospitalization less than 24 hours
3. Lymphatic Filariasis (Payout only once in lifetime)	Commonly known as elephantiasis, a registered medical practitioner must confirm the same and Laboratory examination result must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria: Clear and visible manifestation of the disease as follows: • lymphoedema, • elephantiasis and • scrotal swelling Please note Indoor case papers should be obtained for each claim wherever necessary and the diagnosis of admission should be Filariasis in addition two of the above conditions. Claim against 'Lymphatic Filariasis shall be paid only once in the entire lifetime of the Insured upon first occurrence post start of coverage under this policy. Below are the specific exclusions for this condition: • Any Treatment other than for Filariasis and its complications (as defined above) • Hospitalization less than 24 hours
4. **Kala-azar**	Visceral leishmaniosis, also known as kala-azar, is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anemia.

	The diagnosis must be confirmed by a registered medical practitioner and by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium, as the confirmatory diagnosis or positive serological tests for kala azar should clearly indicate the presence of this disease. Please note Indoor case papers should be obtained for each claim wherever necessary and the diagnosis of admission should be Kala Azar. Below are the specific exclusions for this condition: • Any Treatment other than for Kala Azar (as stated above) • Hospitalization less than 24 hours
5. Japanese Encephalitis	Characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, and spastic paralysis. To confirm Japanese Encephalitis (JE) infection and to rule out other causes of encephalitis requires a laboratory testing of serum or preferably cerebrospinal fluid. The diagnosis must be confirmed by a registered medical practitioner and positive serological test for JE by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF) Please note Indoor case papers should be obtained for each claim wherever necessary and the diagnosis of admission should be Japanese Encephalitis. Below are the specific exclusions for this condition: • Any treatment other than for Japanese Encephalitis (as stated above) • Hospitalization less than 24 hours
6. Chikungunya	Chikungunya is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue and rash. The diagnosis must be documented by a registered medical practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies. Please note Indoor case papers should be obtained for each claim wherever necessary and the diagnosis of admission should be Chikungunya. Below are the specific exclusions for this condition: • Any Treatment other than for Chikungunya • Hospitalization less than 24 hours
7. Zika Virus	People with Zika virus disease can have symptoms like mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache. A diagnosis of Zika virus infection should be confirmed by a registered medical practitioner and by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results. Please note Indoor case papers should be obtained for each claim wherever necessary and the diagnosis of admission should be Zika virus. Below are the specific exclusions for this condition: • Any treatment other than for Zika virus (as stated above) • Hospitalization less than 24 hours

5. Coverage Option

Option 1- Coverage without Restoration

1. **Individual Cover**
   Upon admission of any claim against one of the listed diseases, 100% sum assured will be paid and policy terminates subject to other terms and condition of policy.

2. **Family Floater Cover**

   Upon admission of a claim to any member against one of the listed diseases, 100% sum assured will be paid and policy terminates for the member for whom claim is admitted while policy continues for the remaining members, if more than one claim is allowed under the floater policy. If only one claim is allowed, policy will terminate after admission of the first claim. (refer table below for the number of members and allowed number of claims).

   Illustration

   i. Family floater policy covering two members.

   Policy is bought on 01 January 2019 covering two members without restoration and if any of the member is diagnosed with Dengue on 01 February 2019. We will pay 100% sum assured (subject to fulfillment of other terms and conditions) and the policy shall terminate for both members as maximum number of claim allowable is one.

   If the Policy is renewed within 60 days from the date of admission of the previously paid claim, a 60 days cooling off period shall apply for Dengue in the new policy for member for whom claim is admitted. However other members will be continuously covered (post renewal) without any cooling off period.

   ii. Family Floater Policy covering more than 2 members

   Policy is bought on 01 January 2019 covering more than two members without restoration and if any of the member is diagnosed with Dengue on 01 February 2019. We will pay 100% sum assured (subject to fulfillment of other terms and conditions) and the policy coverage shall cease for named insured member for whom the claim is admitted.
   The policy shall continue for rest of the members covered under the policy. However after payment of 100% sum assured against the second claim (subject to fulfillment of other terms and conditions), the policy shall terminate for all covered members as maximum number of allowable claim are two.

Sr. No.	Covered Members	Max covered members per policy	Max number of claims per policy
1	Self	1	1
2	Self+ Spouse	2	1
3	Self + Spouse+ 1or 2 Member (Child or Parent)	3 or 4	2
4	Self+ Spouse+3or 4 members (Child or/and parents)	5 or 6	2

Under option 3 and 4 above, irrespective of the number of parents / parents in laws covered, max number of members covered in family will not exceed the numbers mentioned above.

Option 2- Coverage with Restoration

1. **Individual Basis**.

   Upon admission of any claim against one of the listed diseases, sum assured will be restored to 100% and the policy continues until allowable number of claims is made under the policy or end of the policy term whichever is earlier subject to cooling off period.

   Illustration –

   If policy is bought on 01 January 2019 by an individual with restoration and Dengue is diagnosed on 1 February 2019. We will pay 100% sum assured (subject to fulfillment of other terms and conditions) and sum assured will be restored to 100%. Coverage will continue for all diseases except Dengue during the 60 days cooling off period.
   However coverage for Dengue will be restored with effect from 03 April 2019 (60 days post 1 February 2019)

2. **Family floater**

   Upon admission of any claim against one of the listed diseases, sum assured will be restored to 100% and policy continues until allowable number of claims is made under the policy or end of the policy term whichever is earlier subject to cooling off period.

   Illustration

   If Policy is bought on 01 January 2019, family floater with restoration and two members are covered. If any of the members is diagnosed with Dengue on 01 February 2019 .We will pay 100% sum assured (subject to fulfillment of other terms and conditions) to named insured member for whom the claim has been made and sum assured will be restored to 100%. Coverage will continue for all diseases except Dengue during the 60 days cooling off period for member for whom claim has been paid. Coverage for this member against Dengue will be restored with effect from 03 April 2019 (60 days post 1 February 2019).

   Other members will continue to be covered for all diseases without any cooling off period. Since two claims are allowed, after the second claim on any of the member, policy will terminate.

Sr. No.	Covered Members	Max covered members per policy	Max number of claims per policy*
1	Self	1	2 claims including 1 restoration
2	Self+ Spouse	2	2 claims including 1 restoration
3	Self + Spouse+ 1or 2 Member (Child or Parent/ Parent In law)	3 or 4	6 claims including 3 restorations
4	Self+ Spouse+ 3 or 4 members (Child or/and Parents/Parent in law)	5 or 6	6 claims including 3 restorations

***Per member max of 2 claims per policy year is allowed.**

Under option 3 and 4 above, irrespective of the number of parents / parents in laws covered, max number of members covered in family will not exceed the numbers mentioned above.

6. Policy Termination

The policy will terminate on death of the life assured or on payment of all allowable claims under the policy or end of the policy term, whichever is earlier

7. Exclusion

This entire Policy does not provide benefits for any loss resulting in whole or in part from, or expenses incurred, directly or indirectly in respect of:

I. General Exclusion

1. Any condition other than Malaria, Lymphatic Filariasis, Dengue Fever, Japanese Encephalitis, and Kala Azar, Chikungunya or Zika virus as defined under this policy.
2. Admission to hospital for less than 24 hours.
3. Any of the covered vector borne disease diagnosed with in the waiting period
4. Diagnosis and treatment outside India. However, this exclusion shall not be applicable in the following countries: Canada, Dubai, Hong Kong, Japan, Malaysia, New Zealand, Singapore, Switzerland, USA, and countries of the European Union. The insurer may review the above list of accepted foreign countries from time to time. Claims documents from outside India are only acceptable in English language unless specifically agreed otherwise, and duly authenticated.
5. Any claim during waiting period

II. Specific Exclusion

1. Any of the listed vector borne disease diagnosed within the first 15 days of the date of commencement of the Policy is excluded. This exclusion shall not apply to an Insured/Insured Persons, as the case may be, for whom coverage has been renewed without a break, for subsequent years provided there are NIL claims in the previous Policies.

2. The initial waiting period of 15 days will be increased to 60 days, if the insured is suffering or has suffered within 60 days prior to the date of proposal, from any one of the listed vector borne disease except Lymphatic Filariasis at the time of taking the policy.

3. In case, if the insured is suffering or has suffered within 60 days prior to the date of proposal, from Lymphatic Filariasis at the time of taking the policy, Lymphatic Filariasis will be excluded from the policy and the other listed vector borne disease shall have an initial waiting period increased to 60 days.

8. Condition(s)

8.1. The premium payable under this policy shall be payable in advance. No receipt of 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 of fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, shall be a condition precedent to any liability of the Company to make 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 authorized official of the Company.

8.2. Due Observance
The due observance of and compliance with the terms, provisions, warranties and conditions of this Policy in so far as they relate to anything to be done or complied with by the Insured and/or the Named Insured shall be a condition precedent to the Company's liability under this Policy

8.3. Insured
No person other than a person named as an Insured shall be covered under this Policy unless and until his name has been notified in writing to the Company. Cover under this Policy shall be withdrawn from any person named as an Insured immediately upon the Named Insured delivering written notice of the same to the Company. The

Named Insured agrees to and shall hold the Company harmless against any and all claims, costs and expenses that may result because of the incorrect or unintentional cancellation of this insurance in relation to any Insured.

8.4. Withdrawal of the policy

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

8.5. Communications

- Any communications, notifications or declarations meant for Us must be in writing and delivered to Our address specified in the Schedule.
- Any communication meant for You will be sent by Us to Your address shown in the Schedule. You must notify Us immediately of any change in Your address.
- Our agents are not authorized to receive communications, notices or declarations on Our behalf.

8.6. Fraud

i. If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
ii. Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
iii. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
    a. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
    b. the active concealment of a fact by the insured person having knowledge or belief of the fact;
    c. any other act fitted to deceive; and
    d. any such actor omission as the law specially declares to be fraudulent

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

8.7. Free Look Period

At the time of inception of the policy, 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 policy if not acceptable. In such a case, the premium refund shall be as follows :

If the Insured has not made any claim during the free look period, the Insured shall be entitled to –

a. 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 and any policy administrative charges or
b. Where the risk has already commenced and the option of return of the policy is exercised by the policy holder, a deduction towards the proportionate risk premium for period on cover or
c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.
d. Free look period shall not be applicable at the time of renewal.

8.8. Cooling off period means no claim period of 60 days will be applicable from the date of admission of a claim against a covered condition in case of restoration or immediate renewal of the policy.

A. Coverage without restoration

No cooling off period will be applicable since each covered individual is covered for 100% sum assured and once the claim is admitted, the coverage terminates.
Under family floater, other members will be continuously covered without any cooling off period.

B. Cover with restoration

Under the restored cover, insured will be covered against all conditions* except the condition for which the claim was made in the previous policy. This claimed condition will be covered after 60 days cooling off period post restoration. Further, the cooling off period will continue to the next policy year in policy renewal falls within this period.

Under family floater, other members will be continuously covered without any cooling off period.
*If a claim is admitted against Lymphatic Filariasis upon renewal of policy, coverage will be available for all conditions except Lymphatic Filariasis. For Lymphatic Filariasis, once the sum assured is paid for any life, no other claim for this particular condition shall be paid to the policyholder in the entire lifetime of the policyholder; the premiums will be adjusted accordingly in the next renewal.

8.9. Renewal

A. Renewal with Nil Claims

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

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience.

B. Renewal upon admission of a claim**:**

i. Upon payment of claim the Insured has option to renew the Policy with immediate effect or on a later date as per below terms & conditions
   - If the Policy is renewed within 60 days from the date of admission of the previously paid claim for the named insured a 60 days cooling off period shall apply for the same disease in the new Policy opted, however there would be no waiting period for other listed vector borne diseases.
   - If the Policy is renewed post 60 days from the date of admission of the previously paid claim for the named insured then a fresh waiting period of 15 days shall apply for all listed vector borne diseases

ii. For Lymphatic Filariasis, once the sum assured is paid for any life,no other claim for this particular condition shall be paid to the Named insured in the entire lifetime.

8.10. Cancellation

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact by sending notice in writing by Registered A/D to the insured at his/her last known address at least 15 days in advance in that case we shall refund pro-rata premium for the unexpired portion of the policy on the date of cancellation, provided no claim has occurred till the date of cancellation.

The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this policy, in which case the Company shall retain the premium for the period this Policy has been in force at the Company's short period scales.

Period on risk	Scale %
Upto 1 month	70%
Exceeding 1 month and upto 3 months	55%
Exceeding 3 months and upto 6 months	30%
Exceeding 6 months and upto 12 months	Nil

8.11. When Claim Arise

A. **Claims Procedure**

a) We must be informed of any event or occurrence that may give rise to a claim under this Policy within 48 hours of hospitalization of the illness. You can intimate us through letter, email, fax or telephone.

b) You or someone claiming on Your behalf must promptly and in any event within 15 days of discharge from a Hospital give Us the necessary documents along with all original supporting documentation, including but not limited to the following, and other information We ask for, to investigate the claim for Our obligation to make payment for it

i. Our claim form duly completed (along with captioned documents) and signed by/ on behalf of the Insured Person.
ii. Original Discharge Summary or copy duly attested by hospital
iii. A precise diagnosis of the treatment for which a claim is made.
iv. Treating doctor's certificate regarding the duration of the illness & etiology.
v. KYC documents.
vi. Laboratory reports.

Note: The Company will examine and relax the time limit mentioned in above conditions depending upon the merits of the case.

B.Claims Payment

a) We shall be under no obligation to make any payment under this Policy unless We have been provided with the documentation and information We have requested to establish the circumstances of the claim or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
b) We will only make payment to You under this Policy. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy.
c) In the event of Your death, We will make payment to the Nominee (as named in the Schedule). No assignment of this Policy or the benefits there under shall be permitted.

C.Settlement of Claims

a) Our Medical Practitioners will scrutinize the claims and flag the claim as settled/ rejected/ pending within the period of 30 days of the receipt of the last necessary documents.
b) In case of '**pending'** claims, We will ask for submission of incomplete documents.
c) '**Rejected'** claims will be informed to the Insured Person in writing with reason for rejection.
d) In the circumstances where a claim warrant an investigation in Our opinion, 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.

Shriram General insurance Co. Ltd.
IN PARTNERSHIP WITH THE **Sanlam** GROUP
Regd.&Corpt. Office:E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022
Phone: +91-141-3928400, 3951111, Fax: +91-141-2770692, 2770693
Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in
Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

e) In the cases of delay in the payment of a '**settled'** 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 which is 2% above the bank rate.

8.12. Refund of premium on death of Insured

In the event of death of insured in the middle of policy year/during the course of policy period when no claim is paid or in the process to be paid during the policy period, premium shall be refunded on pro-rata basis for balance policy period.

Note - Refund of premium will be calculated from the date of demise subject to

a. Submission of death certificate
b. Intimation for refund should be within 30 days from date of demise of insured.

8.13. 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.

If the Policyholder/ Insured Person renew with the Company, without break, any similar individual health insurance policy from any insurance company registered with IRDA, then the Waiting Periods as defined in exclusions shall be reduced by the number of years of continuous coverage under such health insurance policy with the previous insurer(s).

The Company's total liability for payment of all claims in aggregate, incurred during the Policy Period, on account of Portability shall not exceed Sum assured Limit for Portability as defined in Policy Schedule.

The Waiting Periods as defined in policy exclusions shall be applicable individually for each Insured Person and Claims shall be assessed accordingly

For Detailed Guidelines on portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

8.14. Migration

The insured person 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 such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person 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/Circulars_List.aspx?mid=3.2.3

8.15. Examination of Records

We may examine Your records relating to the insurance under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy

8.16. Compliance with policy provisions:

Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

8.17. Territorial Limits and Law

- We cover sickness sustained by the Insured Person during the Policy Period anywhere in India.
- All medical/ surgical treatments including investigations under this policy shall have to be taken in India, however if diagnosis and treatment is taken in following countries/ cities: Canada, Dubai, Hong Kong, Japan, Malaysia, New Zealand, Singapore, Switzerland, USA, and countries of the European Union, the same would be accepted, provided that the claims documents are only in English language unless specifically agreed otherwise, and duly authenticated. The admissible claims thereof shall be payable in Indian currency (Indian Rupees).
- The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian Law.

- The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.

8.18. Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

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

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

8.19. Legal actions:

Without prejudice to Uniform Provision 18 above, no action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) Days after written evidence has been furnished in accordance with the requirements of this Policy. If no evidence has been furnished within one (1) year of the date upon which it should have been furnished, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

If We disclaim liability to You for any claim, and if You do not notify Us in writing within one (1) year from the date of receipt of the notice of such disclaimer that You do not accept such disclaimer and intend to recover this claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

8.20. Endorsement (Change in Policy)

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

ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir immediate family member Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break. The policyholder may be changed during the Policy Period only in case of his/her demise him/her moving out of India.

8.21. Change of Sum assured

Sum assured can be changed (increased/ decreased) only at the time of renewal, subject to underwriting by the Company.

8.22. Terms and condition of the Policy

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

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

8.24. Modification of the terms of the policy

The Company reserves the right to modify the policy terms and conditions or modify the premium of the policy with the prior approval of the Competent Authority. In such an event the insured will be intimated three months in advance.

8.25. Moratorium Period

After completion of eight continuous years under the policy no look back to 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 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim 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, deductibles as per the policy contract.

8.26. Complete discharge

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

8.27. Relief under Section 80-D

Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the amount paid for Health Section by any mode other than cash.

8.28. Governing Law

The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

8.29. Addition /Deletion of Insured Beneficiary(s)

No person other than those persons named as the Insured Beneficiary(s) or those categories of the Insured Beneficiaries specified in the Certificate of Insurance shall be covered under this Policy unless and until his/her name or the category has been notified in writing to the Company, any additional premium due has been paid and the Company's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person or category of persons as an Insured Beneficiary(s)

Cover under Certificate of Insurance shall be withdrawn from any Insured Beneficiary(s) named or any category of Insured Beneficiaries insured immediately upon the Policy Holder delivering written notice of the same to the Company.

8.30. Policy disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

8.31. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand,post, or facsimile/email to E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022

Phone: +91-141-3928400, 3951111, Fax: +91-141-2770692, 2770693

Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in. Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

9. REDRESSAL OF GRIEVANCE

Welcome to Shriram General Insurance and Thank You for choosing us as your insurer.

Please read your Policy and Schedule. The Policy and Policy Schedule set out the terms of your contract with us. Please read your Policy and Policy Schedule carefully to ensure that the cover meets your needs.

We do our best to ensure that our customers are delighted with the service they receive from us. If you are dissatisfied we would like to inform you that we have a procedure for resolving issues. Please include your Policy number in any communication. This will help us deal with the issue more efficiently. If you don't have it, please call your Branch office.

First Step Initially, We suggest you to contact the Branch Manager / Regional Manager of the local office which has issued the Policy. The address and telephone number will be available in the Policy.

Second Step Naturally, We hope the issue can be resolved to your satisfaction at the earlier stage itself. But if you feel dissatisfied with the suggested resolution of the issue after contacting the local office, please e-mail or write to Grievance Cell, HO, headed by a senior executive which will be directly under the control of the MD at the below mentioned address:

Contact Person: Chief Compliance and Grievance Officer
Contact Address: Shriram General Insurance Co. Ltd.
E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur – 302022
Grievance Cell No: 1800-103-3009, 1800-300-30000
E-mail ID: md@shriramgi.com
Fax No.: 91-141-2770693
You can also reach us by email or register their complaints on the website of the Company.

In case your complaint is not fully addressed by the Company, You may use the Integrated Greivance Management System (IGMS) https://igms.irda.gov.in For registration please visit IRDAI website www.irda.gov.in.

The contact details of the ombudsman offices are mentioned below. However, We request you to visit https://www.shriramgi.com for updated details.

Grievance Redressal Cell for Senior Citizens
Our customers who are above 60 years of age we have created special cell to address any health insurance related grievances.
Our senior citizen customers can reach us through the below dedicated channels to enable us to service them promptly.
Grievance Cell No: 1800-103-3009, 1800-300-30000
Exclusive Email address: seniorcitizen@shriramgi.com
In case your complaint is not fully addressed by the Company, You may use the Integrated Greivance Management System (IGMS) https://igms.irda.gov.in For registration please visit IRDAI website www.irda.gov.in.

The contact details of the ombudsman offices are mentioned below. However, We request you to visit https://www.shriramgi.com for updated details.

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

Ombudsman Offices	
Gujarat , Dadra & Nagar Haveli, Daman and Diu	Insurance Ombudsman Office of the Insurance Ombudsman 2nd Floor, Ambica House, Nr. C.U.Shah College, 5, Navyug Colony, Ashram Road, **AHMEDABAD** – 380 014 Tel.079- 27546150/139, Fax:079-27546142 E-mail: bimalokpal.ahmedabad@gbic.co.in
Karnataka	Insurance Ombudsman 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 / 49 E-Mail: bimalokpal.bengaluru@gbic.co.in
Madhya Pradesh & Chhattisgarh	Insurance Ombudsman, Office of the Insurance Ombudsman JanakVihar Complex, 2 nd floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, **BHOPAL** - 462 003 Tel. 0755-2769201/02 Fax:0755-2769203 E-mail: bimalokpal.bhopal@gbic.co.in
Orissa	Insurance Ombudsman, Office of the Insurance Ombudsman 62, Forest Park, **BHUBANESHWAR** – 751 009 Tel.0674-2596461 / 2596455, Fax - 0674-2596429 E-mail: bimalokpal.chandigarh@gbic.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh	Insurance Ombudsman 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 E-mail: bimalokpal.chandigarh@gbic.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.	Insurance Ombudsman, Office of the Insurance Ombudsman 6th Floor , JeevanBhawan, Phase II, Nawal Kishore Rd. Hazratganj, **LUCKNOW** – 226 001 Tel.:0522- 2231330 / 31, Fax: 0522-2231310 E-mail: bimalokpal.lucknow@gbic.co.in
Delhi	Insurance Ombudsman 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 E-mail: bimalokpal.dehli@gbic.co.in

Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, JeevanSeva Annexe , S. V. Road, Santacruz (W), **MUMBAI** – 400 054 Tel: 022-26106552 / 26106960, Fax: 022-26106052 E-mail: bimalokpal.mumbai@gbic.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	Insurance Ombudsman, Office of the Insurance Ombudsman Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, **KOLKATA** – 700 072 Tel.: 033 - 22124339 / 22124340, Fax: 033-22124341 E-mail : bimalokpal.kolkata@gbic.co.in
Kerala, Lakshadweep, Mahe- a part of Pondicherry.	Insurance Ombudsman, Office of the Insurance Ombudsman 2nd Floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM** – 682 015 Tel.: 0484 - 2358759 / 2359338, Fax:0484-2359336 E-mail: bimalokpal.ernakulam@gbic.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Insurance Ombudsman Office of the Insurance Ombudsman JeevanNivesh, 5th Floor, Nr. PanbazarOverbridge , S.S. Road, **GUWAHATI** – 781 001 (ASSAM) Tel. : 0361-2132204 / 2132205, Fax:0361-2732937 E-mail: bimalokpal.guwahati@gbic.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46 , 1 st floor, "Moin Court", Lane Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, **HYDERABAD** – 500004 Tel.: 040 - 65504123 / 23312122, Fax: 040-23376599 E-mail: bimalokpal.hyderabad@gbic.co.in
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)	Insurance Ombudsman Office of the Insurance Ombudsman Fatima Akhtar Court , 4th Floor, 453, Anna Salai, Teynampet, **CHENNAI** – 600 018 Tel. 044-24333668 / 24335284, Fax: 044-24333664 E-mail: bimalokpal.chennai@gbic.co.in
Rajasthan	Insurance Ombudsman Office of the Insurance Ombudsman JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, **JAIPUR** - 302 005 Tel.: 0141 – 2740363 Email: Bimalokpal.jaipur@gbic.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.	Insurance Ombudsman Office of the Insurance Ombudsman BhagwanSahai Palace , 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301 NOIDA Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@gbic.co.in
Bihar, Jharkhand	Insurance Ombudsman Office of the Insurance Ombudsman 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, **PATNA 800 006.**

Shriram General insurance Co. Ltd.

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Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

	Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	Insurance Ombudsman Office of the Insurance Ombudsman JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, **PUNE** – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@gbic.co.in