Policy Wordings

Tata AIG General Insurance Company Limited (We, Our or Us) will provide the insurance cover, described in this Policy and any endorsements thereto, for the Insured Period, as defined in the Policy schedule. The insurance cover provided under this Policy is only with respect to such and so many of the benefits upto the Sum Insured as mentioned in the Policy Schedule. Commencement of risk cover under the policy is subject to receipt of premium by us.

The statements contained in the Proposal signed by the Policyholder (You) shall be the basis of this Policy and are deemed to be incorporated herein. The insurance cover is governed by and subject to, the terms, conditions and exclusions of this Policy.

For **Tata AIG General Insurance Company Limited**

Authorized Signatory
Registered Office:
TATA AIG General Insurance Company Limited,
Peninsula Business Park, Tower A, 15th Floor, G. K. Marg,
Lower Parel, Mumbai- 400013, Maharashtra, India
Toll Free No. 1800 266 7780 or 1800 22 9966 (Senior Citizen)
Visit us at www.tataaiginsurance.in
IRDA of India Registration No.:108
CIN: U85110MH2000PLC128425
"Insurance is the subject matter of solicitation". For more details on risk factors, terms and conditions, please read policy document carefully before concluding a sale.

Preamble

While the policy is in force, if the Insured Person contracts any disease or suffers from any illness or sustains bodily injury through accident and if such event requires the insured Person to incur expenses for Medically Necessary Treatment, We will indemnify You for the amount of such Reasonable and Customary Charges or compensate to the extent agreed, upto the limits mentioned, subject to terms and conditions of the policy. Each Benefit is subject to its Sum Insured, but Our liability to make payment in respect of any and all Benefits shall be limited to the Sum Insured unless expressly stated to the contrary.

In case of family floater policy, the sum insured for all or any of the benefits shall be per policy per year unless explicitly stated to the contrary. In case of individual policy, the sum insured for all or any of the benefits shall be per insured per year unless explicitly stated to the contrary.

The said treatment must be on the advice of a qualified Medical Practitioner.

Section 1 – Benefits

The following benefits are payable subject to Terms and Conditions of the policy:

B1. In-Patient Treatment

We will cover for expenses for hospitalization due to disease/illness/Injury during the policy period that requires an Insured Person's admission in a hospital as an inpatient.

Medical expenses directly related to the hospitalization would be payable.

B2. Pre-Hospitalization expenses

We will cover for expenses for Pre-Hospitalization consultations, investigations and medicines incurred upto 60 days before the date of admission to the hospital.

The benefit is payable if We have admitted a claim under B1 or B4 or B6.

B3. Post-Hospitalization expenses

We will cover for expenses for Post-Hospitalization consultations, investigations and medicines incurred upto 90 days after discharge from the hospital.

The benefit is payable if We have admitted a claim under B1 or B4 or B6.

B4. Day Care Procedures

We will cover expenses for listed Day Care Treatment due to disease/illness/Injury during the policy period taken at a hospital or a Day Care Centre. The list of such day care procedures covered is available on our website (www.tataaig.com)

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

B5. Organ Donor

We will cover for Medical and surgical Expenses of the organ donor for harvesting the organ where an Insured Person is the recipient provided that:

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organs (Amendment) Bill, 2011 and the organ donated is for the use of the Insured Person, and
ii. We have accepted an inpatient Hospitalization claim for the insured member under In Patient Hospitalization Treatment (section B1).

B6. Domiciliary Treatment

We will cover for expenses related to Domiciliary Hospitalization of the insured person if the treatment exceeds beyond three days. The treatment must be for management of an illness and not for enteral feedings or end of life care.

At the time of claiming under this benefit, we shall require certification from the treating doctor fulfilling the conditions as mentioned under the general definitions (Section 2-10) of this policy.

B7. Restore benefits

We will automatically restore the Basic Sum Insured upon exhaustion of the Sum Insured and accrued Cumulative Bonus, during the policy period. This benefit can be availed once during the policy period subject to the following conditions:

a. The restored sum insured can be used for all claims made by the insured person(s) who have not claimed earlier under Sections B1 to B4. In case the insured has claimed

under these sections, then this automatic restoration benefit is available for admissions due to unrelated illness/diseases. However, this benefit for related illness/diseases would be available, in case of claimed insured person(s), for admissions after 45 days from the date of discharge of the earlier claim.

b. In case of Family Floater policy, Reinstatement of Sum Insured will be available for all Insured Persons in the Policy on floater basis
c. This benefit shall be applicable annually for policies with tenure of more than 1 year.
d. .
e. The unutilized restored sum insured cannot be carried forward.

This benefit shall not be applicable for Global Cover (section B13).

B8. AYUSH Benefit

We will cover for expenses incurred on in-patient treatment taken under Ayurveda, Unani, Sidha and Homeopathy in any of the following:

i. government hospital or in any institute recognized by government and/or accredited by Quality Council of India / National Accreditation Board for Hospitals and Healthcare Providers excluding centre for spas, massage and health rejuvenation procedures.
ii. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH)
iii. AYUSH Hospitals having registration with a Government authority under appropriate Act in the State/UT and complies with the following as minimum criteria:
    - has at least fifteen in-patient beds;
    - has minimum five qualified and registered AYUSH doctors;
    - has qualified paramedical staff under its employment round the clock;
    - has dedicated AYUSH therapy sections;
    - maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

B9. Ambulance Cover

We will cover for expenses incurred on transportation of Insured Person in a registered ambulance to a Hospital for admission in case of an Emergency or from one hospital to another hospital for better medical facilities and treatment, subject to Rs. 3000 per Hospitalization.

For this claim to be paid, the claim must be admissible under section B1 or B4 of this policy.

B10. Health Checkup

We will cover for expenses for a Preventive Health Check-up upto 1% of previous sum insured subject to a maximum of Rs. 10,000/- per policy. The limit is the maximum per policy and more than one insured can utilize the amount.

The benefit is payable after every two continuous claim free policy years with us. This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B11. Compassionate travel

In the event the Insured Person is Hospitalized for more than Five consecutive days in a place where no adult member of his immediate family is present, we will cover for expenses related to a round trip economy class air ticket, or first-class railway ticket, to allow the Immediate Family Member be at his bedside for the duration of his stay in the hospital.

The expenses must be incurred within India and shall not exceed Rs. 20,000 during a policy year.
This benefit shall be payable if We have accepted an inpatient Hospitalization claim for the insured member under In Patient Hospitalization Treatment (**Section** B1).

This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.
We shall require the following additional documents (proof of travel) supporting the claim under this benefit: Boarding Pass, or Railway ticket or any other document to show proof of travel

B12. Consumables Benefit

We will pay for expenses incurred, for consumables which are listed in 'Items for which optional cover may be offered by insurers' under 'Guidelines on Standardization in Health Insurance, 2016', which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury.

Following items shall be excluded from scope of this coverage:

- Items of personal comfort, toiletries, cosmetics and convenience shall be excluded from scope of this coverage.
- External durable devices like Bilevel Positive Airway Pressure (BIPAP) machine, Continuous Positive Airway Pressure (CPAP) machine, Peritoneal Dialysis (PD) equipment and supplies, Nimbus/water/air bed, dialyzer and other medical equipments.

For this claim to be paid, the main claim must be admissible under section B1 or B4 of this policy.

B13. Global Cover

We will cover for Medical Expenses of the Insured Person incurred outside India, upto the sum insured, provided that the diagnosis was made in India and the insured travels abroad for treatment.

The Medical Expenses payable shall be limited to Inpatient and daycare Hospitalization only on reimbursement basis. Cashless facility may be arranged on case to case basis. Insured person can contact us for any claim assistance.

The payment of any claim under this benefit will be in Indian Rupees based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion.

Only basic sum insured along with Cumulative Bonus can be used for this and not the restored sum insured.

We shall require the following additional documents supporting the claim under this benefit:

- Proof of diagnosis in India
- Insured's Passport and Visa

B14. Bariatric Surgery Cover

We will cover for reasonable and customary expenses for Bariatric Surgery if the insured fulfills the following conditions:

i. Surgery to be conducted is upon the advice of the Doctor
ii. The member has to be 18 years of age or older and
iii. Body Mass Index (BMI) greater than or equal to 40
iv. BMI greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
    a. Obesity-related cardiomyopathy
    b. Coronary heart disease
    c. Severe sleep apnea
    d. Uncontrolled Type2 Diabetes

B15. In-Patient Treatment - Dental

We will cover for medical expenses incurred towards hospitalization for dental treatment under anesthesia necessitated due to an accident/injury/illness.

B16. Vaccination cover

We will cover for expenses related to the cost of the following vaccines only:

Without any waiting period:

- Anti-rabies vaccine following an animal bite
- Typhoid vaccination

After 2 years of continuous coverage with Us:

- Human Papilloma Virus (HPV) vaccine
- Hepatitis B Vaccine

Expenses related to the doctor, nurse or any incidental expenses are not payable. This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

The maximum payable is actuals or Rs. 5,000/- per policy, whichever is lower.

B17. Hearing Aid

We will cover for reasonable charges for a hearing aid every third year. The maximum amount payable is 50% of actual cost or Rs. 10,000/- per policy, whichever is lower.

The items must be prescribed by a specialized Medical Practitioner as medically necessary.
This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus

B18. Daily Cash for choosing Shared Accommodation

We will pay a fixed amount per day as mentioned in the policy schedule if the Insured Person is Hospitalized in Shared Accommodation in a Network Hospital for each continuous and completed period of 24 hours. The benefit payable per day would be 0.25% of base sum insured and a maximum of Rs. 2000 per day. This benefit is applicable only for those cases where shared accommodation category is not opted by the policy holder in the policy.

For this claim to be paid, the main claim must be admissible under section B1 of this policy. This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B19. Daily Cash for Accompanying an Insured Child

We will pay a fixed amount per day, as mentioned in the schedule, if the Insured Person Hospitalized is a child Aged 12 years or less, for one accompanying adult for each complete period of 24 hours. The benefit payable per day would be 0.25% of base sum insured and maximum of Rs.2000 per day.

For this claim to be paid, the main claim must be admissible under section B1 of this policy.
This benefit has a separate limit (over and above base sum insured) and does not affect cumulative bonus.

B20. Second Opinion

We will provide You a second opinion from Network Provider or Medical Practitioner, if an Insured Person is diagnosed with the below mentioned Illnesses during the Policy Period. The expert opinion would be directly sent to the Insured Person.

i. Cancer
ii. Kidney Failure
iii. Myocardial Infarction
iv. Angina
v. Coronary bypass surgery
vi. Stroke/Cerebral hemorrhage
vii. Organ failure requiring transplant
viii. Heart Valve replacement
ix. Brain tumors

This benefit can be availed by an Insured Person once during a Policy Year.

B21. Accidental Death Benefit (Optional Cover)

If an Insured Person suffers an accident during the policy period and this is the sole and direct cause of his death within 365 days from the date of accident, then we will pay a fixed amount of 100% of the base Sum Insured.

This benefit is not applicable for dependent children covered in the policy.

Benefit under optional cover (if opted) shall be available to the insured person, only if the particular benefit/optional cover is specifically mentioned in the policy schedule.

B22. Cumulative Bonus

i. 50% cumulative bonus will be applied on the Sum Insured for next policy year under the Policy after every claim free Policy Year, provided that the Policy is renewed with Us and without a break. The maximum cumulative bonus shall not exceed 100% of the Sum Insured in any Policy Year.
ii. If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 50% of the Sum Insured in that following Policy Year. There will be no impact on the Inpatient Sum Insured, only the accrued Cumulative Bonus will be decreased.
iii. In policies with a tenure of more than one year, the above guidelines of Cumulative Bonus shall be applicable post completion of each policy year
iv. In relation to a Family Floater, the Cumulative Bonus so applied will only be available in respect of those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.
v. For purpose of computation of Cumulative Bonus, the percentage (%) of Cumulative Bonus will be applied on the base Sum Insured only. Restored sum insured will not be taken into consideration.

Section 2 – General Definitions

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

1. Accident

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Any one illness

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.

3. Cashless facility

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

4. Congenital Anomaly:

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

5. Co-Payment

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

6. Cumulative Bonus

Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

7. Day Care Centre

A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

8. Day Care Treatment

Day care treatment means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition

9. Dental Treatment

Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

10. Domiciliary Hospitalization

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.

11. Grace Period

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.

12. Hospital

A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and 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 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;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

13. Hospitalization

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

14. Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) Acute condition

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 which leads to full recovery

(b) Chronic condition

A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control or relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur

15. Injury

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

16. Inpatient Care

Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

17. Medical Advice

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

18. Medical Expenses:

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.

19. Medical Practitioner

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 its scope and jurisdiction of license.

20. Medically Necessary Treatment

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 the 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.

21. Network Provider

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.

22. OPD treatment

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

23. Pre-Existing Disease

Pre-Existing Disease means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

24. Pre-hospitalization Medical Expenses

Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

25. Post-hospitalization Medical Expenses

Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

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

26. Portability

Portability means the right accorded to an individual health insurance policyholder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

27. Qualified Nurse

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.

28. Reasonable and Customary Charges

Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

29. 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.

30. Room Rent

Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

31. Shared Accommodation

Shared Accommodation means a hospital room with two or more patient beds. This definition does not apply to ICU or ICCU.

32. Surgery or Surgical Procedure

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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

33. Unproven/Experimental treatment

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.

34. Age

Means the completed age of the Insured Person on his / her most recent birthday as per the English calendar, regardless of the actual time of birth.

Section 3 – General Exclusions

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

1. Exclusions with waiting periods

i. We are not liable for any claim arising due to a condition for which appearance of signs/symptoms, consultation, investigation, treatment or admission started within 30 days from policy commencement date except claims arising due to an accident. In case of renewals, this waiting period shall not be applicable to the extent of sum insured under the previous policy in force. If any illness/procedure is specifically covered after a period of two years (under ii) the 30 day waiting period is superseded by the two year waiting period.

ii. A waiting period of 24 months from the first policy commencement date will be applicable to the medical and surgical treatment of illnesses, disease, or surgical procedures mentioned below, unless necessitated due to cancer:

The following Illnesses/diseases would be covered after a waiting period of two years irrespective of the treatment undergone, medical or surgical:

a. Tumors, Cysts, polyps including breast lumps (benign)
b. Polycystic ovarian disease
c. Fibromyoma
d. Adenomyosis
e. Endometriosis
f. Prolapsed Uterus
g. Non-infective arthritis
h. Gout and Rheumatism
i. Osteoporosis
j. Ligament, Tendon or Meniscal tear (due to injury or otherwise)
k. Prolapsed Inter Vertebral Disc (due to injury or otherwise)
l. Cholelithiasis
m. Pancreatitis
n. Fissure/fistula in anus, haemorrhoids, pilonidal sinus
o. Ulcer & erosion of stomach & duodenum
p. Gastro Esophageal Reflux Disorder (GERD)
q. Liver Cirrhosis
r. Perineal Abscesses
s. Perianal / Anal Abscesses
t. Calculus diseases of Urogenital system Example: Kidney stone, Urinary bladder stone.
u. Benign Hyperplasia of prostate
v. Varicocele
w. Cataract
x. Retinal detachment
y. Glaucoma
z. Congenital Internal Diseases

The following treatments are covered after a waiting period of two years irrespective of the illness for which it is done:

a. Adenoidectomy
b. Mastoidectomy
c. Tonsillectomy
d. Tympanoplasty
e. Surgery for nasal septum deviation
f. Nasal concha resection
g. Surgery for Turbinate hypertrophy
h. Hysterectomy
i. Joint replacement surgeries Eg: Knee replacement, Hip replacement

j. Cholecystectomy
k. Hernioplasty or Herniorraphy
l. Surgery/procedure for Benign prostate enlargement
m. Surgery for Hydrocele/ Rectocele
n. Surgery of varicose veins and varicose ulcers

iii. Pre-existing conditions shall be covered after a waiting period of 36 months.. The said conditions must be declared, if known, by the insured at the time of application and must not have been explicitly excluded in the policy.

iv. If You/the Insured Person has exercised the Portability Option at the time of Renewal of Your previous health insurance policy by submitting Your application and the completed Portability form with complete documentation at least 45 days before the expiry of Your previous Policy Period to Us, upon acceptance of the proposal the Insured Person will be provided with credit gained for Pre-existing Diseases in terms of Waiting Periods and time bound exclusions up to the existing Sum Insured and cover in accordance with the existing guidelines of 'The Insurance Regulatory and Development Authority of India(IRDAI).

2. Medical Exclusions

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

i. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS related complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.
ii. The abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies.
iii. Idiopathic/alcoholic pancreatitis and its related disorders or complications arising out of it.
iv. Treatment of Obesity and any weight control program subject to cover under benefit B14
v. Psychiatric, mental disorders (including mental health treatments)
vi. Parkinsons and Alzheimer's disease
vii. General debility or exhaustion or run-down condition

viii. Congenital External Diseases, defects or anomalies;;
ix. Stem cell implantation or surgery; or growth hormone therapy;
x. Sleep-apnoea
xi. Charges related to Peritoneal Dialysis (CAPD), including supplies
xii. Admission primarily for administration of monoclonal antibodies or Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid
xiii. Admission primarily for diagnostic and evaluation purposes only
xiv. Venereal disease, sexually transmitted disease or illness;
xv. Sterility, treatment whether to effect or to treat infertility; any fertility, sub-fertility or assisted conception procedure; surrogate or vicarious pregnancy; birth control, contraceptive supplies or services including complications arising due to supplying services.
xvi. Laser treatment for correction of eye due to refractive error
xvii. Aesthetic or change-of-life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance or carried out in childhood or at any other times driven by cultural habits, fashion or the like or any procedures which improve physical appearance.
xviii. Plastic surgery or cosmetic surgery unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, Cancer or Burns.
xix. Rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.
xx. All preventive care, vaccination including inoculation and immunisations (except in case of post- bite treatment and other vaccines explicitly covered);
xxi. Hospitalization purely for enteral feedings (infusion formulae via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

xxii. Experimental and Unproven treatments, Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Chelation therapy, Hyperbaric Oxygen Therapy.
xxiii. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization & any dental treatment other than specified in 'Inpatient Treatment – Dental'
xxiv. Pregnancy, , voluntary termination of pregnancy, maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to - Inpatient Hospitalization only and miscarriage due to accident.

3. Non-Medical Exclusions

i. **War** or any act of war, invasion, act of foreign enemy, war like operations (whether war be **decl**ared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, ionising radiation.

ii. Any Insured Person’s participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing.

iii. Any Insured Person committing or attempting to commit a breach of law with criminal intent

iv. Intentional self-injury or attempted suicide while sane or insane.

v. Charges incurred at a Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which confinement is required at a Hospital.

vi. Items of personal comfort and convenience like television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient’s diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service

vii. Treatment rendered by a Medical Practitioner which is outside his discipline

viii. Doctor’s fees charged by the Medical Practitioner sharing the same residence as an Insured Person or who is an immediate relative of an Insured Person's family.

ix. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy unless explicitly stated and covered in the policy,

x. Any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

xi. Any treatment or part of a treatment that is not of a reasonable charge, not medically necessary; drugs or treatments which are not supported by a prescription.

xii. Crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively and explicitly stated and covered in the policy).

xiii. Any claim incurred after date of proposal and before issuance of policy where there is change in health status of the member and the same is not communicated to us.

xiv. All expenses incurred by the Policyholder/ Insured Person at the Hospital or any institution about which the Company has expressly notified that the Claim incurred at such Hospital/institution shall not be payable(except reimbursement claims related to accidents and life threatening conditions). The updated list of such Hospitals can be obtained through the Company's website or Call Center.

Section 4 – General Conditions

1. **Condition Precedent**

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

ii. The fulfilment of the terms and conditions of this Policy (including the payment of premium by the due dates mentioned in the Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person shall be conditions precedent to Our liability.

iii. The premium for the policy will remain the same for the policy period as mentioned in the policy schedule.

2. **Premium Payment**

i. Premium to be paid for the Policy Period before Policy Commencement date as opted by You in the proposal form.

ii. If you have opted to pay premium in full (lumpsum) upfront then the entire premium for the policy period shall be paid before the policy commencement date with an option of policy tenure 1/2/3 years.

iii. Long term premium discount of 5% and 10% is applicable for policy with tenure of 2 and 3 years respectively.

3. **Insured Person**

i. Only those persons named as an Insured Person in the Schedule shall be covered under this Policy.

ii. Any person may be added during the Policy Period after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

iii. We will be offering continuous renewal with no exit age subject to regular premium payment and compliance with all provisions and terms & conditions of this policy by the Insured Person.

4. **Loadings**

i. We may apply a risk loading on the premium payable (based upon the declarations made in the proposal form and the health status of the persons proposed for insurance).

ii. The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person.

iii. The loading shall only be applied basis an outcome of Our medical underwriting.

iv. These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us or on the receipt of the request of increase in Sum Insured (for the increased Sum Insured).

   a. We will inform You about the applicable risk loading through a counter offer letter.

b. You need to revert to Us with consent and additional premium (if any), within 15 days of the issuance of such counter offer letter.
c. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 10 days subject to deduction of the Pre-Policy Check up charges, as applicable.

v. Please note that We will issue Policy only after getting Your consent.

5. Entire Contract

i. This Policy, its Schedule, endorsement(s), proposal constitutes the entire contract of insurance. No change in this policy shall be valid unless approved by Us and such approval be endorsed hereon.

ii. This Policy and the Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear such meaning wherever it may appear.

6. Fraud

i. We will not be liable to pay under the policy if any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, and this Policy shall be void ab-initio without any premium refund.

7. Mis-representation, or non-disclosure of material facts

i. We will not be liable to pay under the policy if any Mis-representation or non-disclosure of material facts noted at the time of claim or otherwise, whether by You or any Insured Person or anyone acting on behalf of You or an Insured Person, & Policy shall be void ab-initio without any premium refund.

8. Other Insurance

i. If at the time when any claim is made under this Policy, You have two or more policies from one or more Insurers to indemnify treatment cost, which also covers any claim (in part or in whole) being made under this Policy, then You shall have the right to require a settlement of such claim in terms of any of your policies.

ii. The insurer so chosen by the You shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen policy.

iii. Provided further that, If the amount to be claimed under the Policy chosen by the You, exceeds the Sum Insured under a single Policy after considering the deductibles or co-pay (if applicable), You shall have the right to choose the insurers by whom claim is to be settled.

9. Alterations to the Policy

i. This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by anyone (including an insurance agent or broker) except Us, and any change We make will be evidenced by a written endorsement signed and stamped by Us.

10. Renewal

i. The premium payable on renewal shall be paid to Us on or before the policy period end date and in any event before the expiry of Grace period**.**

ii. If the renewal premium has been received by Us as mentioned above, We will ordinarily offer renewal terms for life unless We believe that You or any Insured Person or anyone acting on Your behalf or on behalf of an Insured Person has acted in a, fraudulent manner or any misrepresentation under or in relation to this Policy or the renewal of the Policy poses a moral hazard.

iii. A Grace Period of 30 days for renewing the Policy is provided under this Policy.

iv. We, however, are not bound to give notice that it is due for renewal. Unless renewed as herein provided, this Policy shall terminate at the expiration of the period for which premium has been paid.

v. We may extend the renewal automatically if opted by You in the Auto-renewal Form and provided we have received the applicable premium prior to expiry or during the grace period.

vi. Any revision / modification in the product will be done with the approval of the Insurance Regulatory and Development Authority of India (IRDAI) and will be intimated to You at least 3 months in advance.

vii. Your renewal premium for this policy will not change unless we have revised the premium and obtained due approval from IRDAI. Your premium will also change if you move into a higher age group, opt for a higher Sum Insured, change the term or change the plan.

viii. There shall no loadings (claim loading) on renewals based on the Your claim experience.

ix. In case of family floater option where the dependent child(ren) attains age of 26 years at the time of renewal, proposal for a separate policy for this member needs to be submitted. Suitable credit of continuity/waiting periods for all the previous policy years would be extended in the new policy, provided the policy has been maintained without a break.

11. Sum Insured Enhancement

i. Sum Insured can be enhanced only at the time of renewal subject to underwriting guidelines of the company.
ii. If the Insured Person increases the Sum Insured one grid up, no fresh medicals shall be required, subject to Our underwriting guidelines. Any such subsequent sum insured increase by one grid up would be subject to our underwriting guidelines.
iii. In cases where the Sum Insured increase is more than one grid up, the case shall be subject to medicals. In case of increase in the Sum Insured waiting period and exclusions will apply afresh in relation to the amount by which the Sum Insured has been enhanced. However, the acceptance of Sum Insured enhancement request & quantum of increase shall be as per Our underwriting guidelines. For claims arising in respect of accident, injury or illness contracted or suffered during a preceding Policy period, liability of the Company shall be only to the extent of the Sum Insured under the Policy in force at the time when it was contracted or suffered.

12. Change of Policyholder

i. The change of Policyholder is permitted only at the time of renewal.
ii. If You do not renew the Policy, the other Insured Persons may apply to renew the Policy.
iii. However, in case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court.

13. Notices

i. Any notice, direction or instruction under this Policy shall be in writing and if it is to:
    a. Any Insured Person, then it shall be sent to You at Your address specified in the Schedule to this Policy and You shall act for all Insured Persons for these purposes.
    b. Us, it shall be delivered to Our address specified in the Schedule to this Policy. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

14. Termination

i. You may terminate this Policy at any time by giving Us written notice, and the Policy shall terminate when such written notice is received.
ii. If no claim has been made under the Policy, then We will refund premium in accordance with the short rate table below. :

Length of time Policy in force	Year		
	1	2	3
Upto 1 Month	75.00%	87.50%	91.5%
>1 month & Upto 3 Months	50.00%	75.00%	88.5%
>3 months & Upto 6 Months	25.00%	62.50%	75%
>6 months & Upto 12 Months	Nil	50.00%	66.5%
>12 months & Upto 15 Months	Not Applicable	25%	50%
>15 months & Upto 18 Months	Not Applicable	12.5%	41.5%
>18 months & Upto 24 months	Not Applicable	Nil	33%
>24 months & Upto 30 months	Not Applicable	Not Applicable	8%
Exceeding 30 months	Not Applicable	Not Applicable	Nil

iii. We may at any time terminate this Policy on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by You or any Insured Person or anyone acting on Your behalf or on behalf of an Insured Person by sending an endorsement to Your address shown in the Schedule to this Policy.

iv. In the event of termination of this Policy on grounds of mis-representation, fraud, non-disclosure of material facts, the policy shall stand cancelled ab-initio and there will be no refund of premium.

v. In the event the policy is terminated on grounds of non-cooperation of the Insured Person the premium shall be computed in accordance with Our short rate table for the period the Policy has been in force, upon 15 days notice by sending an endorsement to Your address shown in the Schedule provided no claim has occurred up to the date of termination. In the event a claim has occurred in which case there shall be no return of premium.

vi. The coverage for the Insured Person shall automatically terminate if:

a. In the case of Your demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy period. The members need to apply fresh proposal for which continuity benefit would be given.

b. If the Insured Person is no longer eligible on grounds of age or dependency, however the insured member will be eligible to apply for a new policy and enjoy continuity benefits upto Sum Insured.

15. Free Look Period

i. You have a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of cancelling the Policy stating the reasons for cancellation.
ii. You will be refunded the premium paid by You after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium.
iii. You can cancel Your Policy only if You have not made any claims under the Policy.
iv. All Your rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of renewal of the Policy.

16. Option to Migrate

We will offer the Insured Person an option to migrate to similar health insurance Policy with Us provided that:

i. Insured Person has been insured with Us for first time under this Policy as a dependant.
ii. This option for migration to similar Indemnity health insurance policy shall be exercised by the Insured Person only when he / she is at the end of specified exit age, and certainly at the time of renewal only.
iii. Insured Person will be offered continuity of coverage & suitable credits, if any , for all the previous policy years, provided the policy has been maintained without a break.

17. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, we will intimate you about the same 3 months prior to expiry of the policy.
ii. You will have the option to migrate to similar health insurance product available with us at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period etc. provided the policy has been maintained without a break as per portability guidelines issued by IRDAI.

18. Conditions applicable for In-patient Treatment (B1)

i. If the insured person is admitted in a hospital room where the room category opted is higher than the eligible category as specified in the policy schedule, then the policy holder/insured person shall bear 10% of the admissible claim amount.

Section 5 – Claims Procedure and Claims Payment

This section explains about the procedures involved to file a valid claim by the insured member and processes related in managing the claim by TPA or Us. All the procedures and processes such as notification of claim, availing cashless service, supporting claim documents and related claim terms of payment are explained in this section.

1. **Notification of Claim**

	Treatment, Consultation or Procedure:	**We or Our TPA* must be informed:**
1	If any treatment for which a claim may be made and that treatment requires planned Hospitalisation:	At least 48 hours prior to the Insured Person's admission.
2	If any treatment for which a claim may be made and that treatment requires emergency Hospitalisation	Within 24 hours of the Insured Person's admission to Hospital.

**TPA as mentioned in the policy schedule*

2. **Cashless Service**

	Treatment, Consultation or Procedure:	Treatment, Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
	If any planned treatment, consultation or procedure for which a claim may be made:	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	At least 48 hours before the planned treatment or Hospitalisation
	If any treatment,	Network Hospital	We will provide	Within 24 hours

	consultation or procedure for which a claim may be made, requiring emergency hospitalisation		cashless service by making payment to the extent of Our liability directly to the Network Hospital.	after the treatment or Hospitalisation

3. Procedure for Cashless Service

i. Cashless Service is available only available at Network Hospitals.

ii. In order to avail of cashless treatment, the following procedure must be followed by You:

   a. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You must call our designated TPA/Us and request pre-authorization.
   b. For any emergency Hospitalisation, our designated TPA/We must be informed no later than 24 hours of the start of Your hospitalization/ treatment.
   c. For any planned hospitalization, our designated TPA/We must be informed atleast 48 hours prior to the start of your hospitalization/treatment.
   d. Our designated TPA/We will check your coverage as per the eligibility and send an authorization letter to the provider. You have to provide the ID card issued to You along with any other information or documentation that is requested by the TPA/Us to the Network Hospital.
   e. In case of deficiency in the documents sent to TPA/Us for cashless authorization, the same shall be communicated to the hospital by TPA/Us within 6 hours of receipt of the documents.
   f. In case the ailment /treatment is not covered under the policy or cashless is rejected due to insufficient documents submitted, a rejection letter would be sent to the hospital within 6 hours.
   g. Rejection of cashless in no way indicates rejection of the claim. You are required to submit the claim along with required documents for us to decide on the admissibility of the claim.
   h. If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.
   i. Pre-authorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

4. Supporting Documentation & Examination

i. You or someone claiming on Your behalf shall provide Us with documentation, medical records and information We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days or earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment.

ii. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if you can satisfy us that it was not reasonably possible for you to give proof within such time.

iii. We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

iv. **Such documentation will include the following:**

   a. Our claim form, duly completed and signed for on behalf of the Insured Person.We, upon receipt of a notice of claim, will furnish Your representative with such forms as We may require for filing proofs of loss or you may download the claim form from our Web site.
   b. Original Bills (pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
   c. All medical reports, case histories, investigation reports, indoor case papers/ treatment papers (in reimbursement cases, if available), discharge summaries.
   d. A precise diagnosis of the treatment for which a claim is made.
   e. A detailed list of the individual medical services and treatments provided and a unit price for each in case not available in the submitted hospital bill..
   f. Prescriptions that name the Insured Person and in the case of drugs: the drugs prescribed, their price and a receipt for payment. In case of pre/post hospitalization claim Prescriptions must be submitted with the corresponding Doctor/hospital invoice.
   g. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made, if and where applicable.
   h. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident, if available
   i. Copy of settlement letter from other insurance company or TPA
   j. Stickers and invoice of implants used during surgery
   k. Copy of MLC (Medico legal case) records, if carried out and FIR (First information report), if registered, in case of claims arising out of an accident and available with the claimant.

l. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
m. Legal heir/succession certificate , if required
n. PM report (wherever applicable)

v. Note: In case You are claiming for the same event under an indemnity based policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

vi. We at our own expense, shall have the right and opportunity to examine insured persons through Our Authorised Medical Practitioner whose details will be notified to insured person when and as often as We may reasonably require during the pendency of a claim hereunder..

5. Claims Payment

i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and We have been provided with the documentation and information We or Our TPA has requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii. 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.

iii. In the event of Your death, We will make payment to the Nominee (as named in the Schedule).

iv. This Policy only covers medical treatment taken within India (except in case of benefit B13- Global cover), and payments under this Policy shall only be made in Indian Rupees within India.

v. We shall settle or reject a claim, as may be the case, within 30 days of the receipt of the last 'necessary' document.

vi. We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days from the date of receipt of last necessary document.

vii. In the case of delay in the payment of a claim, We shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate. For the purpose of this clause, 'bank rate' shall mean bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

viii. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Interests Regulation), 2017.

Section 6 - Grievance Redressal Procedure

We are committed to extend the best possible services to you.

1. **Complaint**

i. However, if You are not satisfied with our services and wish to lodge a complaint, Kindly
   - email the customer service desk at customersupport@tata-aig.com or
   - call our 24X7 Toll free number **1800-266-7780 or** 022-66939500 (tolled)
   - Senior citizens can call our dedicated line at 1800 22 9966

ii. After examining the issue, We will send our response within 10 days from the date of receipt of the complaint by us. In case the resolution is likely to take longer time, We will inform you of the same through an interim reply.

2. **Escalation Level 1**

iii. In case you do not receive a resolution within 10 days or if the resolution still does not meet your expectations, You can write to manager.customersupport@tata-aig.com. We will send our response within a period of 8 days from the date of receipt at this email id.

3. **Escalation Level 2**

iv. In case You do not receive a resolution within 8 days or if the resolution still does not meet your expectations, you can write to Head - Customer Services at head.customerservices@tata-aig.com. We will send You our final response within 7 days from the date of receipt of your complaint on this email id.

4. **Dispute Resolution Clause**

v. Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

5. **Arbitration**

vi. If any dispute or difference shall arise as to the quantum to be paid under this 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 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.

vii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, if We have disputed or not accepted liability under or in respect of this Policy.

6. Ombudsman

viii. If You do not receive a response from us within one month or are not satisfied with our reply, You may approach the nearest Insurance Ombudsman under the Insurance Ombudsman Scheme as per the Redressal of Public Grievances Rules, 2017.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES

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

Office Details	Jurisdiction of Office Union Territory,District)
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@gbic.co.in	Himachal Pradesh, Jammu & Kashmir, Chandigarh.
CHENNAI - Shri/Smt........ 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@gbic.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI - Smt. Sandhya Baliga 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@gbic.co.in	Delhi.
GUWAHATI - Sh. / Smt. Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri/Smt........ 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@gbic.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR - Shri/Smt........ Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in	Rajasthan.
ERNAKULAM - Shri/Smt........	Kerala,

Office Details	Jurisdiction of Office Union Territory,District)
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@gbic.co.in	Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA - Shri. K. B. Saha 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@gbic.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW - Shri. N. P. Bhagat Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@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.
MUMBAI - Shri/Smt........ Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri. Ajesh Kumar Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@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,

Office Details	Jurisdiction of Office Union Territory,District)
	Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri. Sadasiv Mishra Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in	Bihar, Jharkhand.
PUNE - Shri. A. K. Sahoo 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@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

OFFICE OF THE GOVERNING BODY OF INSURANCE COUNCIL
(Monitoring Body for Offices of Insurance Ombudsman)
Shri P. N. Gandhi, Secretary General
Smt. Moushumi Mukherji, Secretary

3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.
Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949
Email: inscoun@gbic.co.in