L&T Insurance

my:health Group Medisure Insurance Policy Wording

A PREAMBLE

The Insured named in the Schedule has, by a Proposal and declaration which shall be the basis of the contract and shall be deemed to be incorporated herein, applied to L & T General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth.

Subject to the terms, conditions, exclusions, stipulations and definitions contained herein or endorsed or otherwise expressed hereon, if during the **Policy Period**, the Insured Person shall is required to get Hospitalised in any Hospital/Nursing Home in India upon the advice of a Medical Practitioner, the Company agrees to pay to the Insured Person or his/her nominee or legal representative or to the Hospital/Nursing Home, as the case may be Medical Expenses related to such treatment by reimbursement of expenses or payment of **Benefits** covered under this Policy, not exceeding the **Sum Insured** for the Insured Persons and their respective family members, whenever covered and for all claims during such Policy Period the total Sum Insured mentioned in the Schedule.

B DEFINITIONS

Following words and expressions which are defined shall bear the same meaning wherever they appear in this Policy:

"Insured" means the Group Owner named in the Schedule who has finalised the terms on behalf of the Insured Persons and in whose name the Policy is issued.

“Insured Person" means the person(s) named in the Schedule to this Policy, having a place of residence in India, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

“We/Our/Us” means the L&T General Insurance Company Limited.

“Accident” is a sudden, unforeseen and involuntary event caused by external and visible and violent means.

“Any one illness” means continuous Period of Illness and it includes relapse with in 45 days from the date of hospitalization at the Hospital/Nursing home where treatment may have been taken

“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 approved.

“Cancellation” defines the terms on which the Policy contract can be terminated either by the Insurer or the Insured by giving sufficient notice to other which is not lower than period of 15 days.

Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

“External Congenital anomaly” means a condition(s) which is in visible and accessible parts of the body

“Internal Congenital anomaly” means a condition(s) which is not in visible and accessible part

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of the body.

“Co-payment” is a cost sharing requirement under a health insurance policy that provides that the Insured will bear a specific percentage of the admissible Claim amount. A Co-payment is applicable on a claim and does not reduce the Sum Insured.

Condition Precedent: shall mean Policy term or condition upon which the Insurers liability under the Policy is conditional upon.

"Critical Illness" means following disease/illness:

1. Cancer (of specific severity)

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- Micro-carcinoma of the bladder
- All tumours in the presence of HIV infection.

2. Open Chest CABG

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

Excluded are: (1) Angioplasty and/or any other intra-arterial procedures (2) any key-hole or laser surgery.

3. First Heart Attack (of specific severity)

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis for this will be evidenced by all of the following criteria:

- a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
- new characteristic electrocardiogram changes
- elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
- other acute Coronary Syndromes
- any type of angina pectoris.

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4. **Kidney Failure (requiring regular dialysis)**

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

5. **Multiple Sclerosis with persisting symptoms**

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

- investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months; and
- well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

Other causes of neurological damage such as SLE and HIV are excluded.

6. **Major Organ/Bone Marrow Transplant**

The actual undergoing of a transplant of:

- one of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- human bone marrow using hematopoietic stem cells.

The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

Coverage includes reimbursement of expenses incurred towards hospitalization of the donor,

provided that the

- organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules,
- organ donated is for the use of the Insured Person.

Coverage under this section shall not pay for any Pre-Post hospitalization expenses of the donor, donor screening, cost of organ or any other medical treatment for the donor consequent on the harvesting.

The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted.

7. **Stroke (resulting in permanent symptoms)**

Any cerebro-vascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and

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embolisation from an extra-cranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Aorta Graft Surgery

The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon. The diagnosis to be evidenced by any two of the following:

- Computerised tomography (CT) scan
- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Abdominal ultrasound (for associated abdominal aneurysms)
- Angiography (an x-ray of the blood vessels).

9. Primary Pulmonary Arterial Hypertension

The first diagnosis of a primary pulmonary hypertension (PPH) which results in elevation of blood pressure in the pulmonary artery with no apparent reason and measures greater than 25 mm Hg at rest or 30 mm Hg during exercise. The diagnosis of the condition to be evidenced by:

- Electrocardiogram or X-Ray and
- Echocardiography
- Pulmonary Function test
- High Resolution Computerized Tomography Scan (HRCT-Chest).

Further diagnosis to be evidenced by Cardiac Catheterization or Pulmonary ateriography in case the above are not sufficient to confirm PPH.

Commencement Date/Inception Date: means the commencement date of this Policy as specified in the Schedule.

Cumulative Bonus: Cumulative Bonus shall mean any increase in Sum Insured granted by Us without an associated increase in Premium.

Contribution: is essentially the right of the Company to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Day Care treatment: refers to medical treatment and/or surgical procedure which is

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- undertaken under General or Local Anaesthesia in a hospital/day care centre for less than 24 hours due to technological advancement, and
- which would have otherwise required hospitalization of more than 24 hours.
- Treatment taken as an outpatient is not included under the Policy.

Day Care Centre: A Day care centre means any institution established for day care treatment of illness and/or injuries or a medical set up with in a hospital and which has been registered with 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:

- Has qualified nursing staff under its employment
- Has qualified medical practitioner (s) in charge
- Has fully equipped operation theater of its own where surgical procedures are carried out
- Maintains daily record of patients and will make these accessible to the Insurance company's authorized personnel.

Dental treatment: is a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants

Dependents: mean only the family members listed below:

i. Insured's legally married spouse ,
ii. Insured's dependent children – being your children (natural or legally adopted) aged between 3 months and 23 years, who is/are financially dependent on the primary insured or proposer and does not have his / her independent sources of income.
iii. Insured's parents or parents in-law

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.

Disclosure to information norm: The Policy shall be void and all Premium paid here on shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Domiciliary hospitalization: means medical treatment actually taken at home for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually undertaken while confined at home under medical advice and under any of the following compelling circumstances:

a. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital

OR

b. The patient takes treatment at home on account of non availability of a room in a hospital.

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Emergency Care: means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and required immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

"Family Floater" means a Policy described as such in the Schedule where under the Insured and his or her Dependents named in the Schedule are insured under this Policy as at the Commencement Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents the Company's maximum liability for any and all claims made by the Insured and/or all of the Dependents during the Policy 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.

"Hospital/Nursing Home" means any institution established for in-patient care and day care treatment of Illness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all the minimum criterias as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified Medical Practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out, maintains daily records of patients and will make these accessible to the respective Insurance company's authorized personnel.

Hospitalization: means admission in a Hospital/Nursing Home for minimum period of 24 consecutive hours in Inpatient Care except for specified procedures/treatments, where such admission could be for period of less than 24 consecutive hours.

"Hospitalisation Expenses" means expenses for treatment in any Instance of Illness or accidental injury as In Patient in a Hospital/Nursing Home for a minimum period of 24 hours (except in respect of Day Care Treatment), as admissible under the Policy.

Intensive Care Unit: Intensive Care Unit 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.

"Instance of Illness" means treatment for a continuous period and includes relapse within 45 days from the date of last consultation at the Hospital/Nursing Home where treatment was taken. Occurrence of same illness after a lapse of 45 days will be considered as fresh illness for the purpose of this Policy.

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

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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.

Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

"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.

"In-patient" means the person(s) named in the Schedule to this Policy who is/are admitted to Hospital/Nursing Home and stays for at least 24 hours for the sole purpose of receiving medical treatment covered under the Policy.

“Inpatient Care” means a treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

"Insured/Insured Person" means the person(s) named in the Schedule to this Policy, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

Maternity expenses: shall include—(a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization). (b) expenses towards lawful medical termination of pregnancy during the policy period.

"Medical Charges" mean reasonable charges unavoidably incurred by the Insured/Insured Person for the medical treatment of disease, illness or injury, the subject matter of the claim as an In-patient in a Hospital/ Nursing Home, and includes the costs as defined under Hospitalisation and Pre & Post Hospitalisation Expenses.

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license, provided that this person is not the Insured/Insured Person or a member of his/her family.

“Medical Expenses” means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account o f 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.

Medical Advise: Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

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"Medically Necessary" treatment means any treatment, tests, medication, or stay in a Hospital/Nursing Home which

- is required for the medical management of the illness or injury suffered by the Insured/Insured Person;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"New Born Baby" means those babies born to the Insured/Insured Person and his/her lawfully wedded spouse during the Policy Period aged between 1 day and 90 days both days inclusive.

"Network provider" means hospitals or health care providers enlisted by an insurer or a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

"Non - Network" means any hospital, day care centre or other provider that is not part of the list of Network.

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

OPD Treatment (Outpatient): OPD treatment is one in which the Insured visits a clinic/hospital or associated facility like a consultation room for a diagnosis and treatment based on the advice of a medical practitioner. The Insured is not admitted as a Day Care or Inpatient.

"Policy" means this Policy document, the Proposal Form, including endorsements and the Schedule.

"Policy Period" means the period between the inception date and the expiry date of the policy as specified in the Schedule to this Policy or the date of cancellation of this policy, whichever is earlier.

"Policy Year" means a year from the date of inception.

"Proposal Form" means the proposal and any other information given by the Insured to the company prior to the inception of the Policy which forms the basis of this contract of insurance.

"Post-hospitalisation expenses" means relevant medical expenses incurred during a period upto 60 days after hospitalisation for treatment of disease, illness or injury sustained and considered as part of a claim for Hospitalisation admissible under this Policy.

Pre-existing disease means any disease/illness/injury or related condition for which Insured Person(s) had signs or symptoms, and / or diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first Policy taken from Us.

Pre Hospitalization Medical Expenses: means medical expenses incurred immediately before the Insured Person is hospitalized provided that;

i. such Medical Expenses are incurred for the same condition for which the Insured Persons's hospitalization was required and
ii. The Inpatient Hospitalization claim for such hospitalization is admissible by Us

Post Hospitalization Medical Expenses: means medical expenses incurred immediately after the Insured Person is discharged provided that;

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i. such medical expenses are incurred 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 Us

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 or from one plan to another plan o f the same insurer, provided the previous policy has been maintained without any break.

Qualified Nurse means a qualified person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

"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 among comparable providers only, taking into account the nature of the illness / injury involved .

Renewal: Renewal defines the terms on which the contract of Insurance can be renewed on mutual consent with a provision of Grace Period for treating the renewal continuous for the purpose of all waiting periods and Cumulative Bonus (if applicable).

Room Rent: means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

"Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Subrogation: Subrogation shall mean the right of the Insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

"Sum Insured" means, subject to terms, conditions and exclusions of this Policy, the Sum Insured representing the Company's maximum liability for any or all claims during the Policy Period specified in the Schedule to this Policy separately in respect of the Insured/ Insured Person.

"Surgery" or "Surgical procedure" means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital/Nursing Home or Day Care centre by a Medical Practitioner.

"Third Party Administrator or TPA/Service Provider" means an organisation or institution that is licensed by the IRDA to act as a TPA by the Company to provide Policy and claims facilitation services to the Insured/Insured Person and the Company.

Alternative Treatment: Alternative treatments are forms of treatments other than treatment under "Allopathy" or "Modern Medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Unproven/Experimental treatment: Treatment including drug experimental therapy which is not based on established medical practice in India and is a treatment experimental or unproven.

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C SCOPE OF COVER

The Company hereby agrees to pay in respect of an admissible claim, any or all of the following **Expenses** subject to the **Sum Insured**, limits, terms, conditions and exclusions contained or otherwise expressed in this Policy.

1. Hospitalisation Expenses

If any Insured Person suffers an Illness or Accident during the Policy Period requiring Hospitalization as an inpatient, then Company will pay:

i. Fees of Surgeon, Anesthetist, Nurses and Specialists;

ii. Cost of Operation Theatre, diagnostic tests, medicines, blood, oxygen and internal appliances like pacemaker as long as these are medically necessary;

iii. Room Rent/ Boarding & Nursing

iv. ICU Rent/Boarding & Nursing

v. Provided that, expenses on account of Room Rent/ ICU Boarding & Nursing if incurred higher than the limits mentioned on the Policy Schedule, shall be reduced in the same proportion as such actual costs bears to the eligible limits above. Such limits shall not apply where Optional Cover for Waiver of Room Rent Sub-limits has been opted.

2. Pre-Hospitalisation Expenses

Company will pay the Medical Expenses incurred in the 30 days immediately before Insured is Hospitalized, provided that:

i. Such Medical Expenses were in fact incurred for the same condition requiring subsequent Hospitalization, and;
ii. We have accepted the claim under Section I 1. “Hospitalization expenses.”

3. Post-Hospitalisation Expenses

Company will pay the Medical Expenses incurred in the 60 days immediately after Insured is discharged, provided that:

i. Such Medical Expenses were in fact incurred for the same condition for which Insured’s Hospitalization was required, and;
ii. We have accepted the Claim under sectionI 1. “Hospitalization expenses”

4. Domiciliary Hospitalisation Expenses

Company will pay Medical Expenses incurred for Domiciliary Hospitalization provided that treatment is actually taken at home for a period exceeding 3 days, for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually undertaken while confined at home under medical advice and under any of the following compelling circumstances:

i. The condition of the Insured Person is such that he/she is not in a condition to be removed to a Hospital

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OR

ii. The Insured takes treatment at home on account of non availability of a room in a hospital.

If We accept a claim under this Section, We will not make any payment for Post-Hospitalization expenses. Pre-hospitalization expenses for up to 30 days will be payable.

5. Day Care Treatment

Company will pay the Medical Expenses incurred for a Day Care Treatment where the treatment or surgery is taken by Insured as an inpatient and;

- Which is undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a hospitalization of more than 24 hours.

D EXCLUSIONS

The Company shall not be liable to make payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following except covered by way of an extension:

1. All pre-existing diseases / illness / injury / conditions as defined in the Policy, until 48 months of continuous covers have elapsed since inception of the first Policy with the Company.
2. Any disease contracted and/or medical expenses incurred in respect of any disease/illness by the Insured/Insured Person during the first 30 days from the commencement date of the Policy except in case of accidental injuries. This exclusion doesn't apply for Insured/Insured Person having any health insurance indemnity policy in India atleast for 1 year prior to taking this Policy as well as for subsequent renewals with the Company without a break.
3. Treatment towards Cataract, Hysterectomy for Menorrhagia or Fibromyoma, Knee Replacement Surgery (other than caused by an accident), Arthritis, Rheumatism, Joint Replacement Surgery (other than caused by accident), Prolapse of Intervertibral discs(other than caused by accident), Varicose Veins and Varicose Ulcers, Hernia, Stones in the urinary uro-genital and biliary systems, Benign Prostate Hypertrophy, Hydrocele, Congenital internal anomoly, Fistula in anus, Piles, Pilonidal sinus, Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps, any type of Breast lumps, Hypertension and Diabetes and related complications during the first two years(24 months) of continuous operation of this insurance cover.
   Diabetes & Related complications include: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper/Hypoglycemic Shocks.
   Hypertension & Related complications include: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nehpropathy, Internal Bleed/Haemorrhages. If these diseases/conditions are pre-existing at the time of proposal or subsequently found to be pre-existing exclusion 1 above shall apply.
4. Any treatment arising from or traceable to pregnancy, childbirth including caesarean section. However, this Exclusion/waiting period will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
5. expenses incurred for treatment of any of the following diseases under Domiciliary hospitalization
   i. Asthma
   ii. Bronchitis
   iii. Chronic nephritis and nephritic syndrome
   iv. Diarrhea and all types of dysenteries including gastroenteritis
   v. Diabetes mellitus and insipidus
   vi. Epilepsy

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vii. Hypertension
viii. Influenza, cough and cold
ix. All psychiatric or psychosomatic disorders
x. Pyrexia of unknown origin for less than 10 days
xi. Tonsillitis and upper respiratory tract infection including laryngitis and pharangitis
xii. Arthritis, gout and rheumatism.

6. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
7. Genetic disorder and stem cell implantation/surgery.
8. Dental treatment or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalization or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.
9. Birth control procedures, hormone replacement therapy and voluntary termination of pregnancy during the first 12 weeks from the date of conception.
10. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, vaccinations except post-bite treatment or for new born baby up to 90 days, issue of medical certificates and examinations as to suitability for employment or travel.
11. Any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III) or Lymphadinopathy Associated Virus (LAV) or Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV and sexually transmitted diseases.
12. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.
13. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition or any other external devices used during or after treatment.
14. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
15. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder(ADHD).
16. Treatment for general debility, ageing, convalescence, run down condition or rest cure, congenital external anomalies or defects, sterility, infertility including IVF, impotency, venereal disease, puberty, menopause or intentional self-injury, suicide or attempted suicide(whether sane or insane).
17. Certification / Diagnosis / Treatment by a family member or from persons not registered as Medical Practitioners under the respective Medical Councils, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven.
18. Ailment requiring treatment due to use, abuse or a consequence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen and treatment for de-addiction, or rehabilitation.
19. Any illness or hospitalisation arising or resulting from the Insured person or any of his family members committing any breach of law with criminal intent.
20. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
21. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured Person was hospitalised.
22. Treatment of any mental illness or sickness or disease including a psychiatric condition, disorganization of personality or mind, or emotions or behaviour, Parkinsons or Alzheimer's disease even if caused or aggravated by or related to an accident or Illness or general debility or exhaustion ("run-down condition").
23. Any cosmetic surgery unless forming part of treatment for cancer or accident or burns, surgery for sex change or treatment of obesity/morbid obesity or treatment/surgery /complications/illness arising as a consequence thereof.
24. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic

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studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital/Nursing Home.
25. Costs of donor screening.
26. Any form of non-Allopathic treatment, Naturopathy, Ayurvedic, Homeopathy, acupuncture, reflexology, chiropractic treatment or any other form of indigenous system of medicine.
27. Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air force operation.
28. Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air Charter Company.
29. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
30. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
31. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured Person was hospitalized, Ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home.
32. Service charges or any other charge levied by the Hospital, except registration/admission charges.
33. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.
34. Pre-Post hospitalization expenses of the donor, donor screening, cost of organ or any other medical treatment for the donor consequent on the harvesting.

E CLAIMS PROCEDURE

It is a condition precedent to the Company's liability that upon the discovery or happening of any disease/illness/injury that may give rise to a claim under this Policy, the Insured/Insured Person shall:-

1. Claim Notification

Give immediate notice to the TPA named in this Policy/Health Card or the Company, by calling the Help Line number as specified in the Policy/Health Card, or in writing to the address shown in the Schedule with particulars as below.

Policy Number,

Name of the Insured/Insured Person availing treatment,

Nature of disease/illness/injury,

Name and address of the attending Medical Practitioner/Hospital

Date of admission & probable date of discharge

Approximate Claim Expenses

Any other relevant information

Intimation of claim must be done at least 72 hours prior to hospitalization in case of planned hospitalization and within 24 hours of hospitalization in case of an emergency hospitalization.

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2. Cashless Facility for Hospitalisation

i)) The Company may provide Cashless facility for Hospitalisation expenses either directly or through the Third Party Administrator (TPA) if treatment is undergone at a **Network Hospital** by issue of pre-authorization by the Company or the TPA.

ii) For the purpose of considering pre-authorization and Cashless facility, the Insured/Insured Person shall submit to the TPA complete information of the disease, illness or injury requiring treatment along with necessary certification from the Medical Practitioner and/or Hospital.

iii) If claim for treatment appears admissible, Company or TPA shall issue pre-authorization to the Hospital concerned for Cashless facility whereby Hospitalisation expenses shall be paid directly by the Company directly or through the TPA as confirmed in the pre-authorization.

iv) Cashless facility for hospitalisation will not be available for treatment in Non-Network Hospital and may be declined even for treatment at Network Hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such a case, Insured/Insured Person shall bear the expenses and claim reimbursement, immediately after discharge from Hospital/Nursing Home in accordance with the stipulations herein.

v) Cashless facility for Hospitalisation benefit shall be limited exclusively to Hospitalisation Expenses incurred for treatment at a Network Hospital for disease, illness or injury which are covered under the Policy and shall not extend to any other Value Added Benefits.

3. Claim Processing for Reimbursement

i) The Insured/Insured Person shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 30 days of discharge from Hospital the following:-

- Claim Form Duly filled with requisite information and signed by Insured & Hospital
- Copy of the claim intimation
- Original Hospital Main Bill
- Original Hospital Bill break up (Where issued by the Hospital)
- Original Hospital Bill Payment Receipt
- Hospital Discharge Card/Summary
- Original Pharmacy Bill with supporting prescriptions
- Medical Investigation report: ECG/X-Ray/USG/CT/MRI/Histopathology/pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor.
- All Doctor's consultation note: confirming provisional & final diagnosis/advise for admission/medical complication/proposed line of treatment/past medical history
- Original bills and receipts for claiming Ambulance charges(if any)

By signing the claim form you are authorizing us to collect the following documents from the Hospital.

If you have obtained these documents, then please submit the same

- Operation Theatre Notes in surgical cases
- Bar code sticker & Invoice for implants and prosthesis (if used)
- In case of Accidental Injuries, Medico Legal Certificate and/ or First information Report, where applicable and self statement giving description of the incident
- Indoor case papers

Pre and Post hospitalization Claims documents

- Duly filled claim form(s)(If claimed Separately)
- Pharmacy Bills with supporting prescriptions
- Medical investigation test reports and payment receipts with doctor's advice note for such investigations.
- All Doctor's consultation note with original bills and receipts for claiming Doctors fees,

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Domiciliary hospitalization Claims documents

- Duly filled claim form(s)
- Original bills from chemists supported by proper prescription
- Original Investigation test reports and payment receipts
- Original bills and receipts for claiming Doctors fees,
- Certificate from treating doctor stating the reason for domiciliary treatment

Know Your Customer (KYC) documents viz. (address proof of claimant (nominee) and photo ID) would be required for all admissible Claims more than Rs. 100000/-.

ii) The Insured/Insured Person shall submit to the TPA at his/her own expense, documents pertaining to the post hospitalization claim within 15 days from the date of expiry of post hospitalsation coverage period.
iii) The Insured/Insured Person shall at any time as may be required authorize and permit the TPA and/or the Company or anyone deputed by them in this behalf to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim.
iv) If required by the Company or the TPA, the Insured/Insured Person shall submit to medical examination by any Medical Practitioner designated by the Company or the TPA.

The Company may , at its sole discretion, call for additional information and/or carry out verification/investigation on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the assessment of loss. Verification carried out, if any, will be done by individuals or entities authorized by the Company to carry out such verification/investigation(s) and the costs for such verification/investigation shall be borne by the Company.

For determining the amount of admissible claim, applicable taxes prevailing at the time of the claim will be considered as part of claim amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Sum Insured.

4. **TPA to Pay or Reject**
The TPA where appointed, shall process and communicate rejection, if a claim is found to be not admissible under this Policy as authorized by the Company. However all decisions shall be the responsibility of the Company.

5. Representation against Rejection

Where rejection is communicated, the Insured/Insured Person, may if so desired, represent to the Company within 15 days for reconsideration of the decision.

6. Condition Precedent

Completed claim forms and documents must be furnished to the Company within the stipulated timelines. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if the Insured can satisfy the Company that it was not reasonably possible for the Insured to submit/give proof within such time.

The due intimation, submission of documents and compliance with requirements by Insured/Insured Person as mentioned above shall be essential failing which Company/TPA shall not be bound to entertain a claim.

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7. Beyond Policy Period

No claim shall be admissible for Hospitalisation/Domiciliary Hospitalization commencing beyond the Policy Period.

8. Claim Settlement

Wherever a claim has not been settled within the stipulations of the Claims Service Clause above, the Company after payment of agreed compensation shall within a period of maximum 30 days on receipt of final completed set of documents/investigation reports (if applicable) offer settlement of the claim. In the event that the Company decides to reject a claim made under this Policy, the Company shall do so within a period of 30 days of receipt of the final completed set of documents/investigation reports (if applicable), in accordance with the provisions of IRDA (Protection of Policyholders' Interests Regulations, 2002).

F General Conditions

1. Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements or misrepresentation, mis-description or non-disclosure or suppression of any material particulars or if any material information had been withheld in the Proposal Form, personal statement, declaration or other documents, or if a claim is found to be fraudulent or any fraudulent` means or device is used by the Insured/ Insured Person or any one acting on his/their behalf to obtain a benefit under this Policy.

Material information to be disclosed includes every matter that the Insured/Insured Person knows, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to the Company's decision to accept the risk of insurance and if so on those terms. The Insured must exercise the same duty to disclose those matters to the Company before the renewal, extension, variation, endorsement or reinstatement of the contract.

2. Observance of Terms and Conditions

The due observance and fulfillment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

3. No Constructive Notice

Any knowledge or information of any circumstance or condition in connection with the Insured Person in possession of any official of the Company shall not be deemed to be notice or be held to bind or prejudicially affect the Company, or absolve the Insured/Insured Persons from their duty of disclosure, irrespective of acceptance of premium by the Company.

3. Reasonable Care

The Insured/Insured Person shall take all reasonable steps to safeguard against any accident or illnesses that may give rise to any claim under this Policy.

4. Notice of Charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured Person or his/her nominees or his/her legal representative or to the Hospital/Nursing Home, as the case may be, of any Benefit under the Policy shall in all cases be an effectual discharge to the Company.

5. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument in writing and signed by the Company shall be deemed to be part of this Policy and shall have effect accordingly.

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6. Electronic Transactions

The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of this Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of section 41 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/ confirmed by the Insured/Insured Person.

7. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured/Insured Person's rights or recovery thereof against any person or organisation, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured/Insured Person's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. This clause does not apply to Benefit Sections.

8. Contribution

If there shall be existing any other insurance covering the same Insured/Insured Person whether effected by the Insured/Insured Person or not and If the Claim amount exceeds the Sum Insured under the Policy after considering the deductible or Co-pay, the Company shall not be liable to pay or contribute more than its ratable proportion of Claim. This clause does not apply where Claim amount is not exceeding the Sum Insured and/or to benefit sections under this Policy. Insured Person has the right to choose the Insurer by who Claim to be settled.

10. Fraudulent Claims

(a) If any claim is in any respect fraudulent, or if any false statement, or declaration be made or used in support thereof, or if any fraudulent means or devices be used by an Insured Person or anyone acting on his / her behalf to obtain any benefit under this Policy then this Policy shall be void for any such Insured Person and all benefits due to him/her under this Policy shall stand forfeited.

(b) Notwithstanding the above and without prejudice thereto, the company shall at all times be at liberty and be entitled, to exercise, all its legal rights and remedies against any Insured Person and others concerned for recovery of the benefit or of moneys paid under the policy in respect of a claim subsequently discovered to be fraudulent or in anywise not payable in terms of sub clause (a) above.

11. Cancellation/Termination

The Company reserves the right and may at any time, cancel this Policy, on grounds of misrepresentation, fraud, non disclosure or suppression of material fact as sought to be declared on the proposal form or non co-operation of the Insured, by giving 15 days notice in writing by Registered Post Acknowledgment Due to the Insured/Insured Person at his/their last known address in which case the Company shall not be liable to repay the premium for the unexpired term.

The Insured/Insured Person may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales as

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Period On Risk	Rate Of Premium Refunded
Up to I month	75% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	25% of annual rate
Exceeding six months	Nil

12. Place/Currency
No claim shall be payable under this Policy for any treatment or expenses outside India. All claims shall be payable in India and in Indian Rupees only.

13. Free-look Cancellation
A period of 15 days from the date of receipt of the Policy document is available to review the terms and conditions of this Policy. The Insured has the option of cancelling the Policy stating the reasons for cancellation, if he has any objections to any of the terms and conditions. The Company shall refund the premium paid after adjusting the amounts spent on stamp duty charges and proportionate risk premium. Cancellation will be allowed only if there are no claims paid or reported under the Policy. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not available at the time of renewal of the Policy. Minimum premium shall not apply for free look cancellations.

14. Law Applicable
The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy or any claim there under.

14. If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and liability of the Company extinguished and shall not be recoverable thereafter.

15. Renewal

i. The Company shall not be bound to give notice that renewal is due.

ii. If the Insured desires renewal he/she shall apply to the Company for the same prior to expiry of the Policy Period of Insurance.

iii. Renewals are deemed to be continuous when received within a period of 30 days from the date of expiry of last policy, subject however, to the effective policy inception date being reckoned from such period when the renewal premium is received by the Company.

iv. Policy would be considered as a fresh policy if there would be break of thirty or more days between the previous policy expiry date and current policy start date.

v. The Company shall not be liable for any claim arising out of an ailment suffered or hospitalisation commencing during the period between the expiry of previous policy and date of commencement of subsequent Policy. Any disease/ condition contracted in the break in period will not be covered and will be treated as Pre-existing condition.

vi. Any enhanced Sum Insured during subsequent policy renewals will not be available for an illness, diseases, injury already contracted under the preceding policy periods. All Waiting periods as defined in the Policy shall apply for this enhanced limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

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vii. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of Policy with the Company.

viii. In case of floater Policies, where dependent child crosses specified age as a dependent ,renewal can be done in a separate Policy under any other available Products with continuity benefits.

ix. Policy shall be ordinarily renewable for lifetime unless:
   a. any fraud, non cooperation, misrepresentation or suppression of material facts as sought to be declared on the Proposal form by the Insured or on his behalf is found either in obtaining insurance or subsequently in relation thereto or,
   b. the Company has discontinued issue of the particular type of Policy, in which event the Insured shall have the option of renewal under any similar Policy being issued by the Company; provided however, benefits payable shall be subject to the terms contained in such other Policy. Such modification or revision of the terms and conditions of the Product shall be intimated to you 3 months in advance along with reasons of modification and revision

x. Based on the experience of the Policy , Premium, terms and conditions may be revised. Such revision shall be intimated to you 3 months in advance with an option of renewal under any similar Policy being issued by Us. However, benefits payable shall be subject to the terms contained in such other Policy. Individual Claims experience loading is not applicable under the Policy.

16. Operation of Master Policy

A Master Policy when issued shall be for a group for the duration as specified in the Schedule. thereto, All additions to the master policy shall be by way of certificate/s of insurance valid for a period of one year commencing from the actual date of addition to the Master Policy, it being agreed and understood that the Company shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on renewal of the Master Policy or until expiry of the certificate of insurance whichever is later.

17. Continuity Benefits

For Roll Over Cases (Portability Policies) Continuity benefits shall be offered to all Insured/Insured Persons in accordance to IRDA circular from time to time.

Portability benefits are not automatically applicable under the Policy unless application for portability has been specifically made and subsequently accepted by the Company.

Where the product is offered to the customers of a specific institution, with which the Company has a tie up, continuity of benefits will be provided under the same or similar policies available with the Insurer during such period in the event that such tie-up has been discontinued.

23. Endorsements: Following type of endorsement are permissible under the Policy.

Premium Bearing

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- Increase in Sum Insured
- Decrease in Sum Insured
- Addition of member – Newly married spouse or New born baby
- Policy cancellation
- Addition of Covers

Non Premium Bearing

- Address change
- Corrections – Names, address etc
- Change of Occupation

Above list is indicative.

24. Customer Support

L&T General Insurance Company has a strong focus on providing exemplary Service to our Customers.

Our customers can contact us through the below mentioned touch points.

Dedicated 16 ×7 (7:00 am to 11:00 pm 7 days a week) Toll free number 1800-209- **5846** (1800-209- **LTIN**)

Email us at help@ltinsurance.com or visit us at www.ltinsurance.com to raise your query

SMS **'LTI'** to 56070 **58** (56070-**LT**) and we will call the customer

Our Network of Branches

Write to us at our Corporate office address –

L&T General Insurance Company Limited
6th Floor, City 2, Plot No. 177,
CST Road, Near Bandra Kurla Telephone Exchange,
Kalina, Santacruz (East), Mumbai – 400098, India.

Senior Citizen Cell

‘Good things come with time’ and so for our customers who are above 60 years of age We have created special channels to address any health insurance related query. At L&T Insurance, our senior citizen customers can reach us through the below dedicated channels to enable us to service them promptly

- Dedicated prompt in our Toll Free Number 1800-209- **5846** (1800-209- **LTIN**)
- SMS “SENIOR” to 5607058

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- Email us at 'senior@ltinsurance.com'

22. Grievances Redressal Procedure

Our Grievance Management process follows a philosophy of providing ease of complaint redressal to the customer as well as influencing effectiveness of service delivery by in depth analysis of grievance causes.

You or your legal representative can approach us through the below mentioned touch points:

- Call us on toll-free number: 1800-209-5846
- Email on 'help@ltinsurance.com'
- Write to us at: Head-Customer Services at our Corporate Office Address

In case You are not satisfied with the decision of the above office, You may:

- Email on 'grievance@ltinsurance.com'
- Write to us at: Grievance Officer at our Corporate Office Address

L&T General Insurance Co. Ltd. shall abide by Insurance Regulatory and Development Authority (Protection of Policy holders Interests) Regulations, 2002. Under this Regulation and with an objective to provide a forum to Policy holders for resolution of claims related complaints, Insurance Ombudsman has been constituted under the aegis of Governing Body of Insurance Council, list of which is given below. For further Information you could refer to http://www.gbic.co.in/contact.html.

The details of the Insurance Ombudsmen and their jurisdiction are as listed below-

Ombudsman Offices	
Areas of Jurisdiction	**Addresses of the Ombudsman Offices**
State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.	**AHMEDABAD** 2nd Floor, Ambica House, Nr. C U Shah College, 5, Navyug Colony, Ashram Road, AHMEDABAD-380014 Tel: 27546150, Fax: 079-27546142 Email: insombalhd@rdiffmail.com
States of Madhya Pradesh and Chattisgarh.	**BHOPAL** 1st Floor, 117, Zone II (Above D M Motors Pvt. Ltd.), Maharana Pratap Nagar, BHOPAL-462 011 Tel: 0755 - 2769200, Fax: 0755-2578103 Email:insombmp@satyam.net.in
State of Orissa.	**BHUBANESWAR** 62, Forst Park, BHUBANESWAR-751 009. Tel: 2535220, Fax: 0674-2531607 Email:susantamishra@yahoo.com, ioobbsr@vsnl.net
States of Punjab, Haryana, Himachal Pradesh, Jammu &	**CHANDIGARH** S.C.O No.101,102 & 103, 2nd Floor, Batra Building, Sector 17

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Kashmir and Union territory of Chandigarh.	D, CHANDIGARH-160 017 Tel: 0172- 2706196 EPBX:0172-2706468 Fax: 0172-2708274
State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).	**CHENNAI** Fatima Akhtar Court , 4th Floor, 453 (Old 312) Anna Salai, Teynampet, CHENNAI-600 018 Tel: 24333678, 24333668, 24335284 Fax: 044-24333664 Email:insombud@md4.vsnl.net.in
States of Delhi and Rajasthan.	**DELHI** 2/2 A, Universal Insurance Bldg, Asaf Ali Road, NEW DELHI-110 002 Tel: 23239611, Fax: 011-23230858 Email: insombudsmandel@netcracker.com
States of Andhra Pradesh, Karnataka and Union Territory of Yanam - a part of the Union Territory of Pondicherry.	**HYDERABAD** 6-2-46, Yeturu Towers, Lane Opp. Saleem Function Palace, A C Guards, Lakdi-Ka-Pool, HYDERABAD-500 004 Tel: 55574325, Fax:040-23376599 Email:insombud@hd2.vsnl.net.in
State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.	**KOCHI** 2nd Floor, CC 27/2603 Pulinat Bldg, Opp. Cochin Shipyard, M G Road, ERNAKULAM-682 015 Tel: 2373334, 2350959, Fax:0484-2373336 Email:insuranceombudsmankochi@hclinfinet.com
States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.	**KOLKATTA** North British Building 29, N S Road, 3rd Floor, KOLKATTA-700 001 Tel: 22212666, 22212669, Fax:033-22212668
States of Uttar Pradesh and Uttaranchal.	**LUCKNOW** Jeevan Bhavan, Phase 2, 6th floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226001 Tel: 0522-2201188, 2231330, 2231331 Fax:0522-2231310 E-mail: ioblko@sancharnet.in
States of Maharashtra and Goa.	3rd Floor, Jeevan Seva Annexe (above MTNL), S V Road, Santacruz (W), Mumbai-400 054 Tel: 26106889, EPBX:022-26106889 Fax:022-26106052, 26106980 Email:ombudsman.i@hclinfinet.com
States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**GUWAHATI** Aquarius Bhaskar Nagar, R G Baruah Road, GUWAHATI 781 021 Tel: 2413525 EPBX:0361-2415430 Fax: 0361-2414051
Address and contact number of Governing Body of Insurance Council	Secretary General Governing Body of Insurance Council 5th Floor, Royal Insurance Building, 14 Jamshedji Tata Road, Churchgate, Mumbai 400020 022-22817515 Email: inscoun@vsnl.net

19. IRDA REGULATIONS: This Policy is subject to Regulations of IRDA (Protection Of Policyholder's Interests) Regulations, 2002 as amended from time to time.

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