भारतीय बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA

Ref: IRDAI/HLT/REG/CIR/193/07/2020 22nd July, 2020

All Insurers (excluding specialized insurers) and TPAs, wherever applicable

Sub: Master Circular on Standardization of Health Insurance Products

1. Objective:

1.1 The extant IRDAI (Health Insurance) Regulations 2016 were notified on 18th July, 2016 superseding IRDA (Health Insurance) Regulations 2013.

1.2 The Guidelines on Standardization in Health Insurance were issued on 29th July, 2016.

1.3 Subsequently Modification Guidelines have been issued from time to time amending aforementioned Guidelines. Further, some new Guidelines have been issued under the provisions of the Insurance Act, 1938 and IRDAI (Health Insurance) Regulations 2016.

1.4 In consolidation of all the Guidelines issued up to 31st March, 2020 and in force as on date, this Master Circular on Standardization of Health Insurance Products is issued.

2. Applicability:

2.1 This Master Circular is applicable to all insurers (excluding specialized insurers) and the TPAs wherever applicable unless otherwise specified thereunder.

3. Legal and other provisions:

3.1 This Master Circular is issued under the provisions of Section 34 (1)(a) of the Insurance Act, 1938, Regulation 14(2)(e) of the IRDAI Act 1999, Regulation 2(i)(o), 18, 31(e) and 37 of IRDAI (Health Insurance) Regulations 2016.

4. Repeal and Savings:

4.1 This Master circular supersedes the following Guidelines/Circulars:

Sl. No.	Circular Reference	Description
1.	IRDA/HLT/REG/CIR/146/07/2016 dated 29.07.2016	Guidelines on Standardization in Health Insurance
2.	IRDA/HLT/CIR/212/10/2016dated 27.10.2016	Clarification to Guidelines on Standardization in Health Insurance
3.	IRDA/HLT/GDL/CIR/257/12/2016 dated 29.12.2016	Clarification to Guidelines on Standardization in Health Insurance
4.	IRDA/HLT/REG/CIR/006/01/2017 dated 10.01.2017	Partial Modification of the provisions of Guidelines on Standardization in Health Insurance
5.	IRDAI/HLT/GDL/CIR/114/07/2018 dated 27.07.2018	Modified Guidelines on Standards and Benchmarks for hospitals in the provider network
6.	IRDAI/HLT/GDL/CIR/136/08/2018 dated 27.08.2018	Modified Guidelines on Items for which optional cover may be offered by insurers
7.	IRDAI/HLT/GDL/CIR/122/07/2019 dated 26.07.2019	Extension of timelines to comply with the Guidelines on Standards and Benchmarks for the Hospitals in the Provider Network
8.	IRDAI/HLT/REG/CIR/176/09/2019 dated 27.09.2019	Modification Guidelines on Standardization in Health Insurance
9.	IRDAI/HLT/REG/CIR/177/09/2019 dated 27.09.2019	Guidelines on Standardization of Exclusions in Health Insurance Contracts
10.	IRDA/HLT/REG/CIR/209/11/2019 dated 26.11.2019	Modified guidelines on Standardization in Health Insurance Business
11.	IRDAI/HLT/REG/CIR/001/01/2020 dated 01.01.2020	Guidelines on Standard Individual Health Insurance Product
12.	IRDAI/HLT/REG/CIR/002/01/2020 dated 01.01.2020	Modification guidelines on standardization in health insurance
13.	IRDAI/HLT/REG/CIR/ 031/01/2020 dated 24.01.2020	Modification Guidelines on Standard Individual Health Insurance Product
14.	IRDAI/HLT/REG/CIR/046/02/2020 dated 10.02.2020	Amendments in respect of provisions of Guidelines on Standardization of Exclusions in Health Insurance Contracts and Modification Guidelines on Standardization in Health Insurance
15.	IRDAI/HLT/REG/CIR/055/03/2020 dated 04.03.2020	Modification Guidelines on Standard Individual Health Insurance Product

5. The Master Circular is divided into three sections.
   5.1 Section 1 - Guidelines on Standardization in Health Insurance,
   Section 2 - Guidelines on Standardization of Exclusions in Health Insurance Contracts; and
   Section 3 - Guidelines on Standard Individual Health Insurance Product

6. Effective date :

   This Master circular shall come into force with immediate effect.

D V S Ramesh
General Manager (Health)

Index

Section 1: Guidelines on Standardization in Health Insurance

Chapter I: Standard Definitions of terminology to be used in Health Insurance Policies

In order to ensure uniformity across the industry certain basic terminology being used in Health Insurance policies are given standard definitions so that prospects and insureds are able to understand them without ambiguity. All insurers shall adhere to the following standard definitions for the terminology listed hereunder, for all insurance products filed hereafter falling under the definition of 'Health Insurance Business' wherever the said terms are referred to in the terms and conditions. Where a particular terminology is not applicable to one or more types of policies, it is indicated against it in brackets.

1. **Accident:**
   An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Any one illness: (not applicable for Travel and Personal Accident Insurance)**
   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. **Condition Precedent:**
   Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

5. **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

6. **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.

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

8. **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.

9. **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.
   (Insurers may, in addition, restrict coverage to a specified list).

10. **Deductible:**
    Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
    (Insurers to define whether the deductible is applicable per year, per life or per event and the manner of applicability of the specific deductible)

11. Dental Treatment:

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

12. Disclosure to information norm:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

13. 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.

14. Emergency Care:

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

15. 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.

16. Hospital (not applicable for Overseas Travel Insurance):

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) of the said act **Or** complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;
ii) has at least 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;

17. Hospitalization (not applicable for Overseas Travel Insurance):

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.

18. 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:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

19. 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.

20. Inpatient Care (not applicable for Overseas Travel Insurance):

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

21. 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.

22. ICU Charges:

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

23. Maternity expenses:

Maternity expenses means;

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.

24. Medical Advice:

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

25. 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.

26. Medical Practitioner (not applicable for Overseas Travel Insurance):

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.

(Insurance companies may specify additional or restrictive criteria to the above e.g. that the registered practitioner should not be the insured or close member of the family. Insurance Companies may also specify definition suitable to overseas jurisdictions where Indian policyholders are getting treatment outside India as per the terms and conditions of a health insurance policy issued in India)

27. Medically Necessary Treatment (not applicable for Overseas Travel Insurance):

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.

28. Network Provider (not applicable for Overseas Travel Insurance):
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.

29. New Born Baby:
Newborn baby means baby born during the Policy Period and is aged upto90 days.

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

31. Notification of Claim:
Notification of claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

32. 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.

33. Pre-Existing Disease (not applicable for Overseas Travel Insurance):
Pre-existing Disease means any condition, ailment, injury or disease:
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer **or**
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
(Life Insurers may define norms for applicability of PED at reinstatement).

(Note: All existing health insurance products that are not in compliance with this definition shall not be offered and promoted from 01st October, 2020 onwards)

34. Pre-hospitalization Medical Expenses
Pre-hospitalization Medical Expenses means medical expenses incurred during pre-defined 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.

35. Post-hospitalization Medical Expenses:

Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined 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.

36. Qualified Nurse (not applicable for Overseas Travel Insurance):

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.

37. Reasonable and Customary Charges (not applicable for Overseas Travel Insurance):

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.

38. 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.

39. Room Rent:

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

40. Subrogation (Applicable to other than Health Policies and health sections of Travel and PA policies):

Subrogation means 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.

41. 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.*

42. 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.

43. AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner*(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH *Medical Practitioner* and must comply with all the following criterion:

    i. Having at least 5 in-patient beds;
    ii. Having qualified AYUSH *Medical Practitioner* in charge round the clock;
    iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

44. AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or

surgical/para-surgical interventions or both under the supervision of registered AYUSH *Medical Practitioner* (s) on day care basis without in-patient services and must comply with all the following criterion:

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

(Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of "Medical Practitioner" under Chapter I of Guidelines)

45. Migration:

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

46. Portability:

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

Chapter II: Standard Nomenclature and Procedure for Critical Illnesses

The following nomenclature and procedure are being prescribed for 22 critical illnesses that could form part of a health insurance policy. All Insurers shall use the definitions without exception wherever the products offer coverage to any of the Critical Illnesses specified herein.

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection.

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

I. The first occurrence of heart attack or 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 Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN CHEST CABG

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

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

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
    i. no response to external stimuli continuously for at least 96 hours;
    ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

7. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

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

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

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

9. PERMANENT PARALYSIS OF LIMBS

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

10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
    i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
    ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

12. ANGIOPLASTY

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

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

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

13. BENIGN BRAIN TUMOR

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

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
    i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
    ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

14. BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:
    i. corrected visual acuity being 3/60 or less in both eyes or ;
    ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

15. DEAFNESS

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing” in both ears.

16. END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

   i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
   ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
   iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
   iv. Dyspnea at rest.

17. END STAGE LIVER FAILURE

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

   Permanent jaundice; and
   Ascites; and
   Hepatic encephalopathy.

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

18. LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

II. All psychiatric related causes are excluded.

19. LOSS OF LIMBS

I. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

20. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

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

III. The Activities of Daily Living are:

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

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

21. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg

on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

22. THIRD DEGREE BURNS

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

Chapter III: Items for which optional cover may be offered by insurers

a. Details of items for which optional cover may be offered by insurers and details of the items that are to be subsumed into costs of room charges, cost of specific procedure charges and cost of treatment are specified under Annexure I. Insurers, however, may endeavour to cover all or some of optional items specified at List I of Annexure – I or design add-ons or optional covers for them.

   (Note: All existing health insurance products that are not in compliance with this shall not be offered and promoted from 01st October, 2020 onwards.)

b. Where the insurer has a list of expenses not covered under the policy, the same has to be mentioned in the policy and the detailed list needs to be put up on the website of the insurer to enable the policyholder to refer to the details as and when required.

c. The instructions given in this Chapter are applicable to Indemnity policies only.

Chapter IV: Standards and benchmarks for hospitals in the provider network

1. Insurers and TPAs, wherever applicable, shall ensure that Network Providers or Hospitals which meet with the definition of 'Hospital' provided in Chapter I of these Guidelines shall meet with the following minimum requirements:

a. All the Network Providers as at 27th July, 2018 shall, comply with the following by 26th July, 2020:

   i. Register with Registry of Hospitals in the Network of lnsurers (ROHlNl) maintained by lnsurance lnformation Bureau (llB). [https://rohini.iib.gov.in].

   ii. Obtain either "NABH Entry Level Certification" (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NOAS), issued by National Health Systems Resources Centre (NHSRC).

   iii. In respect of all the new entrants (after 27th July 2018), only those hospitals that are compliant with the requirements specified at Clause (a) (i) above shall be enlisted as network providers. These network providers shall comply with the requirements stipulated at Clause (a) (ii) above within one year from the date of enlisting as a Network Provider and this shall be one of the conditions of Health Services Agreement.

   iv. lnsurers and TPAs may also endeavour to get hospitals (other than Network Providers) involved in reimbursement claims to meet the requirements stipulated at Clause (a) (i) and (a) (ii) above.

b. AYUSH Hospitals and AYUSH Day Care Centres which meet the definition of AYUSH Hospitals and AYUSH Day Care Centres defined under Chapter I of these Guidelines shall also obtain:

   (i) Either "NABH Entry Level Certification" (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

   (ii) All the existing AYUSH Hospitals and AYUSH Day Care Centres shall comply with the requirements referred above within a period

of twelve months from 26th November, 2019, if the said certificate is not already obtained.

(*Note: The above instructions at a and b are subject to the directions of the Hon'ble Delhi High Court in its order dated 29th May 2019 / 31st May 2019, in respect of W.P(C) 6237 of 2019, which needs to be complied with till further orders of the Hon'ble Court*.)

c. The providers shall comply with the minimum standard clauses in the agreement amongst Insurers, Network Providers and TPAs applicable to providers listed in Annexure 22 of Master Circular Ref. IRDAI/TPA/REG/CIR/130/06/2020 dated 03.06.2020 and as amended from time to time.

d. Providers shall be bound by the Provider Services—Cashless facility admission procedure laid down in Schedule A of Master Circular Ref. IRDAI/TPA/REG/CIR/130/06/2020 dated 03.06.2020 and as amended from time to time.

e. Providers shall be bound by the process of de-empanelment of providers laid down in Schedule B of Master Circular Ref. IRDAI/TPA/REG/CIR/130/06/2020 dated 03.06.2020 as amended from time to time.

f. Providers shall follow the standard discharge summary format prescribed under Schedule C of Master Circular Ref. IRDAI/TPA/REG/CIR/130/06/2020 dated 03.06.2020 and as amended from time to time.

g. Providers shall follow the standard format for provider bills prescribed under Schedule D of Master Circular Ref. IRDAI/TPA/REG/CIR/130/06/2020 dated 03.06.2020 and as amended from time to time.

h. Providers shall ensure that the standard claim form and form for request for cashless hospitalization for Health Insurance Policy provided for under Annexure 30 of Master Circular Ref. IRDAI/TPA/REG/CIR/130/06/2020 dated 03.06.2020 and as amended from time to time are adhered to in respect of all claims.

Chapter V: Health Insurance Returns

a. The periodical returns to be submitted by all the Insurers are specified in Annexure II of these Guidelines.

b. All the returns as specified under Annexure II shall be furnished for data pertaining to Financial Year 2017-18 onwards.

c. The timeline for submission of the returns is specified as under.
   1. All Yearly returns shall be furnished within 90 days from the close of the Financial Year.
   2. All Half Yearly returns shall be furnished within 45 days from the close of every Half - Year.
   3. All Quarterly returns shall be furnished within 30 days from the close of the Quarter.

ANNEXURE I

Items for which optional cover may be offered by Insurers

1. LIST – I: Items that may be offered as optional items – Items specified in the list are the Optional Items to which Insurers may offer coverage.

List I – Optional Items

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)

26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK

63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

2. Where the costs are to be subsumed into the room charges specified in List – II or procedure charges specified in List III or costs of treatment (including costs of diagnostics) specified in List IV, all claims shall be settled in accordance to the terms and conditions of the policy contract. Insurers shall put in place measures to ensure that items which are part of room / surgical procedure / treatment (including diagnostics) as referred in the lists herein shall not be billed to the policyholders by the hospitals and every insurer shall inform or notify the same to the hospitals and the policyholders suitably. Accordingly, all insurers are advised to make it part of their service level agreement with the network providers (hospitals) in case of cashless cases. In case of reimbursements (with other than network providers) Insurers shall settle the claims as per the terms and conditions of the policy contract.

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

Sl No	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER

18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl No.	**Item**
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER

12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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

18	URINE BAG

Annexure II

List of Health Insurance Regulatory Returns

Sno.	Form Number	Description	Freq.	Timeline	Applicability
1	HIR-1-a	Details of product performance - Health Insurance	Yearly	90 days	General/Health Insurers
2	HIR-1-b	Details of product performance - Personal Accident	Yearly	90 days	General/Health Insurers
3	HIR-1-c	Details of product performance - Domestic Travel Insurance	Yearly	90 days	General/Health Insurers
4	HIR-1-d	Details of product performance - Overseas Travel Insurance	Yearly	90 days	General/Health Insurers
5	HIR-2	Details of product performance - Health Insurance Products of Life Insurers	Yearly	90 days	Life Insurers only
6	HIR-3	Details of performance of Health Insurance Riders of Life Insurers	Yearly	90 days	Life Insurers only
7	HIR-4-a	Details of performance of Add-ons - Health Insurance	Yearly	90 days	General/Health Insurers
8	HIR-4-b	Details of performance of Add-ons - Personal Accident	Yearly	90 days	General/Health Insurers
9	HIR-4-c	Details of performance of Add-ons - Domestic Travel Insurance	Yearly	90 days	General/Health Insurers
10	HIR-4-d	Details of performance of Add-ons - Overseas Travel Insurance	Yearly	90 days	General/Health Insurers
11	HIR-5	Details of performance of Combi-products	Yearly	90 days	Life/General/Health Insurers - Data to be submitted by Lead Insurers
12	HIR-6-a-i	Details of State-wise Channel-wise Business - Health Insurance-Group Policies	Yearly	90 days	Life/General/Health Insurers
13	HIR-6-a-ii	Details of State-wise Channel-wise Business - Health Insurance-Individual Policies	Yearly	90 days	Life/General/Health Insurers
14	HIR-6-b-i	Details of State-wise Channel-wise Business - Personal Accident - Group Policies	Yearly	90 days	General/Health Insurers
15	HIR-6-b-ii	Details of State-wise Channel-wise Business - Personal Accident-Individual Policies	Yearly	90 days	General/Health Insurers
16	HIR-6-c-i	State-wise Channel-wise Number of Policies Issued and Gross Premium - Domestic Travel- Group policies	Yearly	90 days	General/Health Insurers
17	HIR-6-c-ii	State-wise Channel-wise Number of Policies Issued and Gross Premium - Domestic Travel- Individual Policies	Yearly	90 days	General/Health Insurers

18	HIR-6-d-i	State-wise Channel-wise Number of Policies Issued and Gross Premium - Overseas Travel- Group Policies	Yearly	90 days	General/Health Insurers
19	HIR-6-d-ii	State-wise Channel-wise Number of Policies Issued and Gross Premium - Overseas Travel- Individual Policies	Yearly	90 days	General/Health Insurers
24	HIR-7-a-i	State-wise details of new business and renewal business - Health Insurance- Group Family Floater	Yearly	90 days	Life/General/Health Insurers
25	HIR-7-a-ii	State-wise details of New Business & Renewal Business - Health Insurance- Group- Other than Family Floater	Yearly	90 days	Life/General/Health Insurers
26	HIR-7-a-iii	State-wise details of New Business & Renewal Business - Health Insurance- Individual Family Floater	Yearly	90 days	Life/General/Health Insurers
27	HIR-7-a-iv	State-wise details of New Business & Renewal Business - Health Insurance- Individual Other Than Family Non-Floater	Yearly	90 days	Life/General/Health Insurers
28	HIR-7-b-i	State-wise details of New Business & Renewal Business - Personal Accident Insurance- Group Insurance	Yearly	90 days	General/Health Insurers only
29	HIR-7-b-ii	State-wise details of New Business & Renewal Business - Personal Accident Insurance- Individual Insurance	Yearly	90 days	General/Health Insurers only
30	HIR-7-c-i	State-wise details of New Business & Renewal Business - Overseas Travel Insurance- Group Insurance	Yearly	90 days	General/Health Insurers only
31	HIR-7-c-ii	State-wise details of New Business & Renewal Business - Overseas Travel Insurance- Individual Insurance	Yearly	90 days	General/Health Insurers only
32	HIR-7-d-i	State-wise details of New Business & Renewal Business - Domestic Travel Insurance- Group Insurance	Yearly	90 days	General/Health Insurers only
33	HIR-7-d-ii	State-wise details of New Business & Renewal Business - Domestic Travel Insurance- Individual Insurance	Yearly	90 days	General/Health Insurers only
34	HIR-8-a-i	Details of product-wise settlement of claims through TPAs- Health Insurance	Yearly	90 days	Life/General/Health Insurers
35	HIR-8-a-ii	Details of product-wise settlement of claims through In-house settlement -Health Insurance	Yearly	90 days	Life/General/Health Insurers
36	HIR-8-b-i	Details of product-wise settlement of claims through TPAs- Personal Accident	Yearly	90 days	General/Health Insurers
37	HIR-8-b-ii	Details of product-wise settlement of claims through In-house settlement -Personal Accident	Yearly	90 days	General/Health Insurers

38	HIR-8-c-i	Details of product-wise settlement of claims through TPAs-Overseas Travel Insurance	Yearly	90 days	General/Health Insurers
39	HIR-8-c-ii	Details of product-wise settlement of claims through In-house settlement -Overseas Travel Insurance	Yearly	90 days	General/Health Insurers
40	HIR-8-d-i	Details of product-wise settlement of claims through TPAs-Domestic Travel Insurance	Yearly	90 days	General/Health Insurers
41	HIR-8-d-ii	Details of product-wise settlement of claims through In-house settlement -Domestic Travel Insurance	Yearly	90 days	General/Health Insurers
42	HIR-9-a	Product wise claims performance and aging - Health Insurance	Yearly	90 days	Life/General/Health Insurers
43	HIR-9-b	Product wise claims performance and aging - Personal Accident	Yearly	90 days	General/Health Insurers
44	HIR-9-c	Product wise claims performance and aging - Domestic Travel	Yearly	90 days	General/Health Insurers
45	HIR-9-d	Product wise claims performance and aging - Overseas travel	Yearly	90 days	General/Health Insurers
46	HIR-10-a-i	State-wise claims paid by mode of settlement of claims (Health) - Individual Policies	Yearly	90 days	Life/General/Health Insurers
47	HIR-10-a-ii	State-wise claims paid by mode of settlement of claims (Health) - Group Policies	Yearly	90 days	Life/General/Health Insurers
48	HIR-10-b-i	State-wise claims paid by mode of settlement of claims (PA) - Individual Policies	Yearly	90 days	General/Health Insurers
49	HIR-10-b-ii	State-wise claims paid by mode of settlement of claims (PA) - Group Policies	Yearly	90 days	General/Health Insurers
50	HIR-10-c-i	State-wise claims paid by mode of settlement of claims (Domestic Travel) - Individual Policies	Yearly	90 days	General/Health Insurers
51	HIR-10-c-ii	State-wise claims paid by mode of settlement of claims (Domestic Travel) - Group Policies	Yearly	90 days	General/Health Insurers
52	HIR-10-d-i	State-wise claims paid by mode of settlement of claims (Overseas Travel) - Individual Policies	Yearly	90 days	General/Health Insurers
53	HIR-10-d-ii	State-wise claims paid by mode of settlement of claims (Overseas Travel) - Group Policies	Yearly	90 days	General/Health Insurers
54	HIR-11-a-i	State-wise channel-wise details of claims paid - Group Health Policies	Yearly	90 days	Life/General/Health Insurers
55	HIR-11-a-ii	State-wise channel-wise details of claims paid - Individual Health Policies	Yearly	90 days	Life/General/Health Insurers

56	HIR-11-b-i	State-wise channel-wise details of claims paid - Group PA Policies	Yearly	90 days	General/Health Insurers
57	HIR-11-b-ii	State-wise channel-wise details of claims paid - Individual PA Policies	Yearly	90 days	General/Health Insurers
58	HIR-11-c	State-wise channel-wise details of claims paid (Domestic Travel)(Group + Individual)	Yearly	90 days	General/Health Insurers
59	HIR-11-d	State-wise channel-wise details of claims paid (Overseas Travel)(Group + Individual)	Yearly	90 days	General/Health Insurers
60	HIR-12-a-i	Details of large claim settled at state wise -through TPAs (Health)	Yearly	90 days	Life/General/Health Insurers
61	HIR-12-a-ii	Details of large claim settled at state wise -through In-House Settlement (Health)	Yearly	90 days	Life/General/Health Insurers
62	HIR-12-b-i	Details of large claim settled at state wise -through TPAs (PA)	Yearly	90 days	General/Health Insurers
63	HIR-12-b-ii	Details of large claim settled at state wise -through In-House Settlement (PA)	Yearly	90 days	General/Health Insurers
64	HIR-12-c-i	Details of large claim settled at state wise -through TPAs (Domestic Travel)	Yearly	90 days	General/Health Insurers
65	HIR-12-c-ii	Details of large claim settled at state wise -through In-House Settlement (Domestic Travel)	Yearly	90 days	General/Health Insurers
66	HIR-12-d-i	Details of large claim settled at state wise -through TPAs (Overses Travel)	Yearly	90 days	General/Health Insurers
67	HIR-12-d-ii	Details of large claim settled at state wise -through In-House Settlement(Overses Travel)	Yearly	90 days	General/Health Insurers
68	HIR-13	State-wise details on number of network providers	Yearly	90 days	Life/General/Health Insurers
69	HIR-14-a- F	Performance of Government sponsored Scheme (Health) - for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
70	HIR-14-a- U	Performance of Government sponsored Scheme (Health) - upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
71	HIR-14-b- F	Performance of Government sponsored Scheme (PA) - for the half-year period	Half-yearly	45 days	General/Health Insurers
72	HIR-14-b- U	Performance of Government sponsored Scheme (PA) - upto the end of the period	Half-yearly	60 days	General/Health Insurers

73	HIR-15-a-i-F	Details of Claims Handled Directly by Insurers (Health)(Group Other Than Family Floater) -for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
74	HIR-15-a-i-U	Details of Claims Handled Directly by Insurers (Health)(Group Other Than Family Floater)-upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
75	HIR-15-a-ii-F	Details of Claims Handled Directly by Insurers (Health)(Group Family Floater) - for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
76	HIR-15-a-ii-U	Details of Claims Handled Directly by Insurers (Health)(Group Family Floater) -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
77	HIR-15-a-iii-F	Details of Claims Handled Directly by Insurers (Health)(Individual Family Floater) - for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
78	HIR-15-a-iii-U	Details of Claims Handled Directly by Insurers (Health)(Individual Family Floater) -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
79	HIR-15-a-iv-F	Details of Claims Handled Directly by Insurers (Health)(Individual Other Than Family Floater) - for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
80	HIR-15-a-iv-U	Details of Claims Handled Directly by Insurers (Health)(Individual Other Than Family Floater) -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
81	HIR-15-b-i-F	Details of Claims Handled Directly by Insurers (PA)(Group Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
82	HIR-15-b-i-U	Details of Claims Handled Directly by Insurers (PA)(Group Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
83	HIR-15-b-ii-F	Details of Claims Handled Directly by Insurers (PA)(Individual Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
84	HIR-15-b-ii-U	Details of Claims Handled Directly by Insurers (PA)(Individual Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
85	HIR-15-c-i- F	Details of Claims Handled Directly by Insurers (Domestic Travel)(Group Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
86	HIR-15-c-i- U	Details of Claims Handled Directly by Insurers (Domestic Travel)(Group Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
87	HIR-15-c-ii- F	Details of Claims Handled directly by insurers (Domestic Travel)(Individual Policies) -for the half-year period	Half-yearly	45 days	General/Health Insurers
88	HIR-15-c-ii- U	Details of Claims Handled directly by insurers (Domestic Travel)(Individual Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers

89	HIR-15-d-i- F	Details of Claims Handled directly by insurers (Overseas Travel)(Group Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
90	HIR-15-d-i- U	Details of Claims Handled directly by insurers (Overseas Travel)(Group Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
91	HIR-15-d-ii- F	Details of Claims Handled directly by insurers (Overseas Travel)(Individual Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
92	HIR-15-d-ii- U	Details of Claims Handled directly by insurers (Overseas Travel)(Individual Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
93	HIR-16-a-i - F	TPA wise details of claims settled (Health)(Group Other Than Family Floater)- for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
94	HIR-16-a-i - U	TPA wise details of claims settled (Health)(Group Other Than Family Floater) -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
95	HIR-16-a-ii- F	TPA wise details of claims settled (Health)(Group Family Floater)- for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
96	HIR-16-a-ii - U	TPA wise details of claims settled (Health)(Group Family Floater) - upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
97	HIR-16-a-iii - F	TPA wise details of claims settled (Health)(Individual Family Floater)- for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
98	HIR-16-a-iii - U	TPA wise details of claims settled (Health)(Individual Family Floater) -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
99	HIR-16-a-iv- F	TPA wise details of claims settled (Health)(Individual Other Than Family Floater)- for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
100	HIR-16-a-iv - U	TPA wise details of claims settled (Health)(Individual Other Than Family Floater) -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
101	HIR-16-b-i- F	TPA wise details of claims settled(PA)(Group Policies)- for the half-year period	Half-yearly	45 days	General/Health Insurers
102	HIR-16-b-i - U	TPA wise details of claims settled (PA)(Group Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
103	HIR-16-b-ii- F	TPA wise details of claims settled (PA)(Individual Policies)- for the half-year period	Half-yearly	45 days	General/Health Insurers
104	HIR-16-b-ii - U	TPA wise details of claims settled(PA)(Individual Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers

105	HIR-16-c-i - F	TPA wise details of claims settled (Domestic Travel)(Group Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
106	HIR-16-c-i - U	TPA wise details of claims settled (Domestic Travel)(Group Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
107	HIR-16-c-ii - F	TPA wise details of claims settled (Domestic Travel)(Individual Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
108	HIR-16-c-ii - U	TPA wise details of claims settled (Domestic Travel)(Individual Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
109	HIR-16-d-i- F	TPA wise details of claims settled (Overseas Travel)(Group Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
110	HIR-16-d-i - U	TPA wise details of claims settled (Overseas Travel)(Group Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
111	HIR-16-d-ii - F	TPA wise details of claims settled (Overseas Travel)(Individual Policies) - for the half-year period	Half-yearly	45 days	General/Health Insurers
112	HIR-16-d-ii - U	TPA wise details of claims settled (Overseas Travel)(Individual Policies) -upto the end of the period	Half-yearly	60 days	General/Health Insurers
113	HIR-17-a-i -F	State-wise data on mode of issuing of policies - Health Insurance - Individual Policies - for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
114	HIR-17-a-i - U	State-wise data on mode of issuing of policies - Health Insurance - Individual Policies -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
115	HIR-17-a-ii- F	State-wise data on mode of issuing of policies - Health Insurance - Group Policies - for the half-year period	Half-yearly	45 days	Life/General/Health Insurers
116	HIR-17-a-ii- U	State-wise data on mode of issuing of policies - Health Insurance - Group Policies -upto the end of the period	Half-yearly	60 days	Life/General/Health Insurers
117	HIR-17-b-i- F	State-wise data on mode of issuing of policies - Personal Accident Insurance - Individual Policies - for the half-year period	Half-yearly	45 days	General/Health Insurers
118	HIR-17-b-i- U	State-wise data on mode of issuing of policies - Personal Accident Insurance - Individual Policies -upto the end of the period	Half-yearly	60 days	General/Health Insurers
119	HIR-17-b-ii-F	State-wise data on mode of issuing of policies - Personal Accident Insurance - Group Policies - for the half-year period	Half-yearly	45 days	General/Health Insurers
120	HIR-17-b-ii-U	State-wise data on mode of issuing of policies - Personal Accident Insurance - Group Policies -upto the end of the period	Half-yearly	60 days	General/Health Insurers

121	HIR-17-c-i -F	State-wise data on mode of issuing of policies - Overseas Travel Insurance - Individual Policies - for the half-year period	Half-yearly	45 days	General/Health Insurers
122	HIR-17-c-i -U	State-wise data on mode of issuing of policies - Overseas Travel Insurance - Individual Policies -upto the end of the period	Half-yearly	60 days	General/Health Insurers
123	HIR-17-c-ii-F	State-wise data on mode of issuing of policies - Overseas Travel Insurance - Group Policies - for the half-year period	Half-yearly	45 days	General/Health Insurers
124	HIR-17-c-ii-U	State-wise data on mode of issuing of policies - Overseas Travel Insurance - Group Policies -upto the end of the period	Half-yearly	60 days	General/Health Insurers
125	HIR-17-d-i-F	State-wise data on mode of issuing of policies - Domestic Travel Insurance - Individual Policies - for the half-year period	Half-yearly	45 days	General/Health Insurers
126	HIR-17-d-i-U	State-wise data on mode of issuing of policies - Domestic Travel Insurance - Individual Policies -upto the end of the period	Half-yearly	60 days	General/Health Insurers
127	HIR-17-d-ii-F	State-wise data on mode of issuing of policies - Domestic Travel Insurance - Group Policies - for the half-year period	Half-yearly	45 days	General/Health Insurers
128	HIR-17-d-ii-U	State-wise data on mode of issuing of policies - Domestic Travel Insurance - Group Policies -upto the end of the period	Half-yearly	60 days	General/Health Insurers
129	HIR-18-A	Details of gross premium, no of persons covered and incurred claims - for the quarter	Quarterly	30 days	Life/General/Health Insurers
130	HIR-18-B	Details of gross premium, no of persons covered and incurred claims - upto the end of the period	Quarterly	60 days	Life/General/Health Insurers
131	HIR - 19-a -i- F	State-wise data on business & claims (Health) - Group Policies (RSBY only) - for the quarter	Quarterly	30 days	General/Health Insurers
132	HIR - 19-a- i- U	State-wise data on business & claims (Health) - Group Policies (RSBY only) -upto the end of the period	Quarterly	60 days	General/Health Insurers
133	HIR - 19-a-ii - F	State-wise data on business & claims (Health) - Group Policies (Other Govt Sponsored Schemes only) - for the quarter	Quarterly	30 days	Life/General/Health Insurers
134	HIR - 19-a-ii- U	State-wise data on business & claims (Health) - Group Policies (Other Govt Sponsored Schemes only) -upto the end of the period	Quarterly	60 days	Life/General/Health Insurers
135	HIR - 19-a -iii - F	State-wise data on business & claims (Health) - Group Policies (Other than Govt Sponsored Schemes & RSBY) - for the quarter	Quarterly	30 days	Life/General/Health Insurers

136	HIR - 19-a - iii - U	State-wise data on business & claims (Health) - Group Policies (Other than Govt Sponsored Schemes & RSBY) -upto the end of the period	Quarterly	60 days	Life/General/Health Insurers
137	HIR - 19-a- iv- F	State-wise data on business & claims (Health) - Individual Policies (Other than Govt Sponsored Schemes & RSBY) - for the quarter	Quarterly	30 days	Life/General/Health Insurers
138	HIR - 19-a- iv- U	State-wise data on business & claims (Health) - Individual Policies (Other than Govt Sponsored Schemes & RSBY) -upto the end of the period	Quarterly	60 days	Life/General/Health Insurers
139	HIR-19-b-i-F	State-wise data on business & claims (PA) - Group Policies (PMSBY only) - for the quarter	Quarterly	30 days	General/Health Insurers
140	HIR-19-b-i-U	State-wise data on business & claims (PA) - Group Policies (PMSBY only) - upto the end of the period	Quarterly	60 days	General/Health Insurers
141	HIR-19-b-ii-F	State-wise data on business & claims (PA) - Group Policies (Other than Govt Sponsored Schemes & PMSBY) - (for the quarter)	Quarterly	30 days	General/Health Insurers
142	HIR-19-b-ii-U	State-wise data on business & claims (PA) - Group Policies (Other than Govt Sponsored Schemes & PMSBY) - upto the end of the period	Quarterly	60 days	General/Health Insurers
143	HIR-19-b-iii-F	State-wise data on business & claims (PA) - Individual Policies - for the quarter	Quarterly	30 days	General/Health Insurers
144	HIR-19-b-iii-U	State-wise data on business & claims (PA) - Individual Policies - upto the end of the period	Quarterly	60 days	General/Health Insurers
145	HIR-19-c-F	State-wise data on business & claims (Domestic Travel) - Group plus Individual Business - for the quarter	Quarterly	30 days	General/Health Insurers
146	HIR-19-c-U	State-wise data on business & claims (Domestic Travel) - Group plus Individual Business - upto the end of the period	Quarterly	60 days	General/Health Insurers
147	HIR-19-d-F	State-wise data on business & claims (Overseas Travel) - Group plus Individual Business - for the quarter	Quarterly	30 days	General/Health Insurers
148	HIR-19-d-U	State-wise data on business & claims (Overseas Travel) - Group plus Individual Business - upto the end of the period	Quarterly	60 days	General/Health Insurers
149	HIR-20	Information on Government Sponsored Health Insurance Schemes	Yearly	90 days	Life/General/Health Insurers

150	HIR-21	Data on Group Health Insurance Schemes offered	Yearly	90 days	General/Health Insurers
151	HIR-22	Health Insurance Pilot Products offered	Yearly	90 days	General/Health Insurers

HIR - 1 (a,b,c,d) Frequency: Yearly

Details of product performance (Health/Personal Accident/Domestic Travel/Overseas Travel)

Objective

To collect the details of product performance of Health, PA and Travel Insurance Business.

Details of all products filed & approved by the Authority which are being offered as at the beginning of the Financial Year shall be submitted (Details of products which were withdrawn before the beginning of the FY need not be submitted)

Filters and Parameters

Financial Year	
Type of Insurer	General/Health
Insurer Name	
Line of Business	**Health / Personal Accident/ Domestic Travel / Overseas Travel**

R.No	Particular	Product 1	Product 2	Product 3	Product 4	Product 5	Grand Total
	Column Code	**a**	**b**	**c**	**d**	**e**	**f**
Product Details							
1	Product Name						
2	Product UIN						
3	Whether the Product is a Micro Insurance Product?						
4	Scope of Cover (Eg. Hospital Care, Critical Illness)						
5	Target Group (Eg. Micro Insurance, Social Sector, Rural sector)						
6	Insured Type (Individual - Family Floater, Individual- Other than Family Floater, Group - Family Floater, Group- Other than Family Floater)						
7	Basis of Payout (Indemnity/Benefit Based/both)						

8	Date of clearance of product (DD/MM/YYYY)						
9	Date of introduction of product (DD/MM/YYYY)						
10	Minimum Policy Period (Days or months or years)	Eg. 7 days, 3 months, 1 Year, etc.					
11	Maximum Policy period (Days or months or years)	Eg. 7 days, 3 months, 1 Year, etc.					
12	Add-on covers included (Yes/No)						
13	Number of Add-on covers included						
14	Whether serviced by TPA? (Yes, No or both In-House & TPA)						
15	Total number of TPAs involved						
Details of New Business (Business procured afresh during the FY)							
16	Number of Policies Issued						
17	Gross Premium Income						
18	Number of Lives Covered						
19	Total Sum Insured						
20	Total Premium Ceded						
21	Reinsurance Commissions Received						
22	Commission/Brokerage paid						
Details of Renewal Business (Business renewed without break-in during the FY)							
23	No. of policies due for renewal						
24	No. of policies renewed						
25	Retention Ratio (% age)						
26	Total Renewal Premium Income						
27	No of lives covered						
28	Total Sum Insured in renewal						
29	Total Renewal Premium Ceded						
30	Reinsurance Commissions Received						
31	Commission/Brokerage paid						
In-force Business Data (applicable only for those policies where the tenure of the policy is more than 1 year)							
32	No. of policies issued						

33	Gross premium income						
34	No of lives covered						
35	Total Sum Insured						
36	Total premium ceded						
37	Reinsurance Commissions Received						
38	Commission/Brokerage paid						
Data on cancellation of policies							
39	Cancellation during free look period -out of new business (No of policies)						
40	Cancellation during free look period -out of new business (amount of premium refunded)						
41	Cancellations during the policy term -out of new business - other than Free-look cancellations (No of policies)						
42	Cancellations during the policy term -out of new business - other than Free-look cancellations (amount of premium refunded)						
43	Cancellation during the policy term -out of renewal business (No of policies)						
44	Cancellation during the policy term -out of renewal business (amount of premium refunded)						
Claims Ratio (Actual on a financial year basis)							
45	Net Earned Premium						
46	Net Claims Incurred						
47	Net Incurred Claims Ratio $						
48	Combined Ratio $$						

Note:

$ Net Incurred Claims ratio = Net Claims Incurred/Net Earned Premium

$$ Combined Ratio = (Total claims paid+other operating expense)/total premium earned.

HIR - 2 Frequency: Yearly

Details of product performance - Health Insurance Product of Life Insurers

Objective

To collect the details of product performance & it is applicable only for life insurers

Details of all products filed & approved by the Authority which are being offered as at the beginning of the Financial Year shall be submitted (Details of products which were withdrawn before the beginning of the FY need not be submitted)

Filters and Parameters

Financial Year	
Type of Insurer	Life
Insurer Name	
Line of Business	**Health Insurance**

R.No.	Particular	Product 1	Product 2	Product 3	Product 4	Product 5	Grand Total
		a	b	c	d	e	f
Product Details							
1	Product Name						
2	Product UIN						
3	Whether the Product is a Micro Insurance Product?						
4	Scope of Cover (Eg. Hospital Care/ Critical Illness)						
5	Target Group (Eg. Micro Insurance, Social, Rural)						

6	Insured Type (Individual - Family Floater, Individual- Other than Family Floater, Group - Family Floater, Group- Other than Family Floater)						
7	Date of clearance of product						
8	Date of introduction of product						
9	Minimum Policy Period						
10	Maximum Policy period						
11	Riders included (Yes/No)						
12	No. of Riders						
13	Whether serviced by TPA? (Yes, No or both In-House & TPA)						
14	Total no. of TPAs involved						
Details of New Business (policies issued during the FY)							
15	No. of policies issued						
16	Gross Premium Income						
17	No of lives covered						
18	Total Sum Insured						
19	Total Premium Ceded						
20	Reinsurance Commissions Received						
Details of Renewal Business							
21	No. of policies due for renewal						
22	No. of policies renewed						
23	Retention Ratio						
24	Total Renewal Premium Income						
25	No of lives covered						
26	Total Sum Insured						
27	Total Renewal Premium Ceded						
29	Reinsurance Commissions Received						
In-force Business Data							
29	No. of policies						

30	Gross Premium Income						
31	No of lives covered						
32	Total Sum Insured						
33	Total premium ceded						
34	Reinsurance Commissions Received						
Data on cancellation of policies							
35	Cancellation during free look period -out of new business (No of policies)						
36	Cancellation during free look period -out of new business (amount of premium refunded)						
37	Cancellations during the policy term -out of new business - other than Free-look cancellations (No of policies)						
38	Cancellations during the policy term -out of new business - other than Free-look cancellations (amount of premium refunded)						
39	Cancellation during the policy term -out of renewal business (No of policies)						
40	Cancellation during the policy term -out of renewal business (amount of premium refunded)						
Claims Data							
41	Number of Claims Registered						
42	Amount of Claims Registered						
43	Number of Claims Paid						
44	Amount of Claims Paid						
45	Number of Claims Repudiated						
46	Amount of Claims Repudiated						
47	Number of Claims Outstanding						
48	Amount of Claims Outstanding						

HIR - 3 Frequency: Yearly

Details of performance of Health Insurance Riders (applicable to Life Insurers only)

Objective

To collect data on performance of riders & are applicable only for life insurance companies

Filters and Parameters

Financial Year	
Type of Insurer	Life
Insurer Name	
Line of Business	**Health Insurance Business**

R.No.	Particular	Rider 1	Rider 2	Rider 3	Rider 4	Rider 5	Total
		a	b	c	D	e	f
Product Details							
1	Name of the Rider						
2	UIN of the Rider						
3	Scope of Cover (Hospital Care/ Critical Illness)						
4	Whether the Rider is offered along with Micro-insurance products						
5	Target Group (Micro Insurance/Social Sector/Rural Sector / Others						
6	Insured Type (Individual/Group)						
7	Basis of Payout (Indemnity/Benefit Based/both)						
8	Date of clearance of rider						
9	Date of introduction of rider						
New Business Data							
10	No. of riders issued						

11	Gross Premium Collected						
12	Total Premium Ceded						
13	No of lives covered						
14	Total Sum Insured						
Renewal Business Data							
15	No. of riders renewed						
16	Gross Premium Collected						
17	Total Premium Ceded						
18	No of lives covered						
19	Total Sum Insured						
In-force Business Data							
20	No. of riders In-Force						
21	Gross Premium Collected						
22	Total Premium Ceded						
22	No of lives covered						
23	Total Sum Insured						
Cancellation Data							
24	Cancellation during free look period -out of new business (No of policies)						
25	Cancellation during free look period -out of new business (amount of premium refunded)						
26	Cancellations during the policy term -out of new business - other than Free-look cancellations (No of policies)						
27	Cancellations during the policy term -out of new business - other than Free-look cancellations (amount of premium refunded)						
28	Cancellation during the policy term -out of renewal business (No of policies)						
29	Cancellation during the policy term -out of renewal business (amount of premium refunded)						

Claims Data							
30	Number of Claims Registered						
31	Amount of Claims Registered						
32	Number of Claims Paid						
33	Amount of Claims Paid						
34	Number of Claims Repudiated						
35	Amount of Claims Repudiated						
36	Number of Claims Outstanding						
37	Amount of Claims Outstanding						

HIR-4 Frequency: Yearly

Details of performance of add-ons (applicable only to General & Health Insurers)

Objective

To collect data on performance of riders & are applicable only for life insurance companies

Filters and Parameters

Financial Year	
Type of Insurer	General/Health
Insurer Name	
Insured Type	Individual Policies / Group Policies
Line of Business	**Health / Personal Accident/ Domestic Travel / Overseas Travel**

R.No.	Particular	Add-on 1	Add-on 2	Add-on 3	Add-on 4	Add-on 5	Total
		a	b	c	d	e	f
Product Details							
1	Name of the Add-on						
2	UIN of the Add-on						
3	Scope of Cover (Eg. Hospital Care/ Critical Illness)						
4	Target Group (Micro Insurance/Social/Rural/Social Security/others)						
5	Basis of Payout (Indemnity/Benefit Based/both)						
6	Date of clearance of Add-on						
7	Date of introduction of Add-on						
8	No of products attached with the Add-on						

New Business Data							
9	No. of add-ons issued						
10	Gross Premium Collected						
11	No of lives covered						
Renewal Business Data							
12	No. of add-ons renewed						
13	Gross Premium Collected						
14	No of lives covered						

HIR-5 Frequency: Yearly

Details of performance of combi products (to be furnished by the Lead Insurer only).

Objective

To collect the details of product performance

Details of all products filed & approved by the Authority which are being offered as at the beginning of the Financial Year shall be submitted (Details of products which were withdrawn before the beginning of the FY need not be submitted)
Information is to be furnished by the Lead Insurer by obtaining the relevant information from other Insurer.

Filters and Parameters

Financial Year	
Type of Insurer	Life/General/Health
Insurer Name	

R.No.	Particular	Product 1		Product 2		Product 3		Product 4		Product 5		Grand Total	
		Health Portion	Life Portion	Health Portion	Life Portion	Health Portion	Life Portion	Health Portion	Life Portion	Health Portion	Life Portion	Health Portion	Life Portion
	Column Code	**a**	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**	**k**	**l**
1	Product Name												
2	Product UIN												
3	Number of policies issued ^^												
4	Gross Premium Income ^^												
5	Number of lives covered ^^												
6	Total Sum Insured ^^												
7	Total Premium Ceded ^^												
8	Reinsurance Commissions Received ^^												

9	Number of claims registered												
10	Amount of claims registered												
11	Number of claims repudiated												
12	Amount of claims repudiated												
13	Number of claims paid												
14	Amount of claim paid												
15	Number of claims outstanding as at the end of FY												
16	Amount of claim outstanding as at the end of FY												

^^ : combined data to be provided for both new & renewal business.

HIR-6 Frequency: Yearly

Details of State-wise Channel-wise Business

Objective

To collect State wise information on Gross Premium, No. of Policies and Total Sum Assured across Channels

The consolidated business information shall be furnished

Filters and Parameters

Name of insurer	
Type of Insurer	Life/General/Health
Financial Year	
Line of Business	**Health / Personal Accident/ Domestic Travel / Overseas Travel**
Name of the channel	**List of Various Channels are Direct Sales (Internet), Direct Sales (Other than Internet), Individual Agents, Banks, Corporate Agents - Other than Banks, Brokers, & Micro-Insurance Agents, Insurance Marketing Firms, Web-aggregators, Common Service Centers, Point of Sales, and Others.**
Insured Type	**Group Policies / Individual Policies**

#	State	No. of policies	No. Of Lives	Gross Premium	Total Sum Insured
	Column Code	**a**	**b**	**c**	**d**
1	Andhra Pradesh				
2	Arunachal Pradesh				
3	Assam				
4	Bihar				
5	Chhattisgarh				
6	Goa				
7	Gujarat				
8	Haryana				
9	Himachal Pradesh				

10	Jammu & Kashmir				
11	Jharkhand				
12	Karnataka				
13	Kerala				
14	Madhya Pradesh				
15	Maharashtra				
16	Manipur				
17	Meghalaya				
18	Mizoram				
19	Nagaland				
20	Odisha				
21	Punjab				
22	Rajasthan				
23	Sikkim				
24	Tamil Nadu				
25	Telangana				
26	Tripura				
27	Uttar Pradesh				
28	Uttrakhand				
29	West Bengal				
30	Andaman & Nicobar Is.				
31	Chandigarh				
32	Dadra &Nagra Haveli				
33	Daman & Diu				
34	Delhi				
35	Lakshadweep				
36	Puducherry				
#	***Total***				

HIR-7 (a,b,c,d) Frequency: Yearly

State-wise details of New Business and Renewal Business

Objective

To capture the statewise new business and renewal business activities for each insurer

Filters and Parameters

Financial Year		**Type of Insurer**	**Life/General/Health Insurer**
Insurer Name		**Line of Business**	**Health / Personal Accident/ Domestic Travel / Overseas Travel**
Insured Type	**Individual - Family Floater, Individual- Other than Family Floater, Group - Family Floater, Group- Other than Family Floater**		

		New Business ^				Renewal Business ^^				In-Force Business				TOTAL			
#	State	No. of policies issued	No. of lives covered	Gross Premium income	Total Sum Insured	No. of policies issued	No. of lives covered	Gross Premium income	Total Sum Insured	No. of policies issued	No. of lives covered	Gross Premium income	Total Sum Insured	No. of policies issued	No. of lives covered	Gross Premium income	Total Sum Insured
Column Code		a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p
1	Andhra Pradesh																
2	Arunachal Pradesh																
3	Assam																
4	Bihar																
5	Chhattisgarh																
6	Goa																

7	Gujarat																
8	Haryana																
9	Himachal Pradesh																
10	Jammu & Kashmir				.												
11	Jharkhand																
12	Karnataka																
13	Kerala																
14	Madhya Pradesh																
15	Maharashtra																
16	Manipur																
17	Meghalaya																
18	Mizoram																
19	Nagaland																
20	Odisha																
21	Punjab																
22	Rajasthan																
23	Sikkim																
24	Tamil Nadu																
25	Telangana																
26	Tripura																
27	Uttar Pradesh																
28	Uttrakhand																
29	West Bengal																
30	Andaman & Nicobar Is.																
31	Chandigarh																

32	Dadra & Nagra Haveli																
33	Daman & Diu																
34	Delhi																
35	Lakshadweep																
36	Puducherry																
#	***Total***																

^New Business for the purpose of this form is the business procured afresh during the FY. ^^ Renewal Business for the purpose of this form is business renewed without break during the FY.

HIR-8 (a,b,c,d) Frequency: Yearly

Details of product-wise settlement of claims through TPA and In-house settlement

Objective

To capture the performance of the products in terms of claims management w.r.t TPA & In-house settlement

Filters and Parameters

Financial Year		**Mode of Settlement of Claims**	**In-House/ Name of the TPA in case of TPA $$**
Type of Insurer	**Life/General/Health**	**Line of Business**	**Health / Personal Accident/ Domestic Travel / Overseas Travel**
Insurer Name			

#	Name of product	Product UIN	No. of policies serviced	No. of claims registered	Amount of claims registered	No. of claims paid	Amount of claims paid	No. of claims repudiated	Amount of claims repudiated	No. of claims outstanding	Amount of claims outstanding
	Column Code	a	b	c	d	e	f	g	h	i	j
	Total										

$$: the data to be submitted separately for each of the TPAs.

HIR-9 (a,b,c,d) Frequency: Yearly

Product wise claims performance and aging

Objective

To collect claims movement and claims aging data

Filters and Parameters

Financial Year		**Insurer Name**	
Type of Insurer	Life/General/Health		
Line of Business (Drop Down Menu)	**Health / Personal Accident/ Domestic Travel / Overseas Travel**		

#	Particulars		Product 1	Product 2	Product 3	Product 4	Product 5	Total
		Column Code	**a**	**b**	**c**	**d**	**e**	**f**
Claims Data								
	Claims outstanding at the beginning of the year	No.						
		Amount						
	Claims registered during the year	No.						
		Amount						
	Claims repudiated during the year	No.						
		Amount						
	Claims paid during the year	No.						
		Amount						
	Claims outstanding at the end of the year	No.						
		Amount						
	Penal Interest Paid during the year	No.						
		Amount						

Aging of claims paid *

	Claims paid within 1 month	No.						
		Amount						
	Claims paid between 1-3 months	No.						
		Amount						
	Claims paid between 4-6 months	No.						
		Amount						
	Claims paid between 7-12 months	No.						
		Amount						
	Claims paid between 1-2 years	No.						
		Amount						
	Claims paid after 2 yrs	No.						
		Amount						

* Age of claims to be reckoned from the date of receipt of last requirement

Aging of claims repudiated **

	Claims repudiated in less than 1 month	No.						
		Amount						
	Claims repudiated between 1-3 months	No.						
		Amount						
	Claims repudiated between 4-6 months	No.						
		Amount						
	Claims repudiated between 7-12 months	No.						
		Amount						
	Claims repudiated between 1-2 years	No.						
		Amount						
	Claims repudiated after 2 yrs	No.						
		Amount						

** Age of claims to be reckoned from date of receipt of last requirement

Aging of claims outstanding***

	Claims outstanding for less than 1 month	No.						
		Amount						
	Claims repudiated between 1-3 months	No.						
		Amount						
	Claims repudiated between 4-6 months	No.						
		Amount						
	Claims repudiated between 7-12 months	No.						
		Amount						
	Claims repudiated between 1-2 years	No.						
		Amount						
	Claims repudiated after 2 yrs	No.						
		Amount						

*** Age of claims to be reckoned from date of first intimation

HIR_10 (a,b,c,d)

Frequency: Yearly

Details of state-wise claims paid by mode of settlement of claims

Objective

The purpose of the form is to collect the details of claims paid at individual state-level

Filters and Parameters

Financial Year		**Type of Insurer**	**Life/General/Health**		
Line of Business	**Health / Personal Accident/ Domestic Travel / Overseas Travel**	**Insurer Name**			
Insured Type	**Group Policies / Individual Policies**				

		Indemnity						**Benefit Based**		**Total**	
		Cashless		**Reimbursement**		**Both Cashless & Reimbursement ##**					
#	**State**	**No. of claims Paid**	**Amount of claims Paid**	**No. of claims Paid**	**Amount of claims Paid**	**No. of claims Paid**	**Amount of claims Paid**	**No. of claims Paid**	**Amount of claims Paid**	**No. of claims Paid**	**Amount of claims Paid**
	Column Code	**a**	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**
1	Andhra Pradesh										
2	Arunachal Pradesh										
3	Assam										
4	Bihar										
5	Chhattisgarh										
6	Goa										
7	Gujarat										
8	Haryana										
9	Himachal Pradesh										
10	Jammu & Kashmir										

11	Jharkhand										
12	Karnataka										
13	Kerala										
14	Madhya Pradesh										
15	Maharashtra										
16	Manipur										
17	Meghalaya										
18	Mizoram										
19	Nagaland										
20	Odisha										
21	Punjab										
22	Rajasthan										
23	Sikkim										
24	Tamil Nadu										
25	Telangana										
26	Tripura										
27	Uttar Pradesh										
28	Uttrakhand										
29	West Bengal										
30	Andaman&Nicobar Is.										
31	Chandigarh										
32	Dadra&Nagra Haveli										
33	Daman & Diu										
34	Delhi										
35	Lakshadweep										
36	Puducherry										
#	***Total***										

where a part of the claim emanating from single claim has been paid in cashless and remaining as reimbursement.

HIR-11 Frequency: Yearly

State-wise channel-wise details of claims paid

Objective

This form collects information on the claims reported in each state during the financial year.

Filters and Parameters

Financial Year		**Period**						
Name of insurer		**Line of Business**	**Health / Personal Accident/ Domestic Travel / Overseas Travel**					
Insured Type	**Group Policies / Individual Policies**							

		Direct Sale (Online)		Direct Sale (Other than Online)		Individual Agents		Corporate Agents-Banks		Corporate Agents - Other Than Banks	
#	State	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid
	Column Code	a	b	c	d	e	f	g	h	i	j

1	Andhra Pradesh										
2	Arunachal Pradesh										
3	Assam										
4	Bihar										
5	Chhattisgarh										
6	Goa										
7	Gujarat										
8	Haryana										
9	Himachal Pradesh										
10	Jammu & Kashmir										
11	Jharkhand										
12	Karnataka										
13	Kerala										
14	Madhya Pradesh										
15	Maharashtra										

16	Manipur										
17	Meghalaya										
18	Mizoram										
19	Nagaland										
20	Odisha										
21	Punjab										
22	Rajasthan										
23	Sikkim										
24	Tamil Nadu										
25	Telangana										
26	Tripura										
27	Uttar Pradesh										
28	Uttrakhand										
29	West Bengal										
30	Andaman & Nicobar Is.										
31	Chandigarh										

32	Dadra & Nagra Haveli										
33	Daman & Diu										
34	Delhi										
35	Lakshadweep										
36	Puducherry										
	Total										

HIR-11
(Continues...)
State-wise channel-wise details of claims paid

Brokers		Microinsurance Agents		Web-aggregators		Insurance Marketing Firms		Point of Sales		Others		Total	
No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid	No. of claims paid	Amount of claims paid
k	l	o	p	q	r	s	t	u	v	w	x	y	Z

HIR-12 (a,b,c,d) Frequency: Yearly

Details of large claim settled at state wise (through TPAs and In-House)

Objective

This form captures the claim details of large claims

Filters and Parameters

Financial Year	
Type of Insurer	**Life/General/health**
Insurer Name	
Line of Business	**Health / Personal Accident/ Domestic Travel / Overseas Travel**
Mode of settlement	**Through TPAs ##/ through In-house**

		Claims Registered		Claims Paid		Claims Repudiated		Claims Outstanding	
#	State	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	e	f
1	Andhra Pradesh								
2	Arunachal Pradesh								
3	Assam								
4	Bihar								
5	Chhattisgarh								
6	Goa								
7	Gujarat								
8	Haryana								
9	Himachal Pradesh								
10	Jammu & Kashmir								
11	Jharkhand								
12	Karnataka								
13	Kerala								

14	Madhya Pradesh								
15	Maharashtra								
16	Manipur								
17	Meghalaya								
18	Mizoram								
19	Nagaland								
20	Odisha								
21	Punjab								
22	Rajasthan								
23	Sikkim								
24	Tamil Nadu								
25	Telangana								
26	Tripura								
27	Uttar Pradesh								
28	Uttrakhand								
29	West Bengal								
30	Andaman & Nicobar Is.								
31	Chandigarh								
32	Dadra & Nagra Haveli								
33	Daman & Diu								
34	Delhi								
35	Lakshadweep								
36	Puducherry								
#	***Total***								

Note: ## the total for all TPAs to be submitted. Not to be submitted at the individual TPA level.

Definition of Large Claims

* In respect of Personal Accident business: Rs. 50 lakh and above per claim per insured.
* In respect of Travel Insurance business: Rs. 50 lakh and above per claim per insured.
* In respect of "Other Health Insurance" business: Rs. 50 lakh and above per claim per insured.

HIR-13 Frequency: Yearly

State-wise details on number of network providers

Objective - To collect the state-wise details of network providers

Filters and Parameters

Financial Year		**Insurer Type**	Life/General/Health	**Insurer Name**	

Rno	State	No. of Network Providers with whom Insurers directly have an agreement																No. Of Network Providers under a tripartite agreement with TPAs and Network Providers															
		No of Network Providers registered only with ROHINI				No of Network Providers complied with pre-accreditation entry level standards of NABH				No of Network Providers registered with ROHINI and also complied with pre-accreditation entry level standards of NABH				Others				No of Network Providers registered only with ROHINI				No of Network Providers complied with pre-accreditation entry level standards of NABH				No of Network Providers registered with ROHINI and also complied with pre-accreditation entry level standards of NABH				Others			
		Metro	Urban	Semi-urban	Others	Metro	Urban	Semi-urban	Others	Metro	Urban	Semi-urban	Others	Metro	Urban	Semi-urban	Others	Metro	Urban	Semi-urban	Others	Metro	Urban	Semi-urban	Others	Metro	Urban	Semi-urban	Others	Metro	Urban	Semi-urban	Others
	Column Code	**a**	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**	**k**	**l**	**m**	**n**	**o**	**p**	**q**	**r**	**s**	**t**	**u**	**v**	**w**	**x**	**y**	**z**	**aa**	**ab**	**ac**	**ad**	**ae**	**af**
1	Andhra Pradesh																																
2	Arunachal Pradesh																																
3	Assam																																
4	Bihar																																

5	Chhattisgarh																																	
6	Goa																																	
7	Gujarat																																	
8	Haryana																																	
9	Himachal Pradesh																																	
10	Jammu & Kashmir																																	
11	Jharkhand																																	
12	Karnataka																																	
13	Kerala																																	
14	Madhya Pradesh																																	
15	Maharashtra																																	
16	Manipur																																	
17	Meghalaya																																	
18	Mizoram																																	
19	Nagaland																																	
20	Odisha																																	
21	Punjab																																	
22	Rajasthan																																	
23	Sikkim																																	

24	Tamil Nadu																														
25	Telangana																														
26	Tripura																														
27	Uttar Pradesh																														
28	Uttrakhand																														
29	West Bengal																														
30	Andaman & Nicobar Is.																														
31	Chandigarh																														
32	Dadra & Nagra Haveli																														
33	Daman & Diu																														
34	Delhi																														
35	Lakshadweep																														
36	Puducherry																														
#	Total																														

Note: For the purpose of this format Metropolitan Centre is a place where population is 10 lacs and above and Urban Center with a population of 1 lac to 9,99,999, semi Urban from 10,000 to 99,999 population and Others with a population of 9,999 and below. Population figures to be reckoned as per the latest available decennial census data.

HIR-14 (a,b)

Frequency: Half-yearly

Performance of Government Sponsored Insurance Schemes

Objective

This form is used to capture the details of the Performance of Government Sponsored Insurance Schemes

Filters and Parameters

Financial Year					**Period (drop-down)**	For the Period / Upto the Period	
Type of Insurer	Life/General/ Health				**Line of Business**	Health / Personal Accident	
Insurer Name							

#	Name of the Scheme	UIN	No. of policies issued	No. of families covered (BPL)	No. of families covered (Other than BPL)	No. of families covered (BPL+ Other than BPL)	Number of Lives covered (BPL)	Number of Lives covered (Other than BPL)	Number of Lives covered (BPL+ Other than BPL)	Gross Premium	Net Earned Permium
	a	b	c	d	e	f	g	h	i	j	k
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

$ Incurred Claims ratio = Total incurred claim/ Total Earned Premium.

No. of claims registered	Amount of Claims registered	No. of claims paid	Amount of claims paid	Net Claims Incurred (amount)	No. of claims repudiated	Amount of claims repudiated	No. of claims O/s	Amount of Claims O/s.	Net Incurred Claim Ratio (%)
l	m	n	o	p	q	r	s	t	u

HIR-15 (a,b,c,d) Frequency: Half-yearly

Details of Claims Handled directly by insurers (In-House Settlement of Claims)

Objective

The purpose of the form is to collect the information on the claims handled directly by insurers.

In case of Life Insurers, details of claims on health policies & riders only to be submitted.

Filters and Parameters

Financial Year		**Period(drop-down)**	**For the Period / Upto the Period**
Type of Insurer	Life/ General/Health Insurers	**Division**	**Individual - Family Floater, Individual- Other than Family Floater, Group - Family Floater, Group- Other than Family Floater**
Insurer Name		**Line of Business**	**Health / Personal Accident/ Domestic Travel / Overseas Travel**

Claims movement Details

		Cashless		Reimbursement		Both Cashless & Reimbursement		Benefit Based		Total	
#	Particulars	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	g	h	i	j
1	Claims outstanding at the beginning of the period										
2	New Claims registered										
3	Claims paid										
4	Claims repudiated										
5	Claims outstanding at the end of the period										
6	Penal interest paid										

Aging of claims paid during the period*

#	Particulars	Cashless		Reimbursement		Both Cashless & Reimbursement		Benefit Based		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	e	f	g	h
1	Claims paid within 1 month										
2	Claims paid between 1-3 months										
3	Claims paid between 3-6 months										
4	Claims paid between 6-12 months										
5	Claims paid between 1-2 years										
6	claims paid beyond 2 years										
7	Total										

* Aging of claims to be reckoned from the date of registration.

Aging of repudiated claims during the period**

#	Particulars	Cashless		Reimbursement		Both Cashless & Reimbursement		Benefit Paid		Total	
		No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	e	f	g	h
1	Claims repudiated within 1 month										
2	Claims repudiated between 1-3 months										

3	Claims repudiated between 3-6 months										
4	Claims repudiated between 6-12 months										
5	Claims repudiated between 1-2 years										
6	claims repudiated beyond 2 years										
7	Total										

** Aging of claims to be reckoned from the date of receipt of last requirement

*Aging of pending claims at the end of the period****

		Cashless		Reimbursement		Both Cashless & Reimbursement		Benefit Based		Total	
#	Particulars	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	e	f	g	h
1	Claims outstanding within 1 month										
2	Claims outstanding between 1-3 months										
3	Claims outstanding between 3-6 months										
4	Claims outstanding between 6-12 months										
5	Claims outstanding between 1-2 years										
6	claims outstanding beyond 2 years										
7	Total										

*** Aging of claims to be reckoned from date of first intimation

HIR-16 (a,b,c,d) Frequency: Half-yearly

TPA wise details of claims settled

Objective

The purpose of the form is to collect the information of the claims handled through TPA.

The data to be submitted by insurers in respect of every TPA enrolled with them.

In case of Life Insurers, details of claims on health policies & riders only to be submitted.

Filters and Parameters

Financial Year		**Period(drop-down)**	**For the Period / Upto the Period**
Type of Insurer	Life/General/Health	**TPA Name**	
Insurer Name		**Division**	**Individual - Family Floater, Individual- Other than Family Floater, Group - Family Floater, Group- Other than Family Floater**
		Line of Business	**Health / Personal Accident/ Domestic Travel / Overseas Travel**

Claims movement Details

		Cashless		**Reimbursement**		**Both Cashless & Reimbursement**		**Benefit Based**		**Total**	
#	**Particulars**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**
	Column Code	**a**	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**

1	Claims outstanding at the beginning of the period										
2	New Claims registered										
3	Claims paid										
4	Claims repudiated										
5	Claims outstanding at the end of the period										
6	Penal interest paid										

Aging of claims paid during the period*

		Cashless		**Reimbursement**		**Both Cashless & Reimbursement**		**Benefit Based**		**Total**	
#	**Particulars**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**	**No. of claims**	**Amount of claims**
	Column Code	**a**	**b**	**c**	**d**	**e**	**f**	**e**	**f**	**g**	**h**
1	Claims paid within 1 month										
2	Claims paid between 1-3 months										
3	Claims paid between 3-6 months										
4	Claims paid between 6-12 months										

5	Claims paid between 1-2 years										
6	claims paid beyond 2 years										

* Reckoned from the date of receipt of last requirement

Aging of repudiated claims during the period**

		Cashless		Reimbursement		Both Cashless & Reimbursement		Benefit Paid		Total	
#	Particulars	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	e	f	g	h
1	Claims repudiated within 1 month										
2	Claims repudiated between 1-3 months										
3	Claims repudiated between 3-6 months										
4	Claims repudiated between 6-12 months										
5	Claims repudiated between 1-2 years										

6	claims repudiated beyond 2 years										

** Reckoned from the date of receipt of last requirement

*Aging of pending claims at the end of the period****

		Cashless		Reimbursement		Both Cashless & Reimbursement		Benefit Based		Total	
#	Particulars	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims	No. of claims	Amount of claims
	Column Code	a	b	c	d	e	f	e	f	g	h
1	Claims outstanding within 1 month										
2	Claims outstanding between 1-3 months										
3	Claims outstanding between 3-6 months										
4	Claims outstanding between 6-12 months										
5	Claims outstanding between 1-2 years										
6	claims outstanding beyond 2 years										

*** Reckoned from date of first intimation

HIR -17 Frequency: Half- Yearly

State-wise data on mode of issuing of policies $$

Objective

To collect the details on state-wise mode-wise issuing of policies and number of persons covered

Filters and Parameters

Financial Year	
Period(drop-down)	For the Period / Upto the Period
Insurer Name	
Insurer Type	Life/General/Health
Line of Business	Health / Personal Accident/ Domestic Travel / Overseas Travel
Type of Policies	Individual Policies/ Group Policies

	Physical policy ^^		**Through Insurance Repository**		**E- Policy ##**	
State/ UT	**No of Schemes/Policies Issued**	**Number of persons Covered**	**No of Schemes/Policies Issued**	**Number of persons Covered**	**No of Schemes/Policies Issued**	**Number of persons Covered**
Andhra Pradesh						
Arunachal Pradesh						
Assam						
Bihar						
Chhattisgarh						
Goa						
Gujarat						
Haryana						
Himachal Pradesh						
Jammu & Kashmir						
Jharkhand						

Karnataka						
Kerala						
Madhya Pradesh						
Maharashtra						
Manipur						
Meghalaya						
Mizoram						
Nagaland						
Orissa						
Punjab						
Rajasthan						
Sikkim						
Tamil Nadu						
Telangana						
Tripura						
Uttar Pradesh						
Uttrakhand						
West Bengal						
Andaman & Nicobar Is.						
Chandigarh						
Dadra &Nagra Haveli						
Daman & Diu						
Delhi						
Lakshadweep						
Puducherry						
Total						

$$ refer to IRDAI (Issuance of e-Insurance Policies) Regulations, 2016.

^^ where the policies are issued only through physical mode and policies are not issued subsequently either through IR or electronic mode.

where the policies are first issued through electronic mode, subsequently the same policies are issued through physical mode also as per above E-Insurance Policies Regulations.

HIR-18 Frequency: Quarterly

Details of gross premium, no of persons covered and incurred claims for the quarter

Objective

To collect the data on premium and claims for different class of business

Filters and Parameters

Financial Year		**Period(drop-down)**	For the Period / Upto the Period
Insurer Type	Life/General/ Health	**Insurer Name**	

A1. Health Insurance excluding Travel (Domestic/Overseas) and Personal Accident Insurance Business

(Unit: all data must be submitted in Actuals)

Type of Business	No.of policies Issued	No. of Persons Covered	Gross Premium Income	Net Earned Premium	No of claims registered	Amount of claims registered	No of claims Paid	Amount of claims paid	Claims Incurred (Gross)	Claims Incurred (Net)	Incurred Claims Ratio (Net)
	a	b	c	d	e	f	g	h	i	j	k
RSBY Business only											
Ayushman Bharat –PradhanMantri Jan ArogyaYojana (AB-PMJAY) Only ^^											
Government Sponsored Schemes other than RSBY & AB-PMJAY											
Group - Other Than Family Floater (Other than Govt. Schemes and RSBY)											
Group - Family Floater (Other than Govt Schemes and RSBY)											
Individual Family Floater											
Individual- Other than Family Floater											
Total											

A2. Personal Accident Insurance Business

(Unit: all data must be submitted in Actuals)

Type of Business	No.of policies Issued	No. of Persons Covered	Gross Premium Income	Net Earned Permium	No of claims registered	Amount of claims registered	No of claims Paid	Amount of claims paid	Claims Incurred (Gross)	Claims Incurred (Net)	Incurred Claims Ratio (Net)
	a	b	c	d	e	f	g	h	i	j	k
PMSBY Business only											
Government Sponsored Schemes other than PMSBY											
Group Insurance (Other than Govt Schemes & PMSBY)											
Individual Insurance											
Total											

A3. Overseas Travel Insurance Business

(Unit: all data must be submitted in Actuals)

Type of Business	No.of policies Issued	No. of Persons Covered	Gross Premium Income	Net Earned Permium	No of claims registered	Amount of claims registered	No of claims Paid	Amount of claims paid	Claims Incurred (Gross)	Claims Incurred (Net)	Incurred Claims Ratio (Net)
	a	b	c	d	e	f	g	h	i	j	k
Group Insurance											
Individual Insurance											
Total											

A4. Domestic Travel Insurance Business

(Unit: all data must be submitted in Actuals)

Type of Business	No.of policies Issued	No. of Persons Covered	Gross Premium Income	Net Earned Permium	No of claims registered	Amount of claims registered	No of claims Paid	Amount of claims paid	Claims Incurred (Gross)	Claims Incurred (Net)	Incurred Claims Ratio (Net)
	a	b	c	d	e	f	g	h	i	j	k
Group Insurance											
Individual Insurance											
Total											

^^ In respect of AB-PMJAY Hybrid model (Trust plus insurance model) data pertaining to Insurance portion shall only be reported.

HIR-19 (a,b,c,d)

Frequency: Quarterly

State-wise data on business & claims settled

Objective

To collect the data on premium and claims for different classes of business

Filters and Parameters

Financial Year		**Period(drop-down)**	For the Period / Upto the Period
Insurer Type	Life/General/Health	**Insurer Name**	
Line of Business	Health / Personal Accident/ Domestic Travel / Overseas Travel		
Type of Policies	PMSBY only/RSBY only/ AB-PMJAY only/Other Govt Sponsored HI Business (Other than RSBY and AB-PMJAY)/Other Govt Sponsored PA Business (other than PMSBY)/ Group Business (Other than Govt Schemes)/ Individual Business		

State/ UT	No.of policies Issued	No. of Persons Covered	Gross Premium Income	No of Claims Registered	Amount of Claims Registered	No. of claims Paid	Amount of claims Paid	No of claims repudiated	Amount of claims repudiated	No of claims o/s	Amount of claims o/s
	a	b	c	d	e	f	g	h	i	j	k
Andhra Pradesh											
Arunachal Pradesh											
Assam											
Bihar											
Chhattisgarh											
Goa											
Gujarat											
Haryana											
Himachal Pradesh											

Jammu & Kashmir											
Jharkhand											
Karnataka											
Kerala											
Madhya Pradesh											
Maharashtra											
Manipur											
Meghalaya											
Mizoram											
Nagaland											
Orissa											
Punjab											
Rajasthan											
Sikkim											
Tamil Nadu											
Telangana											
Tripura											
Uttar Pradesh											
Uttrakhand											
West Bengal											
Andaman & Nicobar Is.											
Chandigarh											
Dadra & Nagra Haveli											
Daman & Diu											
Delhi											
Lakshadweep											
Puducherry											
Total											

Note: In respect of AB-PMJAY Hybrid model (Trust plus insurance model) data pertaining to Insurance portion shall only be reported.

HIR 20 Frequency: Yearly

FORM: IRDAI-GHIS

Information on Government Sponsored Health Insurance Schemes offered by Life or Health or Non-Life Insurers Annual Return

Note: (i) Information to be furnished for the financial year within 90 days from the close of every FY. (ii) Information to be furnished separately for each insurance product in the same format.

Name of the Insurer:
Name of the Insurance Product:
UIN of the Insurance Product:
Financial Year:

TABLE - 1

Geographical Unit (District/State /UT)**	Date of award of tender or Date of launch of the Scheme	No. of Policies sold during the year		No. of Persons Covered		Premium per Person (Rs.)		Total Premium received (Rs.)		No. of Claims settled during the year		Total amount of claims settled		*ICR (%)		Assumed ICR (%) as per the filing made with IRDAI	Reasons, if any for deviation
		CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY		
Total for the product																	

Note: * ICR to be furnished for each Financial Year (CY-Current Year, PY-Previous Year)
****Please specify the Geographical Unit as per award of tender for the scheme, wherever applicable.**

Date: **Signature of Chief Compliance Officer**
Place:

Office seal

HIR 21 Frequency: Yearly

FORM: IRDAI – GHISAR

Data on Group Health Insurance Schemes offered by Health or General Insurers Annual Return (Financial Year-wise & Policy Yearwise)

Note: (i) Information to be furnished for every completed financial year within 90 days from the end of every FY. (ii) Information to be furnished separately for each group insurance product in the same format. (iii) Information in respect of Table – 2 shall be furnished in respect of all group policies whose policy years are completed in the Financial Year in respect of which the information is reported.

Name of the Insurer:

Name of the Product:

UIN:

Financial Year:

TABLE -1

S.No	Name of the Master Policyholder	Policy No.		Policy Period		No. of Persons Covered		Premium per Person (Rs.)		Total Premium received (Rs.)		No. of Claims settled during the year		Total amount of claims settled		ICR (%)		Assumed ICR (%)		Actuarial Justification for deviation in ICR, if any
		CY	PY	From	To	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	

Policy Year-wise:

TABLE- 2

S.No	Name of the Master Policyholder	Policy No.		Policy Period		No. of Persons Covered		Premium per Person (Rs.)		Total Premium received (Rs.)		No. of Claims settled during the year		Total amount of claims settled		ICR (%)		Assumed ICR (%)		Actuarial Justification for deviation in ICR, if any
		CY	PY	From	To	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	CY	PY	

Date: **Name & Signature of the Chief Compliance Officer**

Place: **Office Seal**

HIR 22 Frequency: Yearly

FORM: IRDAI – HIPP

Health Insurance Pilot Products offered by Health or General Insurers

Annual Return

Note: (i) Information to be furnished for every completed financial year within 90 days from the close of every FY. (ii) Information to be furnished separately for each Health Insurance Pilot Product in the same format. (iii)In respect of TABLE – 1, Information to be submitted separately for Individual and Group Products in the same format for all Financial Years since launch of product. (iv)Information in respect of Table – 2 shall be additionally furnished in respect of all Policies issued under Group Health Insurance Pilot Products for each completed policy year since issue of first policy to the group.

Name of the Insurer:

Name of the Pilot Product:

UIN:

Financial Year:

TABLE-1

FY	No. of Policies sold	No. of Persons Covered	Total Premium received (Rs.)	No. of Claims paid during the year	Total amount of claims paid(INR)	ICR (%)	Assumed ICR (%)	Actuarial Justification for deviation in ICR, if any

Policy Year-wise (only for Group Pilot Products) data to be separately furnished for all Completed Policy Years:

TABLE-2

Pol Year	Name of the Master Policyholder	Policy No.	Policy Period		No. of Persons Covered	Premium per Person (Rs.)	Total Premium received (Rs.)	No. of Claims paid during the year	Total amount of claims paid	ICR (%)	Assumed ICR (%)	Actuarial Justification for deviation in ICR, if any
			From	To								

Date: **Name & Signature of the Chief Compliance Officer**

Place: **Office Seal**

Section 2: Guidelines on Standardization of Exclusions in Health Insurance Contracts

Chapter I: GENERAL

1. Applicability

These Guidelines are applicable to all General and Health Insurers offering indemnity based health insurance (excluding PA and Domestic / Overseas Travel) policies offering hospitalisation, domiciliary hospitalisation and day care treatment, in respect of the products filed on or after 01stOctober, 2019. All existing health insurance products that are not in compliance with these Guidelines shall not be offered and promoted from 01st October, 2020 onwards.

2. Definitions:

The words used herein and defined in the Insurance Act, 1938, Insurance Regulatory and Development Authority Act, 1999 and Regulations notified thereunder shall have the same meaning as assigned to them respectively.

Chapter II: Exclusions not allowed in Health Insurance Policies

1. On examining the extant wordings in the health insurance policy contracts and the prevailing exclusions, it is directed that the following exclusions shall not be allowed in health insurance (Other than PA & Travel) policies. No Health Insurance Policy shall incorporate the following exclusions in the terms and conditions of the policy contract.
    a. Diseases contracted after taking the health insurance policy, except for the conditions excluded for which standard wordings are prescribed in Chapter III.
    b. Injury or illness associated with hazardous activities. (Explanation: However, only treatment necessitated due to participation in adventure or hazardous sports is permitted as exclusion.)
    c. Impairment of Persons' intellectual faculties by usage of drugs, stimulants or depressants as prescribed by a medical practitioner.
    d. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health under any circumstances unless in a vegetative state as certified by the treating medical practitioner. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract).
    e. Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders.
    f. Puberty and Menopause related Disorders: Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing.
    g. Age Related Macular Degeneration (ARMD)
    h. Behavioural and Neuro developmental Disorders:
        i. Disorders of adult personality ;
        ii. Disorders of speech and language including stammering, dyslexia;
    i. Expenses related to any admission primarily for enteral feedings.
    j. Internal congenital diseases, genetic diseases or disorders.
    k. If specified aetiology for the medical condition is not known.
    l. Failure to seek or follow medical advice or failure to follow treatment.

Chapter III: Standard Wordings for some of the exclusions in Health Insurance Policies:

1. To make the wordings of exclusions uniform and specific across the Industry, the wordings of the following exclusions are standardized. Where these exclusions or exclusions similar to the ones specified hereunder are used, Insurers shall incorporate the same wordings in verbatim in the health insurance policy contracts.
2. Against each exclusion a code number is specified. Insurers are directed to put in place operational and system procedures to capture exclusion code specific claim repudiations for the purpose of deriving data/information relating to exclusion wise repudiation of health insurance claims.

A. ***Exclusion Name: Pre-Existing Diseases*** **- Code- Excl01**

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of #### months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of ##### months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

(Explanation: Subject to product design the number of months, not exceeding 48 months, shall be specified or a reference may be given to the policy schedule)

B. ***Exclusion Name: Specified disease/procedure waiting period*****- Code- Excl02**

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of <####> months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident. (Explanation: Subject to product design the number of months, not exceeding 48 months, shall be specified)
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures (Explanation: “List of specific diseases / Procedures in respect of which waiting period is imposed shall be specified here or reference to be furnished”.)

C. ***30-day waiting period*- Code- Excl03**

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

D. ***Investigation & Evaluation*- Code- Excl04**

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E. ***Exclusion Name: Rest Cure, rehabilitation and respite care*- Code- Excl05**

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

(Note: However, Insurers may endeavour to develop add-on riders to offer respite care and home care, especially, the coverage that kicks in at age 65 onwards, provided the coverage under base policy is continued without break.)

F. ***Obesity/ Weight Control:* Code- Excl06**

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

G. ***Change-of-Gender treatments:*** **Code- Excl07**

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

H. ***Cosmetic or plastic Surgery:*** **Code- Excl08**

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

I. ***Hazardous or Adventure sports:*** **Code- Excl09**

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

J. ***Breach of law:*** **Code- Excl10**

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

K. ***Excluded Providers:*** **Code- Excl11**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations **or** following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

(Explanation: Details of excluded providers shall be provided with the policy document. Insurers to use various means of communication to notify the policyholders, such as e-mail, SMS about the updated list being uploaded in the website.)

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

M. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

N. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code- Excl14**

O. ***Refractive Error:*** **Code- Excl15**

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

P. ***Unproven Treatments***: **Code- Excl16**

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

Q. ***Sterility and Infertility:*** **Code- Excl17**

Expenses related to sterility and infertility. This includes:

(i) *Any type of contraception, sterilization*

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

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

R. **Maternity: Code Excl18**

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

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

Chapter IV: Existing Diseases allowed to be permanently excluded:

1. Notwithstanding the provisions of Clause (1) of Chapter- II, Insurers are allowed to incorporate the following existing diseases disclosed by the person to be insured at the time of underwriting as permanent exclusions with due consent of the proposer or person to be insured, where underwriting policy of the Insurer does not enable the Insurer to offer the Health Insurance Coverage for the given existing disease disclosed even after levying the loading. The permanent exclusion would be specific for the following listed conditions. However, it is emphasized that these permanent exclusions shall be allowed only in cases where the policyholder may be denied coverage as per the underwriting policy of the Insurer for the existing diseases disclosed at the time of underwriting.

TABLE - 1

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs•C60-C63Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours •C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In

		situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases

6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophagealvarices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083

10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 - Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiency virus [HIV] disease

14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

2. With reference to Sl No. 13 of the above table, Insurers shall comply with the provisions of Section 3 (j) of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act 2017 which specifies that n*o person shall discriminate against the protected person on any ground including the denial of, or unfair treatment in the provision of insurance unless supported by actuarial studies.* While complying with the provisions of the HIV and AIDS (Prevention and Control) Act 2017, Insurers shall be bound by these provisions, where the Actuarial studies support the denial of the health insurance coverage, the above approach of allowing to incorporate HIV / AIDS (refer Sl No. 13) as the permanent exclusion at the time of underwriting, may be considered by the Insurers in order to enable these sections of policyholders to get the health insurance coverage for conditions other than the conditions referred in Sl No. 13 above.
3. Exclusion of coverage in respect of the existing diseases referred in Table – 1 of this chapter shall be limited to the ICD Codes of the respective diseases. No claim which does not relate to the ICD codes referred herein shall be denied by attributing to the diseases referred herein. The policyholders shall be entitled to costs of treatment in respect of any other treatments, other than, the treatment directly attributable to ICD Codes referred in Table – I above subject to terms and conditions of the policy contract.

Chapter V: Modern Treatment Methods and Advancement in Technologies:

1. To ensure that the policyholders are not denied availability of health insurance coverage to Modern Treatment Methods Insurers shall ensure that the following treatment procedures shall not be excluded in the health insurance policy contracts. These Procedures shall be covered (wherever medically indicated) either as in-patient or as part of domiciliary hospitalization or as day care treatment in a hospital.

    A. Uterine Artery Embolization and HIFU

    B. Balloon Sinuplasty

    C. Deep Brain stimulation

    D. Oral chemotherapy

    E. Immunotherapy- Monoclonal Antibody to be given as injection

    F. Intra vitreal injections

    G. Robotic surgeries

    H. Stereotactic radio surgeries

    I. Bronchical Thermoplasty

    J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

    K. IONM - (Intra Operative Neuro Monitoring)

    L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

2. Subject to product design sub-limits may be imposed for any of the above treatments.

3. Insurers may endeavour to cover any other modern treatment methods

Chapter VI: Other guidelines related to exclusions

1. Notwithstanding the provisions of Clause (1) of Chapter – II, Insurers are allowed to incorporate waiting periods for any specific disease condition(s) however to a maximum of 4 years. Subject to product design Insurers are also allowed to impose sub limits or annual policy limits for specific diseases / conditions; be it in terms of amount, percentage of sums insured or number of days of hospitalisation/ treatment in the policy. However, Insurers shall adopt an objective criterion while incorporating any of these limitations and shall be based on sound actuarial principles.

2. Insurers are advised to consider the following options to handle the cases of Non-declaration/Misrepresentation of material facts that are surfaced during the course of the policy contract. The options specified hereunder for the purpose of continuing the health insurance coverage to the policyholders and the underlying claim, if any, shall be subject to terms and conditions of the applicable policy contract.

   a) If the non-disclosed condition or disease is from the list of the Permanent exclusions specified in Chapter IV above, the insurer can take consent from the policyholder or insured person and permanently exclude the existing disease and continue with the policy.

   b) If the non-disclosed condition is other than from the list of permanent exclusions, then the insurer can incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the policy subject to obtaining the prior consent of the policyholder or the insured person. The within referred additional waiting period that may be imposed for the undisclosed conditions is allowed notwithstanding the moratorium period referred in Clause no. 3 hereunder. However, the additional waiting period referred herein, shall be imposed, only in those cases where had the medical condition / disease been disclosed by the policyholder or the Insured person at the point of underwriting, the insurer would have imposed the waiting period not exceeding forty-eight months at the time of underwriting.

   c) Where the non-disclosed condition allows the Insurer to continue the coverage by levying extra premium or loading based on the objective criteria laid down in the Board approved underwriting policy, the Insurer may levy the same prospectively from the date of noticing the non-disclosed condition. However, in respect of policy contracts for a duration exceeding one year, if the undisclosed condition is surfaced before expiry of the policy term, the Insurer may charge the extra premium or loading referred herein retrospectively from the first year of issuance of policy or renewal, whichever is later.

d) The above three options will not prejudice the rights of the insurer to invoke the cancellation clause of 'Disclosure to Information norm' under the policy for non-disclosure /misrepresentation subject to its underwriting policy.

3. After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy. The moratorium period is applicable for health insurance policies issued by General and Health Insurers.

4. The wordings of the exclusions or waiting periods shall be specific and unambiguous. No open-ended exclusions like "Indirectly related to", "such as", "etc." are allowed while incorporating the exclusions and in the waiting periods.

5. Waiting period for life style conditions namely, Hypertension, Diabetes, Cardiac conditions is not allowed for more than 90 days except if these diseases are pre-existing and disclosed at the time of underwriting.

6. Insurers should not deny coverage for claims of Oral Chemo therapy, where Chemo therapy is allowed and Peritoneal Dialysis, where dialysis is allowed subject to product design.

7. Pre/Post hospitalization cover under Domiciliary Treatment benefit shall not be excluded where pre/post hospitalization cover is offered in case of in-patient hospitalization under the product and the underlying product covers domiciliary hospitalization. (Explanation: On a review of the definition given to domiciliary treatment, it is evident that this treatment is taken only under certain unavoidable circumstances that may be beyond the control of the policyholder. Hence, in fitness of things it is important that the policyholder can have pre / post hospitalization expenses as are otherwise made available in case of in-patient hospitalization.)

Section 3: Guidelines on Standard Individual Health Insurance Product

A. Preamble:

1. The health insurance market is having a number of individual health insurance products. Each product has unique features and the insuring public may find it a challenge to choose an appropriate product. Therefore, with the following objectives, it is mandated that all general and health insurers shall offer the standard individual health insurance product:
    a. Insurance policy to take care of basic health needs of insuring public
    b.To have a standard product with common policy wordings across the industry
    c. To facilitate seamless portability among insurers

2. The standard product shall have the basic mandatory covers as specified in these Guidelines which shall be uniform across the market.

3. No add-ons or optional covers are allowed to be offered along with the standard product.

4. The insurer may determine the price keeping in view the covers proposed to be offered subject to complying with the norms specified in the IRDAI (Health Insurance) Regulations, 2016 (HIR, 2016)and Guidelines notified there under.

5. The Standard Product shall be offered on indemnity basis only.

6. The policy tenure of the standard product shall be for a period of one year.

7. The Standard Product shall comply with all the provisions of IRDAI (Health Insurance) Regulations, 2016, all other applicable Regulations, Guidelines on Standardization in Health Insurance, Guidelines on Product Filing in Health Insurance Business, Guidelines on Standardization of Exclusions in Health Insurance Contracts and other applicable Guidelines as amended from time to time.

8. Every General and Standalone health Insurer, who has been issued a Certificate of Registration to transact General and/or Health Insurance Business, shall mandatorily offer this product.

B. Construct of Standard Health Product: The Standard Health Product shall offer the following mandatory covers.

9. **Hospitalisation Expenses:** The Hospitalisation expenses shall cover the following :
   a) Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the Sum insured subject to maximum of Rs.5000/- per day.
   b) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
   c) Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.
   (*Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day*.)
   d) Intensive Care Unit **(ICU)** / Intensive Cardiac Care Unit **(ICCU)** expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.

9A.Other Expenses

   a) Expenses incurred on treatment of Cataract subject to sub limits as specified under Para "C".
   b) Dental treatment necessitated due to disease or injury.
   c) Plastic surgery, necessitated due to disease or injury.
   d) All the day care treatments.
   e) Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

10. **AYUSH Treatment:** Expenses incurred on hospitalisation under AYUSH (as defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

11. **Pre-Hospitalisation** medical expenses incurred for a period of 30 days prior to the date of hospitalisation shall be admissible.

12. **Post Hospitalisation** medical expenses incurred for a period of 60 days from the date of discharge from the hospital, following an admissible claim shall be included.
13. **Cumulative Bonus (CB)**: Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

14. No deductibles are permitted in this product.

C. Other Norms applicable:

Sl.No	Particulars	Norms Applicable
1.	Plan Variants	No plan variants are allowed.
2.	Distributions Channels	Standard product may be distributed across all distribution channels including Micro Insurance Agents, Point of sale persons and Common Public Service Centres. Distribution of standard product shall be governed by the regulations of concerned distribution channels.
3.	Family Floater	Standard product shall be offered on family floater basis also.
4.	Definition of family	Family consists of the proposer and any one or more of the family members as mentioned below: (i) legally wedded spouse. (ii) Parents and Parents-in-law. (iii) dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
5.	Category of Cover	Standard product shall be offered on indemnity basis, as a standalone product. It shall not be combined with Critical Illness Covers or Benefit Based covers.
6.	Grace Period for premium payment	Standard product shall comply with Regulation 2(i)(e) of HIR 2016 at the time of renewal of the policy. For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of

		payment a fixed period of 15 days be allowed as grace period.
7.	Minimum and Maximum Sum Insured	The minimum sum insured under standard product shall be Rs 1,00,000/- Maximum limit shall be Rs 5 lakhs.(in the multiples of fifty thousand)
8.	Policy Period	Standard product shall be offered with a policy term of one year.
9.	Modes of premium payment	All the modes (Yly, Hly, Qly, Mly) shall be allowed for the standard product. ECS (Auto Debit facility) is also allowed in respect of the above mentioned modes.
10.	Entry age	Minimum entry age shall be 18 years for principal insured and maximum age at entry shall be 65, complying to Regulation 12(i) of HIR 2016, along with lifelong renewability. There shall be no exit age. Policy is subject to lifelong renewability. Dependent Child / children shall be covered from the age of 3 months to 25 years subject to the definition of 'Family'
11.	Benefit Structure	The benefit pay out should be explicitly disclosed in the format of application (Form – IRDAI-UNF-HISP) along with other relevant documents.
12.	Co-payment	Fixed Co-pay of 5% shall be applicable across all the ages and it shall be explicitly disclosed in the format of application (Form – IRDAI-UNF-HISP).
13.	Sub limits	Limits on cataract Surgery: The expenses incurred on treatment of Cataract shall be covered up to 25% of Sum insured or Rs.40,000/- whichever is lower, per eye.
14.	Specific Waiting Period:	Following diseases/treatment are covered subject to a waiting period mentioned below: A.24 Months Waiting Period:

		1. Benign ENT disorders 2. Tonsillectomy 3. Adenoidectomy 4. Mastoidectomy 5. Tympanoplasty 6. Hysterectomy 7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps 8. Benign prostate hypertrophy 9. Cataract and age related eye ailments 10. Gastric/ Duodenal Ulcer 11. Gout and Rheumatism 12. Hernia of all types 13. Hydrocele 14. Non Infective Arthritis 15. Piles, Fissures and Fistula in anus 16. Pilonidal sinus, Sinusitis and related disorders 17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident 18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy. 19. Varicose Veins and Varicose Ulcers 20. Internal Congenital Anomalies B.48 Months waiting period 21. Treatment for joint replacement unless arising from accident 22. Age-related Osteoarthritis & Osteoporosis

15.	Underwriting	The insurer shall specify the non-medical limit and relevant details explicitly in the format specified.
16.	Renewal	The Standard product shall be subject to Renewal duly complying with Regulation 13 of HIR, 2016
17.	Free Look Period	The Standard Product shall have free look period complying with Regulation 14 of HIR 2016
18.	Premium Loading and Discounts	The Standard Product shall comply with Regulation 25 of HIR 2016 in respect of loadings on Renewals.
19.	Portability	The Standard Product shall comply with Portability provisions, as specified in Schedule I of HIR 2016 and applicable Guidelines issued there under from time to time.
20.	Pricing	The premium under this product shall be pan India basis and no geographic location / zone based pricing is allowed.

D: Proposed construct of Terms and Conditions for Standard Product:

15. The Policy Terms and Conditions of the Standard Product shall be in the format specified in Annexure – 1. Insurer may suitably modify the definitions and other clauses of the policy contract prospectively based on the Regulations or Guidelines that may be issued by the Authority time to time.

E: Other Norms:

16. The nomenclature of the product shall be Arogya Sanjeevani Policy, succeeded by name of insurance company, (Arogya Sanjeevani Policy, <name of insurer>). No other name is allowed in any of the documents.

17. The Proposal Form used for the product shall be subject to the norms specified under the Guidelines on Product Filing in Health Insurance Business.

18. Insurers shall mandatorily issue Customer Information Sheet as per the format specified in Annexure-2.

19. The Standard Product may be offered as MICRO Insurance Product subject to Sum Insured limits specified in IRDAI (Micro Insurance) Regulations, 2015, and other circulars / guidelines issued in this regard by the Authority from time to time.

20. The Standard product shall be launched without prior approval of the Authority subject to complying with the following conditions.
    a. The product shall be approved by the Product Management Committee.
    b. Insurers shall obtain UIN for the standard product by filing the relevant particulars in Form – IRDAI-UNF-HISP (as specified in Annexure – 3 of these Guidelines) along with a certificate from Chief Compliance Officer that the product filed is in compliance with the norms specified under these guidelines.
    c. On review of the application, the Authority may call for such further information as may be required and may issue suitable directions which shall be retrospectively effected in respect of all contracts issued under this product.

21. General and Health Insurers can start offering “Arogya Sanjeevani Policy” before 1st April, 2020 and should ensure that this product is definitely offered on or before 1st April, 2020. However, if any insurer is currently not offering indemnity based health insurance products at all, the above stipulation will not apply to those. As and when those insurers start offering indemnity based health insurance products, they will have to also offer the standard product “Arogya Sanjeevani Policy”.

22. In terms of the provisions of Regulation 4(iii) of IRDAI (Issuance of e-Insurance Policies) Regulations, 2016 providing policy document in physical form is mandatory when policies are issued in electronic form directly to the policyholders. Since features of Arogya Sanjeevani policy are common across the industry and as the terms and conditions of the policy are already specified by the Authority, with the objective of reducing the oprearating costs and to pass on this benefit of reduced operational cost to the policyholders by way of affordable premiums, insurers are allowed to issue the policy contract of Arogya Sanjeevani Policy in electronic / digital format. The digital form of the policy contract may be forwaded through email or a link shall be provided in the certificate of insurance.However, where policyholder specifically seeks the physical form of the policy contract, the same shall be provided by the insurer.

23. Every insurer offering Arogya Sanjevani Policy shall provide a certificate of insurance to the policyholder indicating the availability of health insuarnce coverage.The certificate shall have a reference to access detailed terms and conditions of the policy contract.

Annexure-1

Arogya Sanjeevani Policy,[Company Name]

1. PREAMBLE

This Policy is a contract of insurance issued by *[name of the Company]* (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/ Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary, expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted and Cumulative Bonus (if any) specified in the Schedule.

3. DEFINITIONS

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

3.1. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

3.3. Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

3.4. AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

3.5. An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3.7. Break in Policy means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

3.8. Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person 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.

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

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

a) Internal Congenital Anomaly

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.

3.11. 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.

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

3.13. Day Care Centre means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

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

3.14. 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 twenty four hours because of technological advancement, and
ii. which would have otherwise required a hospitalisation of more than twenty four hours.

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

3.15. Dental Treatment means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.

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

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

3.18. Family means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

i. legally wedded spouse.
ii. Parents and Parents-in-law.
iii. dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

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

3.20. Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical

Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient 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 shall make these accessible to the Company's authorized personnel.

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

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

i. **Acute Condition** means a disease, illness or injury that is likely to response quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.
ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
    a) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
    b) it needs ongoing or long-term control or relief of symptoms
    c) it requires rehabilitation for the patient or for the patient to be special trained to cope with it
    d) it continues indefinitely
    e) it recurs or is likely to recur

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

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

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

3.26. 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.

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

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

3.29. 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.

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

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

i. is required for the medical management of illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.32. Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

3.33. Network Provider means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

3.34. Non- Network Provider means any hospital that is not part of the network.

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

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

3.37. Pre-Existing Disease (PED): Pre existing disease means any condition, ailment, injury or disease

a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

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

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

3.39. Post-hospitalisation Medical Expenses means medical expenses incurred during the period of 60days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and

ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

3.40. Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person

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

3.42. Policy Schedule means the Policy Schedule attached to and forming part of Policy

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

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

3.45. 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.

3.46. 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.

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

3.48. Sub-limit means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

3.49. Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.

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

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

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

4. COVERAGE

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1. Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs.10,000/- per day.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1. Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits
ii. Dental treatment, necessitated due to disease or injury
iii. Plastic surgery necessitated due to disease or injury
iv. All the day care treatments
v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment

2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

4.2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda,Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

4.3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured orRs.40,000/-, whichever is lower, per each eye in one policy year.

4.4. Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

4.5. Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

4.6. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy- Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

I. Bronchical Thermoplasty

J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)

K. IONM - (Intra Operative Neuro Monitoring)

L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4.7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively.

5. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.
iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons
v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy
vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
viii. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn

6. Waiting Period

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

6.1. Pre-Existing Diseases(Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

6.2. First Thirty Days Waiting Period(Code- Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

6.3. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

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

c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i.24 Months waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system,Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. InternalCongenitalAnomalies

ii. 48 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis

7. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

7.1 Investigation & Evaluation(Code- Excl04)

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

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

7.2 Rest Cure, rehabilitation and respite care(Code- Excl05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment.This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

7.3 Obesity/ Weight Control(Code- Excl06)

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

7.4 Change-of-Gender treatments: (Code- Excl07)

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

7.5 Cosmetic or plastic Surgery: (Code- Excl08)

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

7.6 Hazardous or Adventure sports: (Code- Excl09)

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

7.7 Breach of law: (Code- Excl10)

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

7.8 Excluded Providers: (Code-Excl11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

7.10 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons**. (Code- Excl13)**

7.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code- Excl14)**

7.12 Refractive Error:(Code- Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

7.13 Unproven Treatments:(Code- Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

7.14 Sterility and Infertility: (Code- Excl17)
Expenses related to sterility and infertility. This includes:

(i) Any type of sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

7.15 Maternity Expenses (Code - Excl 18):

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period**.**

7.16 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

7.17 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

7.18 Any expenses incurred on Domiciliary Hospitalization and OPD treatment

7.19 Treatment taken outside the geographical limits of India

7.20 In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

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

9. CLAIM PROCEDURE

1.1 Procedure for Cashless claims:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA. (ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization. (iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification. (iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses. (v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. (vi)In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

1.**2 Procedure for reimbursement of claims**:

For reimbursement of claims the insured person may submit the necessary documents to TPA(if applicable)/Company within the prescribed time limit as specified hereunder.

Sl No	**Type of Claim**	**Prescribed Time limit**
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

9.1 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA(if applicable) as under:

i. Within24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

9.2 Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR(Medico Legal Report copyif carried out and FIR (First information report) if registered, where ever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate , wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment ofthe claim.

[Note: Insurer may specify the documents required in original and waive off any of above required as per their claim procedure]

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

9.3 Co-payment

Each and every claim under the Policy shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the copayment.

9.4 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliestin any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

9.5 Services Offered by TPA(To be stated where TPA is involved)

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

9.6 Payment of Claim

All claims under the policy shall be payable in Indian currency only.

10. GENERAL TERMS &CONDITIONS

10.1 Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

10.2 Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the policy.

10.3 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

10.4 Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

10.5 Complete Discharge

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

10.6 Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

10.7 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

10.8 Multiple Policies

1. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer if chosen by the policy holder shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

2. Policyholder having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall independently settle the claim subject to the terms and conditions of this policy.

3. If the amount to be claimed exceeds the sum insured under a single policy after, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

4. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

10.9 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or

anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.
Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:—

(a) the suggestion ,as a fact of that which is not true and which the Insured Person does not believe to be true;

(b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

(c) any other act fitted to deceive; and

(d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

10.10 Cancellation

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

Refund %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	**1 Yr**
Up to 30 days	75.00%
31 to 90 days	50.00%
3 to 6 months	25.00%
6 to 12 months	0.00%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

b) The Company may cancel the Policy at any time on grounds of mis-represenation, non-disclosure of material facts , fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-represenation ,non-disclosure of material facts or fraud.

10.11 Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate:

1. In the case of his/ her (Insured Person) demise.

However the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must

be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

10.12 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

10.13 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

10.14 Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link ……
(Note: Insurer to provide link to the extant Guidelines related to Migration)

10.15 Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 6 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link ……
(Note: Link to be provided to the extant Guidelines related to portability)

10.16 Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

10.17 Premium Payment in Installments

If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
ii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
iii. The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.

10.18 Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are affected.

10.19 Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of fifteen days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

10.20 . Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be thelegal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

10.21 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

10.22 .Terms and conditions of the Policy

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

10.23 Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For Claim settlement under reimbursement, the Company will pay the policyholder. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

11. REDRESSAL OF GRIEVANCE

Grievance–In case of any grievance relating to servicing the Policy, the insured person may submit in writing to the Policy issuing office or regional office for redressal.

For details of grievance officer, kindly refer the link…….

(Link having details of grievance officer on website to be provided)

IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

Insurance Ombudsman –The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-B.Insurers to take note of the change in domain from gbic.co.in to ecoi.co.in of the email ids as mentioned at Annexure – B. Insurers are further advised to note the revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html and ensure that updated details are prospectively incorporated in the policy documents for the information of the policyholders.

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

12. TABLE OF BENEFITS

Name	ArogyaSanjeevani Policy,[Company Name]
Product Type	Individual/ Floater
Category of Cover	Indemnity
Sum insured	INR On Individual basis – SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years and 65years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members i. legally wedded spouse. ii. Parents and Parents-in-law. iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals
Grace Period	For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible
	Time limit of 24 hrs shall not apply when the treatment is undergone in a Day Care Centre.
Pre Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/doctors fee	1.Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/- per day. 2.Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day
Cataract Treatment	Up to 25% of Sum insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured, during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 4 years
Cumulative bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co Pay	5% co pay on all claims

Annexure-A

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

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

42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl No	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN

15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

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

20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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

Annexure-B

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, JeevanPrakash Building, 6th floor, TilakMarg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road,JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam-682015. Tel.: 0484 - 2358759/2359338 Fax: 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
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.	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad,	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in

Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in

[Note to Insurers: Insurers are advised to mention the correct address, e mail Id, phone number etc. of insurance ombudsmen while issuing policy contracts]

Annexure-2

Customer Information Sheet (Description is illustrative and not exhaustive)

No.	TITLE	DESCRIPTION	Refer to policy clause number
1.	***Product Name***	**Arogya Sanjeevani Policy,<name of the Insurer>.**	
2.	***What am I covered for***	a. Hospitalization expenses- Expenses incurred on hospitalization for minimum period of 24 hours including pre-hospitalization expenses for a period of 30 days and post hospitalization expenses for a period of 60 days.	4.1
		b. Day Care Procedures- Medical expenses for day care procedures.	4.1.1
		c. AYUSH Coverage- Expenses incurred on hospitalization under AYUSH Treatment.	4.2
		d. Expenses incurred on treatment of cataract.	4.3
		e. Expenses incurred on dental treatment and Plastic Surgery: Necessitated due to disease or injury.	4.1.1
		f. Ambulance Charges: Expenses on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.	
3.	***What are the Major exclusions in the policy***	Following is a partial list of the policy exclusions. Please refer to the policy document for the complete list of exclusions: a. Admission primarily for investigation & evaluation	7.1
		b. Admission primarily for rest Cure, rehabilitation and respite care	7.2
		c. Expenses related to the surgical treatment of obesity that do not fulfill certain conditions	7.3
		d. Change-of-Gender treatments	7.4
		e. Expenses for cosmetic or plastic surgery	7.5
		f. Expenses related to any treatment necessitated due to participation in hazardous or adventure sports	7.6
4.	***Waiting period***	a. Pre-Existing Diseases will be covered after a waiting period of forty eight (48) months of continuous coverage	6.1
		b. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident.	6.2
		c. Specified surgeries/treatments/diseases are covered after specific waiting period of 24 months	6.3
		d. Specified surgeries/treatments/diseases are covered after specific waiting period of 48 months	
5.	***Payment basis***	Payment on indemnity basis (Cashless / Reimbursement)	

<table>
<tr><td rowspan="2">6.</td><td rowspan="2">Loss sharing</td><td>In case of a claim, this policy requires you to share the following costs:
a. Expenses exceeding the following Sub-limits:
i. Room Charges(Hospitalization):
a. Room Rent - Up to 2% of SI, subject to max of INR 5,000 per day
b. ICU charges - Up to 5% of SI subject to max of INR 10,000 per day.
c. In case Room/ICU/ICCU rent exceeds the limits specified the claim shall be subject to the proportionate deduction.

ii. Cataract – Up to 25% of Sum Insured or Rs.40,000/- whichever is lower.
iii. Modern treatment methods and Advancements in technology: Up to 50% of the Sum insured.</td><td>4.1

4.3

4.6</td></tr>
<tr><td>b. Each and every claim under the Policy shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy</td><td>9.3</td></tr>
<tr><td>7.</td><td>Renewal Conditions</td><td>The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.</td><td>10.16</td></tr>
<tr><td>8.</td><td>Renewal Benefits</td><td>Cumulative bonus:
a. Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI.
b. In the event of claim the cumulative bonus shall be reduced at the same rate.</td><td>5</td></tr>
<tr><td>9.</td><td>Cancellation</td><td>a. The Insured may cancel this Policy by giving 15 days’ written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed in the policy terms and conditions.
b. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts ,fraud by the Insured Person by giving 15 days’ written notice.</td><td>10.10</td></tr>
<tr><td rowspan="2">10.</td><td rowspan="2">Claims</td><td>a. For Cashless Service:
(Insurer to provide the details /web link from where Hospital Network details can be obtained)</td><td rowspan="2">9</td></tr>
<tr><td>b. For Reimbursement of Claim : For reimbursement of claims the insured person may submit the necessary documents to TPA/Company within the prescribed time limit as specified hereunder.

<table>
<tr><th>Sl No</th><th>Type of Claim</th><th>Prescribed Time limit</th></tr>
<tr><td>1</td><td>Reimbursement of hospitalization, day care and pre hospitalization expenses</td><td>Within thirty days of date of discharge from hospital</td></tr>
<tr><td>2</td><td>Reimbursement of post hospitalization expenses</td><td>Within fifteen days from completion of post hospitalization treatment</td></tr>
</table>

For details on claim procedure please refer the policy document.</td></tr>
<tr><td rowspan="2">11.</td><td>Policy Servicing</td><td>Insurer to provide the details of company officials.</td><td></td></tr>
<tr><td>Grievances/ Complaints</td><td>a. Details of Grievance redressal officer (Insurer to provide the link)
b. IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/</td><td>11</td></tr>
</table>

		c. Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.	
12.	***Insured's Rights***	a. Free Look period of 15 days from the date of receipt of the policy shall be applicable at the inception.	10.19
		b. Lifelong renewability (except on certain specific grounds)	10.16
		c. Right to migrate from one product to another product of the company (Note: Insurer to provide e-mail and address of the Person to be contacted)	10.14
		d. Right to port the from one company to another company (Note: Insurer to provide e-mail and address of the Person to be contacted)	10.15
		e. Change in SI during the policy term or at the time of renewal (Insurer to provide the contact details)	10.21
		f. Insurer to specify the norms on TAT for Pre-Auth and Settlement of reimbursement.	
13.	***Insured's Obligations***	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	
Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.			

Annexure-3

Form IRDAI-UNF-HISP

[All the items should be filled in properly and carefully. No item must be left blank.]

S No	Item	Particulars (to be filled in by insurer)
Section I: General Information		
1.1	Name of Health / General Insurer	
1.2	Registration No. allotted by IRDAI	
1.3	Name of Appointed Actuary [Please note that his/her appointment should be in force as on the date of this application]	
1.4	Brand Name [Give the name of the product which will be printed in Sales Literature and known in the market. This name should not be altered/modified in any form after launching in the market. This name shall appear in all returns etc. which would be submitted to IRDAI	Arogya Sanjeevani, <Name of the insurer>
1.5	Date of approval by PMC	
Section II: Underwriting		
2.	Underwriting –Selection of Risks [This section should discuss how the different segments of the population will be dealt with for the purpose of underwriting (to the extent they are relevant and a brief detail of procedure adopted for assessment of various risk classes may be given.)	
2.1	Specify Non-medical Limit [Where no pre-medical examination is asked for]	
2.2	Specify when and what classes of lives would be subject to medical examination	
2.3	Whether any loading based on the health status are applicable	Yes / No
2.4	Whether any loading based on the occupation are applicable	Yes / No

2.5	Specify, any other underwriting criteria							
2.6	Whether Underwriting of the product aligned to the Board Approved Underwriting policy of the Company		Yes / No					
2.7	Whether full costs of pre policy medical check up are borne by the Insurer		Yes / No					
2.8	If no, specify the percentage proposed to be borne by the Insurer.							
Section III - Distribution Channels								
3	Distribution channels:							
	3.1	Specify the various distribution channels to be used for distributing the product- [reply shall be specific and can not refer to the replies like "as approved by IRDAI]						
	3.1	Commission scales to distribution channels—specify the rates which are to be paid-[reply shall be specific]						
3.2	Expected proportions of business to be procured by each channel shall be indicated for the next 5 years.		Distribution Channel	Year 1	Year 2	Year 3	Year 4	Year 5
			1.Individual Agents					
			2. Corporate Agents					
			3. Insurance Brokers					
			4.Web Aggregators					
			5.Micro Insurance Agents					
			6.CSC					
			7.PoS					
			8.Direct – Only Online					

		9.Direct Marketing - Others					
		(Incorporate separate line for each distribution channel) 10. Others-specify					
		11. Total					
Section IV - Reinsurance arrangements							
4.1	Retention limit						
4.2	Name of the reinsurer (s)						
4.3	Terms of reinsurance (type of reinsurance, commissions, etc.).						
4.4	Any recapture provisions shall be described.						
4.5	Reinsurance rates provided						
4.6	Whether a copy of the reinsurance program and a copy of the Treaty is submitted to the Authority.		Yes/No				
	4.6.1	Whether reinsurance program and a copy of the treaty enclosed (required only if these are not filed with the Authority previously)	Yes/No				
	4.6.2	Whether the reinsurance proposed for the product is in line with the Board approved reinsurance program filed with the Authority	Yes / No				
	4.6.3	If no, furnish the particulars					
Section V: Pricing							
5	*Premium Loadings & Discounts* *(Please provide objective and transparent criteria to offer discounts/rebate/Loadings And complete financial justifications by AA to every item referred hereunder.*						

	In case of General and Health Insurers to be also furnished separately in the Technical Note)		
	5.1	Sum insured rebates/discounts offered, if any	
	5.2	Rebates/charges for different modes offered:	
	5.3	Premium rebates/discounts	
	5.4	Staff rebates	
	5.5	Any other discounts offered	
	5.6	Maximum cap on all Discounts for all variables taken together	
	5.7	Any loadings proposed	
	5.8	Maximum Cap on all Loading for all variables taken together	
	5.9	Subrogation (Not applicable to Health Insurance)	
5.10	**Pricing Assumptions and Methodology:** The pricing assumptions and the methodology may vary depending on the nature of product. Give details of the following		
5.11	Give the actuarial formulae, if any, used; if not, state how premiums are arrived at briefly explaining the methodology and details:		
5.12	Source of data (internal/industry/ reinsurance)		
5.13	Rate of morbidity [The tables whereever relevant shall be the prescribed one.]		
5.14	Rates of policy terminations. [The rates used must be in accordance with insurer's experience. If such experience		

<table>
<tr><td></td><td>is not available, this can be from the industry/reinsurer’s experience .]</td><td></td></tr>
<tr><td>5.15</td><td>Rate of interest, if any. [The rate or rates must be consistent with the investment policy of the insurer.]</td><td></td></tr>
<tr><td>5.16</td><td>Commission scales [Give rates of commission. These are explicit items.]</td><td></td></tr>
<tr><td>5.17</td><td colspan="2">Expenses - Split into First Year, Renewal and Claim related:- [Expense assumptions must be company specific. If such experience is not available, the Appointed Actuary might consider industry experience or make reasonable assumptions.]
<table>
<tr><td>5.17.1</td><td>First Year expenses by: sum assured related, premium related, per policy related</td></tr>
</table>
<table>
<tr><td>First Year Expenses</td><td>sum assured related</td><td>premium related</td><td>per policy related</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>5.17.2</td><td>Renewal expenses where relevant (including overhead expenses) by : sum assured related, premium related, per policy related</td></tr>
</table>
<table>
<tr><td>Renewal Expenses</td><td>sum assured related</td><td>premium related</td><td>per policy related</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>5.17.3</td><td>Claim expenses</td><td></td></tr>
<tr><td></td><td>5.17.4</td><td>Future inflationary increases, if any</td><td></td></tr>
</table></td></tr>
<tr><td>5.18</td><td>Allowance for transfers to shareholder, if any: [Please see section 49 of the Insurance Act, 1938]</td><td></td></tr>
<tr><td>5.19</td><td>Taxation. [Please see the relevant sections of the Income Tax Act, 1961 applicable for payment of taxes by the Insurer]</td><td></td></tr>
<tr><td>5.20</td><td>Any other parameter relevant to pricing of product –specify</td><td></td></tr>
<tr><td>5.21</td><td>Reserving assumptions (please specify all the relevant details)</td><td></td></tr>
</table>

5.22	Base rate (risk premium)-furnish the rate table, if any						
5.23	Gross premium- furnish the rate table, if any						
5.24	Annualised Premium						
	5.24.1 Minimum						
	5.24.2 Maximum						
5.25	Expected loss ratio (for the product) -						
5.26	Age-wise loss ratio-	S.No	Age	Loss ratio			
5.27	Sum insured-wise- loss ratio	S.No	SA	Loss ratio			
5.28	Age and sum insured wise loss ratio -	Table given below (SI band and age bands shall be increased. The format given below is indicative.)					
	S.NO	SI/Age bands	100000	150000	200000	250000	300000
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					
	12	>=66					
5.29	Expected combined ratio						

5.30	Age-wise combined ratio-	
5.31	Sum insured-wise- combined ratio	
5.32	Age and sum insured wise combined ratio - to be furnished for each option or plan separately	Table given below (SI band and age bands shall be increased.The format given below is indicative.)

S.NO	SI/Age bands	100000	150000	200000	250000	300000
1	>=0<=2					
2	>=3<=15					
3	>=16<=25					
4	>=26<=30					
5	>=31<=35					
6	>=36<=40					
7	>=41<=45					
8	>=46<=50					
9	>=51<=55					
10	>=56<=60					
11	>=61<=65					
12	>=66					

5.33	Expected cross-subsidy between age/sum insured
5.34	Experience of similar products, if any for the preceding Five Financial Years

S.No	Exposure	Premium – Rs.	Number of claims	Incurred claims -Rs.	Claim frequency	Average cost per claim	Burning cost-Rs.	Loss ratio	Combined ratio
FY									
FY-1									
FY-2									
FY-3									

	FY-4										
	1. Exposure: earned life year (no of life earned during a particular financial year); 2. Premium: premium earned during the financial year; 3.Number of claims: claims occurred during the financial year; 4. Incurred claims: Incurred amount as of today for claims mentioned in “3”; 5. Claim frequency: No. of claims/ Exposure; 6. Average cost per claim: Incurred claims / No. of claims; 7. Burning cost: Claims frequency* Average cost per claim; 8. Loss ratio: Incurred claims/ Premium; 9. Combined ratio: Loss ratio + Expense ratio;										
5.35	**Results of Financial Projections/Sensitivity Analysis:** [The profit margins should be shown for various model points for base, optimistic and pessimistic scenarios in a tabular format below. The definition of profit margin should be taken as the present value of net profits to the p.v of premiums. Please specify assumptions made in each scenario. For terms less than or equal to one year loss ratio may be used and for terms more than one year, profit margin may be used.]										
5.36	Risk discount rate used in the profit margin										
5.37	Average Sum Insured Assumed										
5.38	Assumptions made under pessimistic scenario										
5.39	Assumptions made under optimistic scenario										
5.40	Age [PM: Profit Margin/Loss Ratio] [Age Band may be revisted based on the product design paratmeters]	*PM (base scenario)*	*PM (pessimistic scenario)*	*PM (optimistic scenario)*							
	>=0<=2										
	>=3<=15										
	>=16<=25										
	>=26<=30										
	>=31<=35										
	>=36<=40										

	>=41<=45			
	>=46<=50			
	>=51<=55			
	>=56<=60			
	>=61<=65			
	>=66			

Section VI: Enclosures to the Application: The following specimen documents should be enclosed:	
6.1	Sales Literature /Prospectus. This is the literature which is to be used by the various distribution channels for selling the product in the market. This shall enumerate all the salient features of the product along with the exclusions applicable for the basic benefits and shall be in complaince with the relevant circulars issued by the Authority at all times).
6.2	Policy Document& Policy Schedule
6.3	Technical Note on Pricing
6.4	Proposal form, wherever necessary
6.5	Premium Table
6.6	Certificates by Appointed Actuary and Chief Compliance Officer
6.7	CIS

Soft ware used for product design and monitoring --- (for information of the Authority)

The Insurer shall enclose a certificate from the Chief Compliance Officer, Appointed Actuary, countersigned by the principal officer of the insurer, as per specimen given below:(The language of this should not be altered)

Certification by Chief Compliance Officer:

I------- (Name of Chief Compliance Officer) the undersigned, on behalf of the Insurer named below, hereby affirm and declare as follows:

1. That the details of the (Name of product) filled in above are true and correct and reflect what the policy and other documents indicate.
2. That the product complies with the various provisions of the IRDAI Health Insurance Regulations, 2016, Guidelines on Standardization of Health Insurance, Product Filing Guidelines, Guidelines on Standardization of Exclusions in Health Insurance Contracts, Guidelines on Standard Individual Health Insurance Product, issued thereon and the applicable provisions of extant IRDAI Regulations and all circulars issued by IRDAI from time to time.

3. That this application and all other documents are complete and have been verified for correctness and consistency not only in respect of each item of each document but also vis-a-vis one another.
4. I certify that the policy wordings and Customer Information sheet filed along with this application is in compliance with IRDAI (Health Insurance) Regulations, 2016, Product Filing Guidelines, Guidelines on Standardization of Health Insurance,Guidelines on Standardization of Exclusions in Health Insurance Contracts, Guidelines on Standard Individual Health Insurance Product issued thereon.
5. I further certify that the Prospectus submitted is in compliance with the applicable provisions of Rules, IRDAI Regulations and Product Filing Guidelines and Insurance Advertisements.

Date: (Chief Compliance Officer)
Name of Insurer

Certification by Appointed Actuary:

"I, (**name of the appointed actuary**), the appointed actuary, hereby solemnly declare that the information furnished in this Application Form is true. I also certify that, in my opinion, the premium rates, advantages, terms and conditions of the above product are workable and sound, the assumptions are reasonable and premium rates are fair."

I have carefully studied the requirements of the Product Filing Procedure in relation to the design and rating of insurance products.

The rates, terms and conditions of the above mentioned product are determined on technically sound basis and are sustainable on the basis of the information and claims experience available in the records of the insurer.

An adequate system has been put in place for collection of data on premiums and claims based on every rating factor that will enable review of the rates and terms of the cover from time to time. It is planned to review the rates, terms and conditions of cover (--- mention periodicity of review) based on emerging experience.

It is further certified that the underwriting of the product now filed shall be within the Board approved underwriting philosophy of the Company.

The requirements of the Product Filing Procedure have been fully complied with in respect of this product or revision or modification of the product.

I further declare that except the Sections mentioned in S.No., no other feature/benefit/clause is modified in the product (applicable only for revision or modification of the product)

Place Signature of the Appointed Actuary
Date:

Certification by Principal Officer or CEO

I (name of the Principal Officer or CEO), (mention designation) hereby confirm that:

1. The rates, terms and conditions of the above-mentioned product filed with this certificate have been determined in compliance with the IRDA Act, 1999, Insurance Act, 1938, and the Regulations and guidelines issued there under, including the File and Use / Product Filing guidelines.

2. The prospectus, sales literature, policy and endorsement documents, and the rates, terms and conditions of the product have been prepared on a technically sound basis and on terms that are fair between the insurer and the client and are set out in language that is clear and unambiguous.

3. These documents are also fully in compliance with the underwriting and rating policy approved by the Board of Directors of the insurer.

4. The statements made in the filing Form -IRDAI-UNF-HISP are true and correct.

5. The requirements of the Product Filing Guidelines have been fully complied with in respect of this product.

Date: Signature of Principal Officer or Designated Officer

Place: Name and designation along with Company's seal