PREAMBLE:

The insurance cover provided under this Policy to the Insured / Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium and (c) Disclosure to Information Norm (including by way of the Proposal or Information Summary Sheet) and (d) Policy Schedule/ Certificate of Insurance.

SECTION 1- DEFINITIONS:

Any word or expression, to which a specific meaning has been assigned in any part of this Policy Wording or the Policy Schedule/ Certificate of Insurance, shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning as set forth herein below:

- **"Accident"** means a sudden, unforeseen, and involuntary event caused by external, visible and violent means.

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

- **"AYUSH"** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

  - **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.

  - 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:

Bharti AXA General Insurance Company Limited, "HOSTO CENTER" 1st Floor No.43,Millers Road. Vasanth Nagar Bangalore -560052 Ph: 1800-103- 2292, CIN : U66030KA2007PLC043362 Wesbite:www.bharti-axagi.co.in IRDA Reg. No: 139, Email : customer.service@bhartiaxa.com

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.

- **"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.

- **"Certificate of Insurance"** means the document issued to Individual Insured by the Company detailing the effective date, instalment date, Insured Person(s), Benefits, Sum Insured, Deductible, Franchise, Premium and more generally all special conditions and or endorsements.

- **"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.

- **"Company/We/Our/Ours"** means Bharti AXA General Insurance Company Limited.

- **"Condition Precedent"** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

- **"Congenital Anomaly"** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

I. **Internal Congenital Anomaly -** Congenital anomaly which is not in the visible and accessible parts of the body;

II. **External Congenital Anomaly-** Congenital anomaly which is in the visible and accessible parts of the body.

- **"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.

- **"Day Care treatment"** means medical treatment, and / or surgical procedure which is:

I. undertaken under general or local anesthesia in hospital/day care centre in less than 24 hours 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.The list of Day Care Treatment is available in our website.

- **"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 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 will make these accessible to the Insurance Company's authorized personnel.

- **"Daily Allowance"** means the benefit amount payable to the Insured/Insured Person for each continuous and completed period of 24 hours as inpatient care in the hospital upto the limits as specified in the Policy Schedule/ Certificate of Insurance .

- **"Deductible"** means a cost sharing requirement under a health insurance policy that provides that the company will not be liable for a specified rupee amount in case of indemnity sections and for a specified number of days/hours in case of hospital cash section which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

- **"Dependent Child"** means a natural or legally adopted child, aged between 91 days to 23 years and financially dependent on the Policy holder.

- **"Disclosure to information norm"** means 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.

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

- **"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:

A. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
B. the patient takes treatment at home on account of non-availability of room in a hospital.

- **"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.

- **"Family Floater"** means the Sum Insured shown in the Policy Schedule/ Certificate of Insurance which represents the Company's maximum liability for any and all claims made by any one Insured and/or all Insured Person(s) together during the Policy Period.

- **"Franchise**" means the company is not responsible for the loss which does not exceed specified amount or number of days/hours, but is responsible to cover the risk from the first amount or the first day/hour if it exceeds specified amount or specified number of days/hours.

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

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

- **"Hospitalisation"** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for Day care treatments, where such admission could be for a period of less than 24 consecutive hours.

- **"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.

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

I. **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

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

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

- **"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

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

- "**Insured/You/Your**" means the primary Insured who has the highest age amongst other person named in the Policy Schedule/ Certificate of Insurance in case of family floater Policy. In case of an Individual Policy the only member mentioned in the Policy Schedule/ Certificate of Insuranceshall be referred as **"Insured"**.

- **"Insured Person(s)"** means the person(s) named in the Policy Schedule/ Certificate of Insurance.

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

- **"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.

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

- **"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.

- **"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.

- "**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.

The registered practitioner should not be the insured or close member of the family.

- **"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.

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

- **"Newborn baby"** means baby born during the Policy Period and is aged upto 90 days.

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

- **"Notification of claim"** means the process of intimating a claim to the insurer through any of the recognized modes of communication.

- **"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.

- **"Period of Insurance"** means the period between the date when the policy had first incepted, its subsequent renewals without any break till policy expiry date under the last renewed policy.

- **"Policy Holder"** means the entity named in the Policy Schedule who is responsible for remitting the premium

- **"Policy period"** means the period between the inception date and the expiry date as specified in the Policy Schedule/ Certificate of Insuranceor the cancellation of this insurance, whichever is earlier.

- **"Policy Schedule"** means the document issued to the Policyholder which is attached to and forming part of this Policy mentioning the details of the Insured Person(s), the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

- **"Policy Year"** means the duration of each 12 calendar months from the inception date under the policy. Eg., Period of first 12 months shall be termed as First Policy Year, period exceeding 12 months upto 24 months shall be termed as Second Policy Year and period exceeding 24 months upto 36 months shall be termed as Third Policy Year.

- **"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.

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

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

- **"Pre-Existing Disease"** means any condition, ailment, injury or disease:

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

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

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

- **"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.

- "**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.

- **"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.

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

- **"Senior citizen"** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

- **"Subrogation"** means the right of the insurer to assume the rights of the Policyholder/insured person to recover expenses paid out under the policy that may be recovered from any other source.

- **"Sum Insured"** means the amount specified in the Policy Schedule/ Certificate of Insurance against any one or all the sections, which represents the Company's maximum, total and cumulative liability for any and all claims made in respect of the Insured Person during the Period of Insurance, under that any one or all the sections. Sum Insured, as specified in the Policy/Certficate of Insurance, can be a lump sum benefit payment upon occurrence of an insured event or indemnity payment basis expenditure of the Insured Person for coverage as specified in the Policy Wording upon occurrence of the insured event

- **"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.

- **"Third Party Administrators or TPA''** means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations.

- **"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.

SECTION 2- EXCLUSIONS

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 48/36/24 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability / migration 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 Insurer.

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 24/12 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.
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

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy

17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22) Gout and Rheumatism
23) Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

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.

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- Excl 11
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.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

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- Exel 16
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- Excl 17
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.

S. 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.

T. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

U. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

V. Treatment taken outside the geographical limits of India

W. 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.

X. List I: Optional Items

SECTION 4 -Standard General Terms and Clauses

I. Disclosure of Information

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

II. Basis of Claims settlement:

The Basis of claims settlement under the policy may be either on indemnity basis or benefit basis. The basis of admissibility shall be specified in the Policy Schedule/Certificate of Insurance specified against the sections.

III. Consideration :

The Frequency of Premium payable under the policy and or each Certificate of the Insurance issued under this Policy shall be single payment premium or instalment basis.

- In the case of single payment – full premium is payable before the beginning of risk.

IV. Condition Precedent to Admission of Liability:

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

V. Material Change:

The Policyholder/ Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person's own expense. The Company may, adjust the scope of cover and / or the premium, if necessary, accordingly.

VI. 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 and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shal! be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not belieVe to be true;
b) the actiVe concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceiVe; and
d) any such act or omission as the law specially declares to be fraudulent

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

VII. No Constructive Notice:

The Company shall not take notice of any information relating to the Insured person unless such information is submitted in writing by the Policyholder/ Insured, even if such information was available with the Company.

VIII. Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Policyholder/ Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

IX. Special Provisions:

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

X. Electronic Transaction:

The Policyholder/ Insured / Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDAI regulations for protection of Policy holder's interests.

XI. Duty of the Insured on occurrence of loss/event leading to claim

On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Policyholder/ Insured / Insured Person shall:

- Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
- Allow the Medical Practitioner or any representative of the Company to inspect the medical and hospitalization records and to examine the Insured / Insured Person
- Assist and not hinder or prevent the Company or any of its representatives in pursuance of their duties

In case the Policyholder/ Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Policyholder/ Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

XII. Right to Investigate:

If required by the Company, a representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to investigate into the circumstances of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of investigation required under this section.

XIII. Position after a claim:

As from the day of receipt of the claim amount by the Policyholder/ Insured / Insured Person, the days Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount.

XIV. Multiple policies:

- In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person 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 chosen by the insured person 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.
- Insured person 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 shall independently settle the claim subject to the terms and conditions of this policy.
- If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
- Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.
-

XV. Forfeiture of claims:

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

XVI. 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;

XVII. Grace Period:

All applications for renewal of the Policy must be received by us before the end of the Policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy.

However, there is no coverage provided during the break period for which premium is not received.

XVIII. Cancellation:

- The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policyperiod as detailed below.

Period on Risk	Rate of Premium to be retained by Company
Up to 1 month	25%
Exceeding 1 month Up to 3 months	50%
Exceeding 3 months Up to 6 months	75%
Exceeding 6 months Up to 12 months	100%

Credit linked policies may be issued for a period not exceeding 5 years. The refund on cancellation of Policy/Certificate of Insurance by the Policyholder/ Insured shall be made as per the Company's short period scales given below provided no claim has/is occured/reported up to the date of cancellation of this Policy/Certificate of Insurance.

Loan Period(Year)	1	2	3	4	5/5+
Policy Period (Year)	1	2	3	4	5
Year Of Cancellations	**Rate of Premium to be retained by Company**				
1	100%	50%	33%	25%	20%
2		100%	67%	50%	40%
3			100%	75%	60%
4				100%	80%
5					100%

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

- The Company may cancel thepolicy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured personby giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

XIX. Termination :

The Policy will terminate at the expiration of the period for which premium has been paid or on Expiration Date shown in the Policy Schedule, whichever is earlier.

Termination of Individual Certificates of Insurance : Each Certificate of Insurance will terminate on the earliest of the following dates

- The date the expiry of the certificate of Insurance.
- The date the Insured person is no more eligible to get covered under the group.
- The instalment premium is not paid.
- The date We or You cancel the Certificate of Insurance.

XX. Cause of action/Currency of payment:

Coverage under the policy shall be primarily restricted to terrritorial limits of India except when worldwide cover is opted by the Policyholder/Insured Person and specified under the Schedule/Certificate of Insurance for Medical Evacuation and International treatment for 25 critical illness (indemnity basis).All claims shall be payable in India in Indian Rupees only.

XXI. Policy Disputes:

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Policyholder/ Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

XXII. Arbitration:

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.
It is hereby agreed and understood that no dispute or difference shall be referred to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.
It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss shall be first obtained.

XXIII. Renewal of Policy

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

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

XXIV. Inclusion of members under the Policy:

New Person can be added to this Policy, either by way of endorsement in case of mid-term inclusion or at the time of renewal subject to acceptance by underwriters.

XXV. Renewal Notice:

The Company shall not be bound to accept any renewal premium or to give notice that such is due.

XXVI. Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to ;

- In case of the Policyholder/ Insured, at the address given in the Policy Schedule/ Certificate of Insurance.
- In case of the Company, to the Policy issuing office/nearest office of the Company.

XXVII. Premium Payment in Instalments

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

- For Yearly and single 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.
- During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
- The insured person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” in the event of payment of premium within the stipulated grace Period.
- No interest will be charged If the instalment premium is not paid on due date.
- In case of instalment premium due not received within the grace period, the policy will get cancelled.
- In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

XXVIII. Portability

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

For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

XXIX. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently co\/ered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

XXX. Withdrawal of policy

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

XXXI. Moratorium Period

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

XXXII. 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 effected.

XXXIII. 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. 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.

SECTION 5- GRIEVANCES REDRESSAL PROCEDURE

In case of any grie\lance the insured person may contact the company through via:

•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at.

Escalation Level 1

In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at :
Write to: Bharti AXA General Insurance, Spectrum Towers, 3rd floor, Malad Link Road, Malad (west), Mumbai- 400064

Call: 022-48815939
Email: NGRO@bhartiaxa.com
3rd floor, Spectrum Tower, Rajan Pada
Mindspace, Malad (W), Mumbai - 400 064

Escalation Level 2

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:
Email : CGRO@bhartiaxa.com

Escalation Level 3

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, If Policyholder/ Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.
•Website: www.bharti-axagi.co.in
•Email: customer.service@bhartiaxa.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office
Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI

The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.
Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/
•Website: igms.irda.gov.in
•Email: complaints@irda.gov.in
•Toll Free Number 155255 (or) 1800 4254 732
Fill and send the Complaint Registration Form along with any letter or enclosures, if felt necessary, by post or courier to:

General Manager
Consumer Affairs Department- Grievance Redressal Cell,

Insurance Regulatory and Development Authority of India(IRDAI),
Sy.No.115/1,Financial District, Nanakramguda,
Gachibowli, Hyderabad-500032

The Compliant Registration Form is available for download at http://www.policyholder.gov.in/uploads/CEDocuments/complaintform.pdf

List of Ombudsmen

If Insured person is not satisfied with the redressal of grie\lance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
Refer Link for updated list- http://ecoi.co.in/ombudsman.html

This list has to be included in the policy wording and sales literature:

List and Details of Insurance Ombudsman:

Office Details	
AHMEDABAD – Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048/26652049 Email: bimalokpal.bengaluru@ecoi.co.in
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201/2769202 Fax: 0755 – 2769203 Email: bimalokpal.bhopal@ecoi.co.in	BHUBANESHWAR – Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel: 0674 – 2596461/2596455 Fax: 0674 – 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
CHANDIGARH – Dr. Dinesh Kumar Verma 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	CHENNAI – Shri M. Vasantha Krishna 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.chandigarh@ecoi.co.in	Email: bimalokpal.chennai@ecoi.co.in
DELHI – Shri Sudhir Krishna 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	GUWAHATI – Shri Kiriti B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S. S. Road, Guwahati – 781001 (ASSAM). Tel: 0361 – 2632204/2602205 Email: bimalokpal.guwahati@ecoi.co.in
HYDERABAD - Shri I. Suresh Babu 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	JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	KOLKATA – Shri P.K. Rath 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
LUCKNOW –Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
NOIDA – Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar,	PATNA – Shri N.K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006.

U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	
PUNE – Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in		

SECTION 6: CLAIM SERVICING:

I. Claim Notification - Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured Person/Insured Person's representative to intimate the claim to the Company. The intimation can be given in following ways:

- Toll Free call Centre of the TPA (24x7) - 1800-103-2292
- Toll Free call Centre of the Insurance Company (24x7) - 1800-103-2292
- Login to the website of the Insurance Company and intimate the claim – http://www.bharti-axagi.co.in/contact-us
- Send an email to the TPA/Company- customer.service@bhartiaxa,.com
- Post/courier to TPA/Company - Claims, Bharti AXA General Insurance Company Limited spectrum Tower, 3rd flr, Chincholi Bunder Rd, Rajan Pada, Mindspace, Malad West, Mumbai, Maharashtra 400064

- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 19th Floor, Parinee Crescenzo, G-Block, Bandra Kurla Complex, Opposite MCA Club, Bandra (E), Mumbai - 400051

In all the above, the intimations are directed to a central team for prompt and immediate action.

II. Information Details

When the Insured Person/Insured Person's representative intimate the claim as mentioned above the following information should be given for prompt services.

- Policy number
- Name of the Policyholder/ Insured
- Name of Covered person/Insured member making the claim
- Contact details

- Nature of the Disease, Illness or Injury
- Name and address, phone number of the attending medical practitioner/hospital.
- Date of hospitalization
- The Insured / Insured Person must provide notification of claim within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. The Notification of Claim should be ideally provided by the Insured/Insured Person. In the event Insured / Insured Person is unwell, then the Notification of Claim should be provided by Insured Person's representative.

III. Claim Form

On occurance of any claim under this policy, you are requested to submit completed and duly filled claim form along with other requisite documents. Claim forms will be available with the network hospitals, TPA and Company offices and on its website.

IV. Claim Procedure

- The Company shall be under no obligation to make any payment under this Policy unless all the premium payments are received in full and all payments have been realized.
- The Company will only make payment as per the Policyholder/ Insured's direction. In case of Insured's unfortunate demise, the Company will only make payment to the Nominee (as named in the Policy Schedule/ Certificate of Insurance).
- Unless otherwise specified, This Policy only covers medical treatment taken in India, and payments under this Policy shall only be made in Indian Rupees within India.
- The Company is not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured/ Insured Person could reasonably have minimised the costs incurred, or that is brought about or contributed to by the Insured/ Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
- The Company will process the claims and make claim payments.
- If there is any deficiency in the documents/ information submitted by Insured person, the Company will send the deficiency letter within 7 days of receipt of the claim documents.
- On receipt of the complete set of claim documents to the Company's satisfaction, the Company will send offer of settlement, along with a settlement statement within 30 days to the insured. Payment will be made within 7 days of receipt of acceptance of such settlement offer.

V. Claim Service Guarantee

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, the offer of settlement will be made to the Insured in any case not later than 30 days maximum. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid, The period of 7 days mentioned above is included in the maximum period of claim settlement (30 days) stated above.

VI. Documents

It is the Policy of the Company to seek documents in a single request. Based on documents submitted, if any further documentation is required then it will be sought promptly, at the earliest.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude. Every attempt will be made to keep the process transparent.

VII. Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country.

VIII. Complete Discharge

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

IX. Claim settlement

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

List of documents required for Claims processing:

Sr.No.	Required documents
1	Claim form Part -A & Part - B duly signed along with the attending physician statement
2	Pre-authorization form in cashless claim
3	Discharge summary
4	Hospital final bill

5	Hospital payment receipt in case of reimbursements
6	Medicines bill with doctors prescription
7	Diagnostic reports with doctors prescription

For Reimbursement Claims :

- If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming amount from other organization/provider (which is otherwise not payable under our policy), then on request from the Insured Person, We will provide attested copies of the bills and other documents submitted by the Insured Person along with settlement letter.
- In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, The Company shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider along with settlement letter.

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

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	FLEX I 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	BLANKETS/VARMER 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\SPIRITS 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