

1) Preamble

1.1 WHEREAS the Insured designated in the Schedule to this Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of this contract and shall be deemed to be incorporated herein, has applied to Bharti AXA General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

1.2 NOW THIS POLICY WITNESSETH:

That subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the period as specified in the Schedule to this Policy, the Insured / Insured Person shall contract any disease, illness or sustain any injury and if such disease, illness or injury shall upon the advice of a duly qualified Medical Practitioner require such Insured/Insured Person, to undertake treatment for such disease, illness or injury at any Hospital/ Nursing Home in India as an inpatient, then the Company will pay to the Insured/Insured Person, his /her assignee, or legal representatives, as the case may be, a fixed allowance as compensation in manner, for the period and to the extent of the Sum Insured as specified in this Policy.

2) Definitions

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

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

2.2) "**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.

2.3) "**Condition Precedent**" means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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

2.4.1) **Internal Congenital Anomaly** - which is not in the visible and accessible parts of the body.

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

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

Policy Wordings –

– Smart health Essential Insurance Policy

UIN : BHAHLIP21507V022021

Bharti AXA General Insurance Company Limited, "HOSTO CENTER" 1st Floor No.43, Millers Road. Vasanth Nagar. Opp .Imperial Restaurant. Bangalore -560046 Ph: 1800-103- 2292, CIN: U66030KA2007PLC043362; Website: www.bharti-axa.co.in; IRDA Reg. No: 139, Email: customer.service@bharti-axa.com

2.6) "**Disclosure to information norm**" means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation , mis-description or non-disclosure of any material fact.

2.7) "**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.

2.8) "**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.

2.9) "**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:

2.9.1) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

2.9.2) the patient takes treatment at home on account of non-availability of room in a hospital.

2.10) "**Family**" means the Insured, his/her lawful spouse and maximum of two dependant children upto the age of 23 years.

2.11) "**Hospital**" - A hospital means any institution established for in-patient care and day care treatment of illness and/ or injuries and which has been registered as a hospital with the local authorities under 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:

2.11.1) has qualified nursing staff under its employment round the clock;

2.11.2) 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;

2.11.3) has qualified medical practitioner(s) in charge round the clock;

2.11.4) has a fully equipped operation theatre of its own where surgical procedures are carried out;

2.11.5) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

2.12) "**Hospitalisation**" 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.

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2.13) "**Hospitalisation expenses**" mean expenses on hospitalisation for minimum period of 24 hours incurred in India, which are admissible under this Policy.

2.14) "**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.

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

a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.

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

i) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

ii) it needs ongoing or long-term control or relief of symptoms

iii) it requires your rehabilitation or for you to be specially trained to cope with it

iv) it continues indefinitely

v) it recurs or is likely to come recur

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

2.17) "**Insured**" means the individual who has a permanent place of residence in India and on whose name the Policy is issued. In case of group policies it means the group, organization, institution, firm, society or body corporate engaged in any trade or business in India on whose name the Policy is issued

2.18) "**Insured Person**" means the person named in the Schedule to the Policy, who has a permanent place of residence in India and for whose benefit the insurance is proposed and appropriate premium paid.

2.19) "**Medical Advice**" means Any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up Prescription

2.20) "**Medical Practitioner**" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/Insured Person's family.

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2.21) "**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.

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

2.22) "**Notification of claim**" is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

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

2.24) "**Policy**" means this document of Policy describing the terms and conditions of this contract of insurance including the Company's covering letter to the Insured, if any, the Schedule attached to and forming part of this Policy, the Insured's Proposal Form and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

2.25) "**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.

2.26) "**Pre-existing Disease**" means any condition, ailment, injury or disease:
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

2.27) "**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.

2.28) "**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 all waiting periods.

2.29) "**Subrogation**" mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

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2.30) "**Third Party Administrator (TPA)**" means any organization or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured / Insured Person as well as to the Company for an insurable event.

2.31) "**Schedule**" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

2.32) "**Sum Insured**" means the sum as specified in the Schedule to this Policy against the name of Insured / each Insured Person, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period.

2.33) "**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 or prolongation of life, performed in a hospital or day care centre by a medical practitioner

2.34) "**Terrorism/Terrorist Incident**" means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or the commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

2.35) "**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.

2.36) Double Benefit for ICU/CCU – In case the insured gets admitted in ICU/CCU, the benefits payable shall be double for maximum period of 5 days after first three days.

3) Scope of cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay and/or reimburse the following benefit in manner, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

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In case the Insured / Insured Person is hospitalized for treatment of any disease / illness contracted or injury sustained during the Policy period and if the period of such hospitalisation exceeds more than 3 days, this Policy provides for payment of a daily allowance up to the specified limits as mentioned in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to overall Sum Insured.

Double benefit in case of ICU admission – If the Insured get hospitalized in the ICU, the daily cash benefit will get double. The double cash benefit is paid for 5 days after first three days. This benefit will be applicable for the Plan B and Plan C.

3.1 Additional features

Income Tax Benefit – Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income tax Act.

Renewal Discount - Discount equivalent to 5% of renewal premium every year on a progressive scale will be given back to the Insured as No claim Bonus at the time of renewal, where the Policy which is renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed upto 25%. In case of renewal of a Policy where there is a loss, the Insured will lose the entire Renewal Discount accumulated. This additional benefit is available on the policies taken and renewed with our Company continuously without any break and without any claim.

3.2 Portability and Migration

The insured person will have the option to port the policy to other insurers by applying to such insurer 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

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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For Detailed Guidelines on migration, kindly refer the link

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4) Exclusions

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

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 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 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 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

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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

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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

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iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

G. Change-of-Gendertreatments: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 email, 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

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O. Refractive Error:Code- Excl15

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

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.

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:

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.

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.

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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 OPD treatment unless covered under the policy.

V Treatment taken outside the geographical limits of India

X. Maternity expenses where maternity cover is opted: The benefits will not be available for any condition(s) as defined in the Policy, until 9 months since inception of the first Policy with the Company. In all other cases where maternity benefit cover is not opted, all claims directly or indirectly related to maternity stands excluded always.

5) General conditions

5.1) Duty of Disclosure:

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 by the policyholder.

Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

5.2) Floater Policy:

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period.

5.3) Reasonable Care:

The Insured/Insured Person shall take all reasonable steps to safeguard the interests of the Insured/Insured Person against accidental loss or damage that may give rise to a claim.

5.4) 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.

5.5) Material Change:

The Insured / Insured Person shall immediately notify the Company by fax or in writing of any material change in the risk and cause at his own expense such additional precaution to be taken as circumstances may require to ensure safety thereby containing the circumstances that may give rise to a claim and the Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

5.6) Fraud:

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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 shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

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.

5.7) No Constructive Notice:

Any knowledge or information of any circumstances or condition in connection with the Insured / Insured Person, in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of the premium.

5.8) Notice of Charge

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

5.9) Overriding effect

The terms and conditions contained herein and in the Schedule shall be deemed to form part of the Policy and shall be read as if they are specifically incorporate herein.

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5.10) Electronic Transaction:

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

5.11) Duty of the Insured/Insured person on occurrence of loss:

On the occurrence of loss within the scope of cover under the Policy, the Insured / Insured Person shall:

5.11.1) forthwith file/submit a claim form in accordance with "Claim Procedure" clause.

5.11.2) allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalisation records and to examine the Insured/Insured Person

5.11.3) assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the 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.

5.12) Right to Inspect

If required by the Company, representative of the Company including a Physician appointed in that behalf shall in case of any loss or any circumstances that have given rise to a claim to the Insured/Insured Person be permitted at all reasonable times to examine into the circumstances of such 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 claim or such circumstance in his/her possession including presenting himself 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 will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy. Such examination to certain the claim under the policy will be conducted at insurer's cost.

5.13) Position after a claim

anyone acting on his or her behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this Condition as well as under Condition No 1 of this Policy

5.14 Multiple policies and Contribution:

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- i. 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.
- ii. 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.
- iii. 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.
- iv. 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.

5.15) Forfeiture of claims:

If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided herein, within 12 calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

5.16) Free Look Period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document 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 person, 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;

5.17) 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 for injury sustained or disease contacted during this period.

5.18) Cancellation/Termination:

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

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Period On Risk	Rate Of Premium to be retained
Up to 1 month Up to 3 months	25% of annual rate 50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	100%

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.

ii. 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. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

5.19) Cause of action/Currency of payment:

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian Rupees only.

5.20) 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 Insured and the Company to be subject to Indian law. Each party agrees to be subject to the executive jurisdiction of the High Court of Karnataka and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court within Indian territory.

5.21) 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 two Arbitrators and 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 the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliations Act 1996. It is hereby agreed and understood that no dispute or difference shall be referable to arbitration, as hereinbefore 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

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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.

5.22 Renewal of Policy:

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

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

Withdrawal of Policy

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

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.

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.

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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.

Loading and / or exclusion

We may apply a risk loading on the premium payable and /or exclude an illness / disease (based upon the declarations made in the proposal form, investigation reports and the health status of the persons proposed for insurance). The maximum risk loading applicable for an individual shall not exceed above 100% per diagnosis / medical condition and an overall risk loading of over 150% per person. These loadings are applied from Commencement Date of the policy including subsequent renewal(s) with us or on the receipt of the request of increase in sum insured (for the increased Sum Insured).

We will inform you about the applicable risk loading and / or exclusion. You need to revert to us in writing with consent and additional premium (if any) and exclusion, within 15 days of such information. In case, you neither accept such loading and / or exclusion nor revert to us within 15 days, we shall cancel your application and refund the premium paid within next 7 days. Please note that we will issue policy only after getting your consent.

5.23) Renewal Notice:

The Company shall not be bound to accept any renewal premium or to give notice that such is due. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration hereinbefore mentioned and that nothing is known to the Insured / Insured Person that may result to enhance the risk of the Company. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

5.24) Notices:

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

5.22.1) In case of the Insured / Insured Person, at the address given in the Schedule to the policy.

5.22.2) In case of the Company, to the address as mentioned in the policy schedule /nearest office of the Company.

5.25) Customer Service:

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If at any time the Insured / Insured Person requires any clarification or assistance, the insured/ Insured Person may contact the Policy issuing office or any other office of the Company or the TPA.

5.26) Grievances Redressal:

In case of any grievance the insured person may contact the company through via:

- Website: www.bharti-axagi.co.in
- Email: customer.service@bharti-axa.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 company branches. For updated details of grievance officer, kindly refer the link www.bharti-axagi.co.in

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@bharti-axa.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@bharti-axa.com

Escalation Level 3

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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.

5.27) 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@bharti-axa.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://iqms.irda.gov.in/>

•Website: igms.irda.gov.in

•Email: complaints@irda.gov.in

•Toll Free Number 155255 (or) 1800 4254 732

LIST OF INSURANCE OMBUDSMEN

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If Insured person is not satisfied with the redressal of grievance 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>

Location	Office Details	Jurisdiction of Office, Union Territory, District
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	Gujarat, Dadra & Nagar Haveli, Daman and Diu
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	Karnataka
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	Madhya Pradesh Chattisgarh
Bhubaneshwar	Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455	Odisa

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	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 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
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.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
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	Delhi
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	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

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Hyderabad	<p>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</p>	<p>Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry</p>
Jaipur	<p>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</p>	<p>Rajasthan</p>
Ernakulam	<p>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</p>	<p>Kerala, Lakshadweep, Mahe-a part of Pondicherry</p>
Kolkata	<p>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</p>	<p>West Bengal, Sikkim, Andaman & Nicobar Islands</p>

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<p>Lucknow</p>	<p>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</p>	<p>Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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</p>
<p>Mumbai</p>	<p>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</p>	<p>Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane</p>
<p>Noida</p>	<p>Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in</p>	<p>State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur</p>

Policy Wordings –

– Smart health Essential Insurance Policy

UIN : BHAHLIP21507V022021

Bharti AXA General Insurance Company Limited, "HOSTO CENTER" 1st Floor No.43, Millers Road. Vasanth Nagar.

Opp .Imperial Restaurant. Bangalore -560046 Ph: 1800-103- 2292, CIN: U66030KA2007PLC043362; Website:

www.bharti-axagi.co.in; IRDA Reg. No: 139, Email: customer.service@bharti-axa.com

Patna	Shri N. K. Singh 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	Bihar, Jharkhand
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	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

6.1) Claims notification - Multi Model Intimation

It is the endeavor of Company to give multiple options to the Insured/covered person/patient's care taker to intimate the claim to the Third party administrator (TPA)/Company. The intimation can be given in following ways:

- 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@bharti-axa.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.

Information Details

When the insured/covered person/patient's care taker intimate the claim as mentioned above the following information should be kept handy for prompt services.

- Policy number
- Name of the Insured/Covered person
- Contact details
- Nature of the disease, illness or injury
- Name and address of the attending medical practitioner/hospital

Claim Form

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Upon the notification of the claim the Company will dispatch the claim form to the Insured/Covered person. Claim forms will also be available with the network hospitals and Company offices.

6.2) Claim procedure

- All reimbursement claims should be intimated to TPA/Insurance company within 7 days from date of discharge.
- Insured/covered person admitted can send the claim documents to the TPA/ Company for the reimbursement within 30 days from the date of discharge.

6.3) Documents

It is the policy of the Company to seek documents in a single shot. If any further documentation is required then it will be sought promptly. 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.

6.4) Repudiations

The power to repudiate claims is vested in the Corporate office to ensure transparency and standardization across the country. This is also with a view to keep the guidelines of regulator in mind. In the unfortunate event of repudiation, the retail customers will be informed of the existence of forums for grievance redressal.

6.5) Checklist of documents for settling Claims:

- Claim form duly signed along with attending physician Statement
- Discharge summary
- Copy of hospital final bill

Claim Settlement (provision for Penal Interest)

1. 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.

2. 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.

3. 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.

4. 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.

Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due

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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.

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