Policy Terms & Conditions

1. **Preamble:** The proposal and declaration given by the proposer and other documents if any shall form the basis of this Contract and is deemed to be incorporated herein. The two parties to this contract are the Policy Holder / Insured Members and Care Health insurance Ltd. (also referred as Company), and all the Provisions of Indian Contract Act, 1872, shall hold good in this regard. The references to the singular include references to the plural; references to the male include the references to the female; and references to any statutory enactment include subsequent changes to the same and vice versa. The sentence construction and wordings in the Policy documents should be taken in its true sense and should not be taken in a way so as to take advantage of the Company by filing a claim which deviates from the purpose of Insurance.

In return for premium paid, the Company will pay the Insured in case a valid claim is made:

In consideration of the premium paid by the Policy Holder, subject to the terms & conditions contained herein, the Company agrees to pay/indemnify the Insured Member(s), the amount of such expenses that are reasonably and necessarily incurred up to the limits specified against respective benefit in any Cover Period.

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other benefits, various procedures and conditions which have been built-in to the product are to be construed in accordance with the applicable provisions contained in the product.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate

2. Definitions

2.1. Standard Definitions:

2.1.1 **Accidental / Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.1.2 **Any One Illness (not applicable for Travel and Personal Accident Insurance)** means a continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where the treatment was taken.

2.1.3 **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such 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.

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

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

I. Having at least 5 in-patient beds;
II. Having qualified AYUSH Medical Practitioner in charge round the clock;
III. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

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

2.1.5 **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.

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

2.1.7 **Congenital Anomaly**

Congenital Anomaly means a condition(s) 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

2.1.8 **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 claim amount. A co-payment does not reduce the Sum Insured

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

2.1.10 **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

2.1.11 **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:

i. undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24hours because of technological advancement, and
ii. which would have otherwise required a Hospitalization of more than 24 hours.

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

2.1.12 **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.

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

2.1.14 **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

2.1.15 **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

ii. The patient takes treatment at home on account of non-availability of a room in a Hospital.

2.1.16 **Emergency care (Emergency)** 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 Member's health.

2.1.17 **Grace Period** means the specified period of time immediately following the premium due date during which 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.

2.1.18 **Hospital (not applicable for Overseas Travel Insurance)** 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 Company's authorized personnel.

2.1.19 **Hospitalization** (not applicable for Overseas Travel Insurance) 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.

2.1.20 **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.

2.1.21 **Illness** means a sickness or a disease or a 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:

(a) It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests;

(b) It needs ongoing or long-term control or relief of symptoms;

(c) It requires rehabilitation for the patient or for the patient to be specially trained to cope with it;

(d) It continues indefinitely;

(e) It recurs or is likely to recur.

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

2.1.23 **In-patient Care** (not applicable for Overseas Travel Insurance)means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.1.24 **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.

2.1.25 **Maternity Expense/Treatment** shall include—

i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

ii. expenses towards lawful medical termination of pregnancy during the Policy Period.

2.1.26 **Medical Advice** means any consultation or advice from a Medical Practitioner including issue of any prescription or follow-up prescription.

2.1.27 **Medical Expenses** means those expenses that an Insured Member 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 Member had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

2.1.28 **Medically necessary treatment** (not applicable for Overseas Travel Insurance) 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 Member;

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.

2.1.29 **Medical Practitioner** (not applicable for Overseas Travel Insurance) means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

2.1.30 **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.

2.1.31 **Network Provider** (not applicable for Overseas Travel Insurance) means the Hospitals enlisted by an insurer, TPA or jointly by a TPA and insurer to provide medical services to an Insured by a Cashless Facility.

2.1.32 **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.

2.1.33 **Non-Network means** any Hospital, Day Care Centre or other provider that is not part of the network.

2.1.34 **Notification of Claim (Intimation)** means the process of intimating a Claim to the insurer or TPA through any of the recognized modes of communication.

2.1.35 **Out-Patient Treatment (OPD Treatment)** means the one in which the Insured Member 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 Member is not admitted as a day care or in-patient.

2.1.36 **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.

2.1.37 **Post-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the insurance Company.

2.1.38 **Pre-existing Diseases** (not applicable for Overseas Travel Insurance) means any condition, ailment, Injury or disease

I. 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

II. 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 insurer or its reinstatement.

2.1.39 **Pre-hospitalization Medical Expenses** means Medical Expenses incurred during pre-defined number of days preceding the Hospitalization of the Insured Person, provided that :

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.1.40 **Qualified Nurse** (not applicable for Overseas Travel Insurance) means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.1.41 **Reasonable and Customary Charges** (not applicable for Overseas Travel Insurance) 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.

2.1.42 **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.

2.1.43 **Room Rent** mean the amount charged by a Hospital towards Room & Boarding expenses and shall include associated Medical Expenses.

2.1.44 **Subrogation** (Applicable to other than Health Policies and health sections of Travel and PA policies) means the right of the insurer to assume the rights of the Insured Member to recover expenses paid out under the Policy that may be recovered from any other source.

2.1.45 **Surgery/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 a Day Care Centre by a Medical Practitioner.

2.1.46 **Unproven/Experimental Treatment** means a treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

2.2. Specific Definitions:

2.2.1 **Age** means the completed age of the Insured Member as on his last birthday

2.2.2 **Annexure** means the document attached and marked as Annexure to this Policy

2.2.3 **Break in Policy** occurs at the end of the existing Policy term, when the premium due date for Renewal on a given policy is not paid on or before the premium Renewal date or within 30 days thereof.

2.2.4 **Certificate of Insurance** means the certificate the Company issues to an Insured Member evidencing cover under the Policy.

2.2.5 **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of specified benefits in respect of the Insured Member as covered under the Policy.

2.2.6 **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.

2.2.7 **Company (also referred as Insurer/We/Us)** means the Care Health Insurance Limited.

2.2.8 **Cover End Date** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy expires.

2.2.9 **Cover Period** means the period commencing from the Cover Start Date and ending on the Cover End Date for each Insured Member as specified in Annexure 'A' (Certificate of Insurance).

2.2.10 **Cover Start Date:** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy commences.

2.2.11 **Family** means a unit comprising of husband, wife, dependent parents, dependent parents-in-law and maximum of three dependent children and who is named in the Certificate of Insurance as an Insured Member.

2.2.12 **Hazardous Activities** mean any sport or activity, which is potentially dangerous to the Insured Member whether he is trained or not. Such sport/activity includes racing and competition or stunt activity of any kind, adventure racing, base jumping, biathlon, big game hunting, rafting of any kind, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, vave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling of any kind and activities of similar nature.

2.2.13 **Indemnity/Indemnify** means compensating the Insured Person up to the extent of Expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the Insurance Cover.

2.2.14 **Insured Event** means an event that is covered under the Policy; and which is in accordance with the Policy Terms & Conditions.

2.2.15 **Insured Member (Insured/Insured Person)** means a member whose name specifically appears under Insured in the Certificate of Insurance and is a covered group member.

2.2.16 **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize, reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

2.2.17 **Nominee** means the person named in the Policy Schedule or as declared with the Policyholder who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Insured Person is deceased.

2.2.18 **Policy** means these Policy Terms & Conditions, the Proposal Form/data sheet, Policy Schedule and Annexures which form part of the policy contract and shall be read together.

2.2.19 **Policy Schedule** is a certificate attached to and forming part of this Policy.

2.2.20 **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof.

2.2.21 **Policyholder** also referred as You) means the member or entity, who is the Group Administrator and named in the Policy Schedule as the Policyholder.

2.2.22 **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Schedule

2.2.23 **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Schedule.

2.2.24 **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Schedule.

2.2.25 **Primary Insured Member** means a member of the group who satisfies and continues to satisfy the eligibility criteria as specified in Policy Schedule and who is named in Annexure 'A' (Certificate of Insurance) to the Policy as an Insured Member.

2.2.26 **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.

2.2.27 **Sum Insured (Coverage Amount)** means the amount specified in the Policy Schedule which represents the company's maximum, total and cumulative liability for that Insured Member for any and all Claims incurred in respect of that Insured Member during the Cover Year.

Whereas in case of Floater, **Sum Insured** means the amount specified in the Policy Schedule which represents the company's maximum, total and cumulative liability for all Insured Members for any and all Claims incurred during the Cover Year.

2.2.28 **TPA or Third Party Administrator**, means a company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under IRDAI (TPA-Health Services) Regulations as amended from time to time.

2.2.29 **Associate Medical Expenses** means those Medical Expenses as listed below :

(a) Room, boarding, nursing and Operation theatre expenses as charged by the Hospital where the Insured Member availed medical treatment

(b) Fees charged by surgeon, anesthetist, Medical Practitioner

Note: Associate Medical Expenses are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

3. Scope of Cover

General Conditions applicable to all Base Benefit and Optional Benefit:

a) In case, any claim is paid for Primary Insured Member or his/her spouse under Base Benefit 2(Accidental Death), Base Benefit 3(Permanent Total Disablement) coverage for that Insured Member under this benefit shall terminate for that Cover Year.

b) Option of Mid-term inclusion of a Member in the Policy will be only upon marriage or childbirth.

c) Coverage under Base Benefit 2(Accidental Death), Base Benefit 3 (Permanent Total Disablement) and Base Benefit 4 (Permanent Partial Disablement) is available for Spouse only if Primary Insured Member is covered under that Base benefit and are available on Individual basis

d) All Claims shall be payable subject to the terms, conditions, wait periods and exclusions of the Policy and subject to availability of the Coverage amount against each and every Base Benefit or Optional Benefit

e) Customer has to choose atleast one of the Base Benefits mandatorily

f) If Base Benefit 1 (Hospitalization Expenses) is opted then only Optional Benefit 2 (Waiver of Initial Waiting period), Optional Benefit 3 (Waiver of Maternity Waiting period), Optional Benefit 4 (Modification of Pre & Post Hospitalization Medical Expenses), Optional Benefit 5 (Modification of Maternity Expenses), and Optional Benefit 7 (Room Rent Modification) can be opted. If Base Benefit 2(Accidental Death) and/or Base Benefit 3 (Permanent Total Disablement) and/or Base Benefit 4 (Permanent Partial Disablement) is opted then only Optional Benefit 1 (Accidental hospitalization) can be opted. Coverage under Optional Benefit 6 (Daily Cash Allowance) can be opted only if Base Benefit 1 (Hospitalization Expenses) or Optional Benefit 1 (Accidental Hospitalization) is opted for

g) Admissibility of a Claim under Base Benefit 1 (Hospitalization Expenses) is a pre-condition to the admission of a Claim under Optional Benefit 4 (Modification of Pre & Post Hospitalization Expenses) and Optional Benefit 6 (Daily Cash Allowance), Optional Benefit 7 (Room Rent Modification). Similarly admissibility of a Claim under Optional Benefit 1 (Accidental Hospitalization) is a pre-condition to the admission of a Claim under Optional Benefit 6 (Daily Cash Allowance)

h) The maximum, total and cumulative liability of the Company towards an Insured Member(s), for any and all Claims arising under this Policy during the Cover Year, on occurrence of an insured event in relation to that Insured Member, shall not exceed the Coverage Amount of that Insured Member which is specified against every Base Benefits /Optional Benefit , mentioned in the Policy Schedule

i) Under this Product, the Company will provide Policy Schedule to Policyholder and access of Certificate of Insurance will be provided to each Insured Member, therefore the references to the 'Policy Schedule' shall include references to the 'Certificate of Insurance'

3.1. Base Benefit 1: Hospitalization Expenses

If an Insured Member is diagnosed with an Illness or suffers an Injury (including pre-existing diseases covered from the inception of the Policy subject to exclusions as per Clause-4) which requires the Insured Member to be admitted in a Hospital in India, which should be Medically Necessary, during the Cover Year and while the Policy is in force for:

3.1.1 In-patient Care

The Company will indemnify the Insured member for Medical Expenses incurred on Hospitalization up to the Coverage amount specified in the Certificate of Insurance provided that the Hospitalization is for a minimum period of 24 consecutive hours and was on the advice of a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were necessarily incurred.

3.1.2 Day Care Treatment

The Company will indemnify the Insured member for Medical Expenses incurred on Day Care Treatment up to the Coverage amount specified in the Certificate of Insurance provided that:

a) the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions; and
b) the period of treatment of the Insured Member in a Hospital does not exceed 24 hours; and
c) the Day Care Treatment was taken on the advice of a Medical Practitioner; and
d) the Medical Expenses incurred are Reasonable and Customary Charges that were necessarily incurred.

Note: Advanced Technology Methods

The Company will indemnify the Insured Member for medical expenses incurred under 'In-patient Care' and 'Day Care Treatment' for treatment taken through following advance technology methods:

a. Uterine Artery Embolization and HIFU
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy- Monoclonal Antibody to be given as injection
f. Intra vitreal injections
g. Robotic surgeries
h. Stereotactic radio surgeries
i. Bronchical Thermoplasty
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM - (Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

Conditions applicable for Hospitalization Expenses (Base Benefit 1):

(a) Room/Boarding and nursing expenses as charged by the Hospital where the Insured Member availed medical treatment (Room Rent / Room Category):

If the Insured Member is admitted in a Hospital room where the Room Category opted or *Room Rent incurred is higher than the eligible Room Category/ Room Rent* as specified in the Certificate of Insurance, then,

I. The Insured Member shall bear the ratable proportion of the total Associate Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Certificate of Insurance or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

The Certificate of Insurance will specify the eligibility of Room Rent or Room Category applicable for the Insured Member under the Policy as follows:

1) If the Certificate of Insurance states 'up to 1% of the Coverage Amount per day' as eligible Room Rent, it means the maximum eligible Room Rent of the Insured Member payable by the Company is limited to 1% of the Coverage Amount per day of Hospitalization.

2) The nomenclature of Room categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the Rooms mentioned in the Policy.

(b) <u>Intensive Care Unit Charges (ICU Charges):</u>

The Certificate of Insurance will specify the Limit of ICU Charges applicable for the Insured Member under the Policy. The ICU Charges available under this Policy are as follows:

1) If the Certificate of Insurance states 'up to 2% of the Coverage Amount per day' as eligible ICU Charges per day of Hospitalization, it means the maximum eligible ICU charges of the Insured Member payable by the Company is limited to 2% of the Coverage Amount per day of Hospitalization.

3.1.3 Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses

a) The Company will indemnify the Medical Expenses up to the Coverage amount specified in the Certificate of Insurance provided that is incurred for the Insured Member:

i. As Pre-hospitalization Medical Expenses, for a period of 1 day immediately prior to the Insured Member's date of admission to the Hospital provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were incurred before the Cover Start Date unless it is continuation of Policy for the Insured
ii. As Post-hospitalization Medical Expenses, for a maximum period of 5 days immediately following the date of the Insured Member's discharge from Hospital.

Provided that the Medical Expenses relate to the Illness/Injury for which the Company has accepted the Insured Member's Claim and which falls within the Cover Year.

b) If the provisions of Clause 6.6(c) Payment terms is applicable to a Claim, then:
i. The date of admission to Hospital for the purpose of this Benefit shall be the date of the first admission to the Hospital for the Illness deemed or Injury sustained to be Any One Illness; and
ii. The date of discharge from Hospital for the purpose of this Benefit shall be the last date of discharge from the Hospital in relation to the Illness deemed or Injury sustained to be Any One Illness.

3.1.4 Maternity Expenses:

The Company will indemnify for the Medical Expenses incurred in respect of the Hospitalization of the Insured Member up to the Coverage amount during the Cover Year for treatment taken in a Hospital arising from pregnancy including Normal Delivery / Caesarean/ Miscarriage and / or abortion induced by accident or other medical emergency.

Specific Conditions applicable to this Benefit:

i. The Company shall be liable to make payment under this Benefit, only if the Insured Member who has delivered the child is the Primary Insured Member or the Primary Insured Member's spouse and over the age of eighteen (18) years of age.
ii. Claims under this benefit are admissible only after the completion of waiting period of 9 months. The wait period shall start from the Cover Start Date or on attaining age of 18 years, whichever is later.
iii. Coverage under this Benefit is not available in case the Insured Member's age is greater than 45 years at the time of Cover start date
iv. The Company shall cover pre-natal and post-natal expenses under this benefit, provided that the condition necessitates treatment in a Hospital and the Insured Member is hospitalized.
v. Claim in respect of only first two living children will be considered in respect of any one insured member covered under the policy or any renewal thereof.
vi. Congenital Diseases (internal & external) of new born child is covered under this Benefit.
vii. Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit except induced by accident or other medical emergency to save the life of mother.
viii. Clause 4.1.2 (xv) under Exclusions is superseded to the extent covered under this Benefit.

3.1.5 Reinstatement of Coverage Amount:

a) If a Claim is paid under the Policy, then the Coverage amount for all Insured Members will be reinstated once for that Cover Year, provided that:
   i. The Reinstated amount shall be utilized only after the Coverage amount has been completely exhausted in that Cover Year.
   ii. Reinstatement of Coverage amount is applicable only for Benefit 3.1.1, Benefit 3.1.2, Benefit 3.1.3 and Benefit 3.1.4.
   iii. The Reinstated amount shall be available only for all future Claims and not in relation to any Illness or Injury for which a Claim has already been admitted for that Insured Member during that Cover Year.
   iv. Any unutilized Reinstated amount cannot be carried forward to any subsequent Cover Year.
   v. If the Policy is issued on a Floater basis, then the Reinstatement will also be available only on Floater basis.
   vi. The balance of the Reinstated amount shall be available during the Cover Year till it is exhausted completely.

3.2. Base Benefit 2: Accidental Death

a) If the Primary Insured Member and/or his/her Spouse suffers an Injury during the Cover Year, which directly results in the Primary Insured Member's and/or his/her Spouse death within 12 months from the date of Accident (including date of Accident), the Company will pay the Coverage amount as specified in the Certificate of Insurance against this Benefit to the Primary Insured Member and/or his/her Spouse (or Nominee or Legal Heir)

b) **Documents to be submitted for any Claim under 'Accidental Death':**
It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Documents as specified in Clause 6.3.
ii. Medical reports giving the details of the Accident, nature of Injury and the details of treatment provided, Admission and Death Summary, Accident Report
iii. Original Death Certificate
iv. Post Mortem Report(if applicable), Inquest Panchnama Report issued by the Police(if applicable), F.I.R (First Information Report) (if applicable)
v. Legal Heir Certificate or Succession Certificate (if no nomination has been made)
vi. Investigation Reports (Lab tests, X-Ray, MRI, etc.), Medical Bills and Cash receipts
vii. Chemical Analysis Report (if available), Newspaper cutting (if available)
viii. Bank details of the claimant seeking compensation

3.3. Base Benefit 3: Permanent Total Disablement

a) If the Primary Insured Member and/or his/her Spouse suffers an Injury during the Cover Year, which directly results in any of the following Insured Events within twelve calendar months of the occurrence of the Injury, the company will pay the amount specified against this Benefit in the Certificate of Insurance:

S.No	Insured Events	Amount payable = % of the Base Benefit 3 Coverage Amount specified in the Certificate of Insurance
1	i. Total and irrecoverable loss of sight of both eyes, or speech or hearing of both ears or ii. Actual loss by physical separation of two entire hands or two entire feet or One entire hand and one entire foot or iii. Total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot	100%
2	Paraplegia or Quadriplegia or Hemiplegia	100%

b) For the purpose of this Benefit only:

(i) "Hemiplegia" means complete and irrecoverable paralysis of the arm, leg, and trunk on the same side of the body;
(ii) "Paraplegia" means complete and irrecoverable paralysis of the whole of the lower half of the body (below waist) including both the legs;
(iii) "Quadriplegia" means complete and irrecoverable paralysis of all four limbs.

Notes:

1) Physical separation of a hand or foot shall mean separation of the hand at or above the wrist and of the foot at or above the ankle.
2) Total loss of functional use of a body part or organ has continued for at least 180 days from the onset of such disability and the Company is satisfied that there is no reasonable medical hope of improvement.

Insured Event means an event that is covered under the Policy and which is in accordance with the Policy Terms & Conditions.

c) **Documents to be submitted for any Claim under 'Permanent Total Disablement':**

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Documents as specified in Clause 6.3
ii. Disability Certificate issued by CMO (Chief Medical Officer) as appointed by the Hospital Authorities
iii. Accident Report, Copy of F.I.R (First Information Report) (if applicable)
iv. Details of treatment taken by the patient/injured after accident, Medical Bills and Cash receipts, Investigation Reports (Lab tests, X-Ray, MRI, etc.)
v. Admission/Discharge summary
vi. A newspaper cutting about accident (if available)
vii. Bank details of the claimant seeking compensation.

3.4. Base Benefit 4: Permanent Partial Disablement

a) If the Primary Insured Member and/or his/her Spouse suffers an Injury during the Cover Year, which directly results in any of the following Insured Events within twelve calendar months of the occurrence of the Injury, the company will pay the amount specified against this Benefit in the Certificate of Insurance:

Sr. No.	Insured Events	Amount payable = % of the Base Benefit 4 Coverage Amount specified in the Certificate of Insurance
I	Total and irrecoverable loss of hearing in: -	
	a) Both ears	75%
	b) One ear	20%
II	Loss of toes	
	a) All	20%

	b) Both phalanges of great toes bilateral	5%
	c) Both phalanges of one great toe	2%
	d) Both phalanges of other than great toes for each toe	1%
III	Loss of four fingers and thumb of one hand	40%
IV	Loss of four fingers of one hand	35%
V	Loss of thumb	
	a) both phalanges	25%
	b) one phalanx	10%
VI	Loss of index finger	
	a) three phalanges	10%
	b) two phalanges	8%
	c) One phalanx	4%
VII	Loss of middle finger	
	a) three phalanges	6%
	b) two phalanges	4%
	a) One phalanx	2%
VIII	Loss of ring finger	
	a) three phalanges	5%
	b) two phalanges	3%
	c) One phalanx	2%
IX	Loss of little finger	
	a) three phalanges	4%
	b) two phalanges	3%
	c) One phalanx	2%
X	Loss of metacarpus	
	first or second	3%
	third, fourth or fifth	2%
XI	Permanent partial disablement not otherwise provided for under Sr. No. I to X inclusive.	Percentage of the Coverage Amount will be determined in accordance with the medical assessment carried out by the Medical Practitioner provided that the percentage under Insured Event Sr. No. XI shall not exceed 50% of the Coverage Amount

Notes:

For the purpose of Insured Events II to X, loss means either actual physical separation or total and irrecoverable loss only.

It is further agreed that in case of multiple events, the Company's maximum liability shall not exceed the amount specified against this benefit.

Insured Event means an event that is covered under the Policy and which is in accordance with the Policy Terms & Conditions.

b) **Documents to be submitted for any Claim under 'Permanent Partial Disablement':**

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Documents as specified in Clause 6.3
ii. Disability Certificate issued by CMO (Chief Medical Officer) as appointed by the Hospital Authorities
iii. Accident Report, Copy of F.I.R (First Information Report) (if applicable)
iv. Details of treatment taken by the patient/injured after accident, Medical Bills and Cash receipts, Investigation Reports (Lab tests, X-Ray, MRI, etc.)
v. Admission/Discharge summary
vi. A newspaper cutting about accident (if available)
vii. Bank details of the claimant seeking compensation.

3.5. Optional Benefit 1: Accidental Hospitalization

In case any Claim is made of any Injury due to an Accident during the Cover Year as in-patient/Day care, the Company shall indemnify the medically necessary expenses incurred by Insured Member, as specified in Certificate of Insurance

Note: This benefit can be opted only if either of Accidental Death or Permanent Total Disablement or Permanent Partial Disablement benefit is opted for

3.6. Optional Benefit 2: Waiver of Initial Waiting Period

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to waive off the 'Initial Waiting Period' of 30 days subject to all provisions stated in clause 4.1.1 holds true for this clause 3.6 as well

3.7. Optional Benefit 3: Waiver of Maternity Waiting Period

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to waive off the 'Maternity Waiting Period' of 9 months subject to all provisions stated in clause 4.2.1 holds true for this clause 3.7 as well

3.8. Optional Benefit 4: Modification of Pre & Post Hospitalization Medical Expenses

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to modify the Duration as specified against this Benefit in the Certificate of Insurance subject to all provisions stated in clause 3.1.3 holds true for this clause 3.8 as well

3.9. Optional Benefit 5: Modification of Maternity Expenses

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to modify the Coverage amount under 'Maternity Expenses' as specified

against this Benefit in the Certificate of Insurance subject to all provisions stated in clause 3.1.4 holds true for this clause 3.9 as well

3.10. Optional Benefit 6: Daily Cash Allowance

The Company will pay *a fixed amount,* as specified against this Optional Benefit in the Certificate of Insurance, for each continuous and completed period of 24 hours of Hospitalization of an Insured Member, subject to the conditions specified below:

(i) The Company shall not be liable to make payment under this Optional Benefit until the deductible (in no. of days) opted (as specified in the Certificate of Insurance) is exhausted

(ii) The Company is liable to make payment under this Optional Benefit up to a maximum 30 days in a Cover Year

(iii) This Benefit is valid only for that Insured Member subject to claim admissibility under Base Benefit 1 (Hospitalization Expenses) or Optional Benefit 1 (Accidental Hospitalization).

3.11. Optional Benefit 7: Room Rent Modification

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to the following under this Policy:

a) Non-ICU Room Category:

The Company agrees to make payment for Medical Expenses incurred under Non-ICU room category of Base Benefit 1 (Hospitalization expenses) shall be limited to the percentage (%) of the Coverage Amount per day or No Sub-limit as specified in Certificate of Insurance

b) ICU Room Category:

The Company agrees to make payment for Medical Expenses incurred under ICU room category of Base Benefit 1 (Hospitalization expenses) shall be limited to twice the percentage (%)opted for Non ICU Room Category of the Coverage Amount per day as specified in the Certificate of Insurance.

Note: No Sub-limit for Coverage Amount if No sub-limit is opted under Non ICU Room Category

4. Exclusions

4.1. Standard Exclusions

1. Waiting Periods:

30-day waiting period- (Code- Excl03) (applicable only for Base Benefit 1 (Hospitalization Expenses))

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 Member has Continuous Coverage for more than twelve months.

c. The referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

Note: The Waiting Period as defined above shall be applicable individually for each Insured Member and Claims shall be assessed accordingly.

2. Permanent Exclusions:

Any Claim of an Insured Member for the complications arising due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy Terms and conditions.

i. 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.

ii. 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.

iii. Obesity/ Weight Control: (Code- Excl06)

Expenses related to the surgical treatment of obesity that does not fulfill 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

iv. 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.

v. 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.

vi. 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.

vii. 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.

viii. 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.

Note: Refer Annexure – II of the Policy Terms & Conditions for list of excluded hospitals.

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

x. 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)**

xi. 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)**

xii. Refractive Error: (Code- Excl15)

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

xiii. 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.

xiv. 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

xv. Maternity: (Code Excl18)

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

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

4.2. Specific Exclusions:

1. Waiting Period:

Maternity wait period (applicable only for Benefit 3.1.4- Maternity Expenses of Base Benefit 1 (Hospitalization Expenses))

a. Claims will not be admissible for any expenses incurred for diagnosis / treatment related to any Maternity Expenses until 9 months since the inception of the first Policy with the company.

b. This exclusion shall not, however, apply if the Insured Member has Continuous Coverage for more than twelve months.

Note: The Waiting Period as defined above shall be applicable individually for each Insured Member and Claims shall be assessed accordingly.

2. Permanent Exclusions:

Any Claim of an Insured Member for the complications arising due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

i. Any condition or treatment as specified in List of Non-Medical Items (Annexure – II to Policy Terms & Conditions).

ii. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

iii. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability.

iv. 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.

v. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of intoxicating drugs and alcohol or hallucinogens.

vi. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.

vii. 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:

I 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.

II 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.

III 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.

viii. Any condition caused by or associated with any sexually transmitted disease except arising out of HIV.

ix. Charges incurred in connection with cost of routine eye, and ear examinations,, spectacles and contact lens, hearing aids, laser surgery for correction of refractory errors, dentures, artificial teeth and all other similar external appliances and/or devices whether for diagnosis or treatment.

x. Expenses related to any kind of Advance Technology Methods other than mentioned in Base Benefit 1.

xi. Any expenses incurred on prosthesis, corrective devices, external durable medical / Non-medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.

xii. Screening, counseling or treatment of any external Congenital Anomalies or Illness or defects or anomalies or treatment relating to external birth defects. However, Congenital Diseases (internal & external) of new born child shall be covered during the currency of the policy only.

xiii. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

xiv. Any Dental treatment, Aesthetic treatment, or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury or disease which requires hospitalization for treatment and mentioned in Annexure-I (List of Day Care Procedures).

xv. All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment).

xvi. Any expense unless forming part of treatment for injury or disease as certified by the attending Physician.

xvii. All expenses related to donor treatment, including surgery to remove organs from the donor, in case of transplant surgery.

xviii. Non-allopathic treatment

xix. Any OPD Treatment.

xx. Treatment received outside India.

xxi. Expenses incurred for Artificial life maintenance, including life support machine use, post confirmation of vegetative state or brain dead by treating medical practitioner where such treatment will not result in recovery or restoration of the previous state of health under any circumstances.

xxii. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

xxiii. Expenses related to any kind of RMO charges, service charge, surcharge, night charges levied by the Hospital under whatever head.

xxiv. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.

4.3. Additional Exclusions applicable to Accidental Death, Permanent Total Disablement, Permanent Partial Disablement

Any Claim in respect of Primary Insured Member and/or his/her Spouse for the complications arising due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

i. Any pre-existing injury or disability;

ii. An Insured Member operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or Scheduled Airline or any airline personal;

iii. An Insured Member flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;

iv. Sexually transmitted conditions, mental or nervous conditions, insanity, disorder or depression.

v. Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor;

vi. Training for or participating in professional sport of any kind;

vii. The Primary Insured Member and/or his/her Spouse serving in any branch of the military, navy, air force or any branch of armed forces or any paramilitary forces;

viii. Primary Insured Member and/or his/her Spouse working in or with mines, tunneling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs or ship crew services or as jockeys or circus personnel

or aerial photography or engaged in any Hazardous Activities as specified under Clause 2.2.12.

ix. Impairment of the Primary Insured Member's and/or his/her Spouse intellectual faculties by abuse of stimulants or depressants or by the illegal use of any solid, liquid or gaseous substance;

x. Resulting due to any disease or infection except where such condition arises directly as a consequence of an accident during the Cover Year.

xi. Persons whilst working with in activities like racing on wheels or horseback, winter sports, canoeing involving white water rapids, any bodily contact sport.

xii. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).

xiii. Treatments rendered by a Doctor who shares the same residence as an Insured Member or who is a member of an Insured Member's family.

xiv. As a result of any curative treatments or interventions that the Insured Member has carried out or have carried out on the Insured Member's body.

5. General Terms and Clauses

5.1 Standard General Terms & Clauses:

5.1.1 Disclosure of Information

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

Note:

a. "Material facts" for the purpose of this clause 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.

b. In continuation to the above clause the Company may also adjust the scope of cover and / or the premium paid or payable, accordingly.

5.1.2 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.

5.1.3 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 valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.1.4 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate .

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the 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 the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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.

5.1.5 Multiple Policies

a) In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the 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.

b) 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.

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

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

5.1.6 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims 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 a insurance Policy:-

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

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

(c) Any other act fitted to deceive; and

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

The Company shall not repudiate the 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.

5.1.7 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 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

5.1.8 Cancellation / Termination

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

Refund % to be applied on premium received

Cancellation date from Cover Start Date	Policy Tenure – 1 Year
Up to 1 month	75.0%
1 month to 3 months	50.0%
3 months to 6 months	25.0%
6 months to 12 months	0.0%

b) 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.

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

Notes:
In case of demise of the Policyholder,

(i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded (exclusive of taxes) for the unexpired period of this Policy at the short period scales subject to no claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy

(ii) Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:

I. Written notice in this regard is given to the Company before the Policy Period End Date; and

II. A person over Age 18 who satisfies the Company's criteria to become a Policyholder.

5.1.9 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 cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

5.1.10 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.

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

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

5.1.12 Portability

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.careinsurance.com/other-disclosures.html

5.1.13 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 atleast 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

For Detailed Guidelines on Migration, kindly refer the link: https://www.careinsurance.com/other-disclosures.html

5.1.14 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.

5.1.15 Redressal of Grievances

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

Website: www.careinsurance.com
Toll free: 1800-xxx-xxxx
E-mail: customerfirst@careinsurance.com
Courier: Any of 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

Care Health Insurance Limited,
Unit No. 604 - 607, 6th Floor, Tower C,
Unitech Cyber Park, Sector-39,
Gurgaon, Haryana – 122001
For updated details of grievance officer, kindly refer the link https://www.careinsurance.com/customer-grievance-redressal.html

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.
Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms. irda.qov. in/

Note: The Contact details of the Insurance Ombudsman offices have been provided as Annexure IV.

5.2 Specific General Terms & Clauses:

5.2.1 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder/ Insured Member shall immediately notify the Company in writing of any material change in the risk on account of change in occupation or business of any Insured Member at his own expense. The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

5.2.2 Records to be maintained

The Policyholder and Insured Member shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Member shall furnish such information as the Company may require under this Policy at any time during the Policy Period or Cover Period or until final adjustment (if any) and resolution of all Claims under this Policy.

5.2.3 No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Member which is in possession of the Company other than that

information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

5.2.4 Free Look Period

a. The Policyholder/Insured may, within 15 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.
b. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.
c. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

5.2.5 Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

5.2.6 Limitation of liability

Any Claim under this Policy for which the notification or intimation of Claim is received after 12 calendar months of the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder/Insured Member proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond its/his control.

5.2.7 Communication

a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule/ Certificate of Insurance. Any communication meant for the Policyholder or Insured Member will be sent by the Company to his last known address or the address as shown in the Policy Schedule/ Certificate of Insurance.
b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule/ Certificate of Insurance. Agents are not authorized to receive notices and declarations on the Company's behalf.
c. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

5.2.8 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company.

5.2.9 Out of all the details of the various benefits provided in the Policy Terms and Conditions, only the details pertaining to benefits chosen by policyholder as per Policy Schedule shall be considered relevant.

5.2.10 Electronic Transactions

The Policyholder and Insured Member agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, 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. Any terms and conditions related to electronic transactions shall be within the approved Policy Terms and Conditions

6. Other Terms and Clauses

CLAIM INTIMATION, ASSESSMENT AND MANAGEMENT

Upon the occurrence of any event that may give rise to a Claim under this Policy, then as a condition precedent to Company's liability under the Policy, the Policyholder or Insured Member (or the Nominee or legal heir if the Insured Member is deceased) shall undertake in addition to any specific requirements specified within the Benefit under which the Claim is made:

6.1. Claims Intimation

a. If any Illness is diagnosed or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Policyholder or Insured Member (or the Nominee or legal heir if the Insured Member is deceased), shall notify the Company either at the Company's call center or in writing immediately and in any event within the timeframe (if any) specified in the Benefit under which the Claim is made.

b. If the Insured Member is to undergo planned Hospitalization, the Insured Member shall give written intimation to the company of the proposed Hospitalization at least 24 hours prior to the planned date of admission to Hospital.

c. In case of an Emergency Hospitalization, the Company shall be notified either at the Company's call center or in writing immediately and in any event within 24 hours of admission to Hospital. Health card will need to be produced and authenticated within 24 hours of admission and no pre-authorization is required in case of emergency hospitalization.

d. It is agreed and understood that the following details are to be provided to the Company at the time of intimation of the Claim:

   i. Policy Number;
   ii. Name of Primary Insured Member;
   iii. Name of the Insured Member in whose relation the Claims is being made;
   iv. Nature of Illness or Injury or contingency for which Claim has been made and the Benefit under which the Claim is being made;
   v. Date and place of Injury or Death and/or Date of admission to Hospital or proposed date of admission to Hospital for planned Hospitalization;
   vi. Name and address of the attending Medical Practitioner and Hospital;
   vii. Any other information, documentation or details requested by the Company.

6.2. Claim Procedure

a. Cashless: Cashless treatment facilities are available only at Network Provider. The Insured Member can avail of this cashless facility at the time of admission into a Network Provider by completing the following procedure.

   i. Pre-authorization: The Policyholder/ Insured Member must call the Company's call centre number as specified in the Policy Schedule and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least within 24 hours of admission to the Network Provider.

ii. Present the health card provided by the Company under this Policy along with a valid photo identification document (Voter ID card / Driving License / Aadhar card / Passport / PAN Card or any other identification documentation as approved by the Company).

iii. The Company will process the request for authorization after having obtained accurate and complete information for the Illness or Injury for which cashless facility for is sought to be availed. The Company will confirm in writing authorization or rejection of authorization to avail cashless facility for the Insured Member's Hospitalization.

iv. If the request for availing cashless facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Member shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing cashless facility.

v. In case Policyholder/Insured Member cannot avail the cashless facility, payment for the treatment will have to be made by the Policyholder or Insured Member to the Network Hospital, following which a Claim for reimbursement may be made to the Company which will be considered by the Company subject to the Policy terms and conditions.

b. It is agreed and understood that:

i. When authorizing the availing of cashless facility under this Policy, the Company may authorize the Policyholder's or Insured Member's request for direct settlement of admissible Claims resulting from the Hospitalization in accordance with the agreed charges and the terms and conditions between the Network Provider and the Company. If this authorization is provided then, the Company will directly pay all amounts payable in accordance with the terms and conditions of the Policy to the Network Provider to the extent the Claim is admissible under the Policy.

ii. The Company may modify or add to the list of Network Provider or modify or restrict the extent of cashless facilities that may be availed at any particular Network Provider. The updated list would be available at the Company's website or call centre.

iii. Before availing the cashless facility, the Policyholder or the Insured Member is required to check the applicable list of Network Provider for the area where he intends to avail the cashless facility through the call centre number as provided in the Policy Schedule.

c. Reimbursement :

i. It is agreed and understood that in all cases where intimation of a Claim has been provided under this provision, all the information and documentation specified against the Benefit and Clause 6.3 below shall be submitted (at the Insured Member's expense) to the Company immediately and in any event within 30 days of Insured Member's discharge from Hospital or completion of treatment or date of loss, whichever is later.

6.3. Claim Documentation

The Policyholder or Insured Member (or Nominee or legal heir if the Primary Insured Member is deceased) shall (at his expense) give the documentation specified below and any additional information or documentation specified in the Benefit provision under which the Claim is being made to the Company immediately and in any event within 30 days of the occurrence of the Injury.

The following information and documentation shall be submitted to the company in accordance with the procedures and within the timeframes specified in Clause 6 of the Policy in respect of all Claims:

i. Duly completed and signed Claim form, in original;
ii. Copy of Health Card;
iii. Medical Practitioner's referral letter advising Hospitalization;
iv. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;
v. Original bills, receipts and discharge card from the Hospital / Medical Practitioner;
vi. Original bills from pharmacy / chemists;
vii. Original pathological / diagnostic test reports and payment receipts;
viii. Indoor case papers

Note:

i. Additional documents as specified against any benefit shall be submitted to the company.
ii. The company may seek any other document as required to assess the Claim.
iii. The company will only accept bills/invoices which are made in the Insured Member's name.
iv. Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company, the company will accept properly verified photocopies of such documents attested by such other insurance company along with an original certificate of the extent of payment received from such insurance company.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

6.4. POLICYHOLDER'S OR INSURED MEMBER'S OR CLAIMAINT'S DUTY AT THE TIME OF CLAIM

It is agreed and understood that as a condition precedent for a Claim to be considered under this Policy:

a. The Insured Member shall check the updated list of Network Provider before availing Cashless Facility
b. All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.
c. Intimation of the claim, notification of the claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6 of the Policy and the specific procedures and timeframes specified under the Benefit under which the Claim is being made.
d. The Insured Member will, at the request of the Company, submit himself / herself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.
e. The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Member's medical and hospitalization records and to investigate the facts and examine the Insured Member.
f. The Company shall be provided with complete documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

6.5. CLAIM ASSESSMENT

a. All admissible Claims under this Policy shall be assessed by the company.
b. The Claim amount assessed would be deducted from the following amounts in the following progressive order:

   i. Coverage Amount;
   ii. Reinstatement of Coverage Amount (if applicable).

6.6. Payment terms

a. This Policy covers treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.
b. For Cashless Claims, the payment shall be made to the Network Provider whose discharge would be complete and final.
c. If the Insured Member suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim.
d. For Reimbursement Claims, the Company will make payment to the Insured Member unless specified otherwise in the Certificate of Insurance. In the event of Primary Insured Member's death, the Company will make payment to the Nominee (as named in Certificate of Insurance) and in case of no Nominee to the legal heir of the Primary Insured Member whose discharge shall be treated as full and final discharge of the Company's liability under the Policy.
e. On payment of renewal premium, the Primary Insured Member shall give written notice to the company of any disease, physical defect or infirmity or change in occupation or profession.
f. The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Member during the Cover Year, once Sum of Coverage Amount and Reinstatement of Coverage Amount (if applicable) for that Insured Member is exhausted.
g. The Company shall settle any Claim within 30 days of receipt of all the necessary documents/ information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder an offer of settlement of Claim and upon acceptance of such offer by the Policyholder the Company shall make payment within 7 days from the date of receipt of such acceptance.
h. The Claim shall be paid only for the Cover Year in which the Insured event which gives rise to a Claim under this Policy occurs.

Annexure –I: List of Day Care Procedures / Surgeries

Category	Procedure / Surgery Name
Dental	Apisectomy including LA
Dental	Cyst under LA (Large)
Dental	Cyst under LA (Small)
Dental	Flap operation per Tooth
Dental	Fracture wiring including LA
Dental	Gingivectomy per Tooth
Dental	Flap operation involving 1-3 teeth
Dental	Flap operation involving 4-6 teeth
Dental	Flap operation involving 7-11 teeth
Dental	Gingivectomy involving 1-3 teeth
Dental	Gingivectomy involving 4-6 teeth
Dental	Gingivectomy involving 7-11 teeth
Ear	Ear lobe repair – single
Ear	Excision of Pinna for Growth (Squamous/Basal/ Injuries) Skin and Cartilage
Ear	Excision of Pinna for Growth (Squamous/Basal/ Injuries) Skin Only
Throat	Retro pharyngeal abscess - Drainage
General Surgery	Corn - Large - Excision
General Surgery	Dermoid Cyst - Large - Excision
General Surgery	Dermoid Cyst - Small - Excision
General Surgery	Dorsal Slit and Reduction of Paraphimosis
General Surgery	Drainage of large Abscess
General Surgery	Epidymal Cyst
General Surgery	Excision of Small Growth from Tongue
General Surgery	Excision of Large Swelling in Hand
General Surgery	Excision of Small Swelling in Hand
General Surgery	Ganglion - Small - Excision
General Surgery	Growth – Excision
General Surgery	Nodular Cyst
General Surgery	Lipoma
General Surgery	Sebaceous Cyst - Excision
General Surgery	Dressing under GA
General Surgery	Excision of Corns
General Surgery	Excision of Molluscumcontagiosum
General Surgery	Excision of Sebaceous Cysts
General Surgery	Excision of Superficial Liipoma

General Surgery	Excision of Superficial Neurofibroma
General Surgery	Phimosis Under LA
General Surgery	Urtheral Dilatation
General Surgery	Vasectomy
General Surgery	Heamodialysis
Gynaecology	Bartholin abscess I & D
Gynaecology	Bartholin cyst removal
Gynaecology	Cyst – Labial
Gynaecology	Cyst -Vaginal Enucleation
Gynaecology	D&C (Dilatation & curretage)
Gynaecology	Electro Cauterisation Cryo Surgery
Gynaecology	Fractional Curretage
Gynaecology	Haemato Colpo/Excision - Vaginal Septum
Gynaecology	Perineal Tear Repair
Gynaecology	Vaginal Tear -Repair
Gynaecology	D&C (dilatation & Curretage) upto 12 wks
Gynaecology	D&C (Dilatation & curretage)upto 8 wks
Gynaecology	Insertion of IUD Device
Endoscopic procedures	Ablation of Endometriotic Spot
Endoscopic procedures	Cyst Aspiration
Endoscopic procedures	Esophageal Sclerotheraphy for varies first sitting
Endoscopic procedures	Esophageal Sclerotheraphy for varies subseqent sitting
Endoscopic procedures	Upper GI endoscopy
Endoscopic procedures	Upper GI endoscopy with biopsy
Hysteroscopic	Ablation of Endometrium
Hysteroscopic	Polypectomy
Ophthalmology	Abscess Drainage of Lid
Ophthalmology	Cataract – Unilateral
Ophthalmology	Cataract + Pterygium
Ophthalmology	Corneal Grafting
Ophthalmology	Cyclocryotherapy
Ophthalmology	Cyst
Ophthalmology	Pterigium + Conjunctival Autograft
Ophthalmology	Exentration
Ophthalmology	Ectropion Correction
Ophthalmology	Intraocular Foreign Body Removal
Ophthalmology	Limbal Dermoid Removal
Ophthalmology	Pterygium (Day care)
Ophthalmology	Ptosis
Ophthalmology	Small Tumour of Lid - Excision

Ophthalmology	Iridectomy
Ophthalmology	Acid and alkali burns
Ophthalmology	Cataract with IOL by Phoco emulsification tech. unilateral
Ophthalmology	Cataract with IOL with Phoco emulsification Bilateral
Ophthalmology	Cauterisation of ulcer/subconjuctival injection - both eye
Ophthalmology	Cauterisation of ulcer/subconjuctival injection - One eye
Ophthalmology	Chalazion - both eye
Ophthalmology	Chalazion - one eye
Ophthalmology	Conjuntival Melanoma
Ophthalmology	Dacryocystectomy (to be removed duplicated)
Ophthalmology	Dacryocystectomy (DCY)
Ophthalmology	DCR (Dacryocystorhinostomy)
Ophthalmology	Entropion correction
Ophthalmology	Epicantuhus correction
Ophthalmology	Epiliation
Ophthalmology	Laser for retinopathy
Ophthalmology	Laser inter ferometry
Ophthalmology	Lid tear
Orthopaedic	Dislocation - Elbow
Orthopaedic	Dislocation - Shoulder
Orthopaedic	Drainage of Abscess Cold
Orthopaedic	Hip Spica
Orthopaedic	Shoulder Jacket
Orthopaedic	Trigger Thumb
Orthopaedic	Wound Debridiment
Orthopaedic	Application of Skeletal Tractions
Orthopaedic	Application of Skin Traction
Orthopaedic	Aspiration & Intra Articular Injections
Urology	Reduction of Paraphimosis
Oncology	Chemotherapy - Per sitting
Oncology	Radiotherapy - Per sitting
Oncology	Chemotherapy - per siting plus cost of injections subject to approval for Insurance administrator
Other commonly used procedures	Upto 30% burns first dressing
Other commonly used procedures	Upto 30% burns subsequent dressing

Sr. No.	**Annexure – II List of Expenses Generally Excluded ("Non-medical") in Hospital Indemnity Policy**
	List I – Optional Items
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

Sr. No.	
List II – Items that are to be subsumed into Room Charges	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

Sr. No.	
List III – Items that are to be subsumed into Procedure Charges	
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

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

Annexure - III - List of Network Provider

The below is non-exhaustive list of Network provider empanelled specifically for the product. Please visit the company website for latest and complete list of Network Provider

Hospital Name	Address Line 1	Address Line 2	Location	City	District	State	Zone	Pin Code
Getwell Hospital	Opposite Power House,Mirag,	Mohindergar,	Hamidpur	Narnaul	Mahendragarh	Haryana	North	123001
Chhabra Hospital	I-A,Narain Singh Park,	Assandh Road,	Model Town	Panipat	Panipat	Haryana	North	132103
Kurukshetra Nursing Home	Pipli Road,	Opposite Sector 13,	Pipli	Kurukshetra	Kurukshetra	Haryana	North	136118
Guru Nanak Hospital	Sham Nagar,Near L.I.C.Office,	Rajpura,	Shyam Nagar	Rajpura	Patiala	Punjab	North	140401
Simrita Nursing Home	68,	Dalima Vihar,	Rajpura Township	Rajpura	Patiala	Punjab	North	140401
Avasthi Bone & Joint Clinic & Hospital	No.135,Green Park,	Opposite Prince Hostel,	Civil Lines	Ludhiana	Ludhiana	Punjab	North	141001
Bassi Nursing Home Pvt. Ltd.	No.970/B,Near Dhobhi Ghat,	Rajpura Road,	Civil Lines	Ludhiana	Ludhiana	Punjab	North	141001
Kapil Hospital	Near New Courts,Opposite Commissioners Office,	Industrial Area,	Near New Courts	Jalandhar	Jalandhar	Punjab	North	144001
Gursimran Hospital	Naloian Chowk,	Dasuya Road,	Hoshiarpur City	Hoshiarpur	Hoshiarpur	Punjab	North	146001
Garg Mission Hospital	7,Dhillon Marg,	-	Model Town	Patiala	Patiala	Punjab	North	147001
Shri Ganga Ram Memorial Hospital	Daafi,Lanka,	-	Daafi	Varanasi	Varanasi	Uttar Pradesh	North	221011
Shalimar Hospital	A-989,	Indira Nagar Colony,	Indira Nagar	Lucknow	Lucknow	Uttar Pradesh	North	226016
Muskan Nursing Home	A-288/289,Ashiana I,Kanth Road,	-	Town Hall	Moradabad	Moradabad	Uttar Pradesh	North	244001
Gopi Krishna Hospital	709 General Ganj,	-	Mathura	Mathura	Mathura	Uttar	North	281001

						Pradesh		
Shree Ramkrishna Netralaya	Shree Balaji Apartments,	L.B.S Marg,Agra Road,	Thane	Thane	Thane	Maharashtra	West	400601
Akshay Childrens Hospital & Maternity Home	No.272/32,	Balikashram Road,Opposite Cosmic Housing Society,	Balikashram Road	Ahmednagar	Ahmed Nagar	Maharashtra	West	414003
Charak Hospital Pvt. Ltd.	Film Bhawan,Rani Sati Gate,	J.N.Road,	J.N.Road	Indore	Indore	Madhya Pradesh	West	452001
Athena Hospital	Athena Hospital Complex,	Falnir Road,	Falnir	Mangalore	Dakshina Kannada	Karnataka	South	575001
Hi-Tech Medical College & Hospital	Health Park,	-	Rasulgarh	Bhubaneswar	Khorda	Odisha	East	751010
Prashant Memorial Charitable Hospital	Juran Chopra Road No 4,	-	Muzaffarpur	Muzaffarpur	Muzaffarpur	Bihar	East	842001
Cheema Medical Complex	Phase -4,Near Telephone Exchange,	S.A.S.Nagar,	Mohali	Mohali	Rupnagar	Punjab	North	160059
Indus Hospital	S.C.F.98-100,	Phase 3B2.Mohali,	Phase 3B2	Mohali	Rupnagar	Punjab	North	160059
M/S Vasantham Health Centre	Dennison Road,	Near Vadassery Bus Stand,	Nagercoil	Nagercoil	Kanyakumari	Tamil Nadu	South	629001
SKR Hospital & Trauma Centre Pvt Ltd	New Fly Over,	Malikpur Choowk,	Sarna	Pathankot	Gurdaspur	Punjab	North	145025
Shanti Health Care Hospital	157,Co-operative Colony,	-	Bokaro Steel City	Bokaro	Bokaro	Jharkhand	East	827001
Sharda Hospital	No.106-5,	Near Gurdawava,	Modle Town Hisar	Hisar	Hisar	Haryana	North	125005
Thareja Nursing Home	No.1,	Ram Khirteer Company Bagh Road,	Alwar	Alwar	Alwar	Rajasthan	North	301001
Jaspal Nursing Home	No.69,	Model Town,	Model Town	Ambala	Ambala	Haryana	North	133001
Dhami Eye Care Hospital	82-B,	-	Kichlu Nagar	Ludhiana	Ludhiana	Punjab	North	141001
Sirish Hospital	B-XX,1140,	-	Krishna Nagar	Ludhiana	Ludhiana	Punjab	North	141001
Chugh Eye Surgery Centre	L-637,	Near Deep Hospital,	Model Town	Ludhiana	Ludhiana	Punjab	North	141002
Khanna Nursing Home	G T Road,	Opposite Gill Petrol Pump,	G.T.Road	Khanna	Ludhiana	Punjab	North	141401

Dr Om Parkash Eye Institute Pvt.Ltd.	117-A,Mall Road,	Near Novelty Omaxe,	Mall Mandi	Amritsar	Amritsar	Punjab	North	143001
Maharishi Dayanand Hospital & MRC	228-BC Road,	Rehari Chugi,	Reharimohalla	Jammu	Jammu	Jammu & Kashmir	North	180005
Kamla Nagar Hospital	Pal Link Road,	-	Housing Board	Jodhpur	Jodhpur	Rajasthan	North	342008
Disha Eye Hospital And Research Centre Pvt. Ltd.	88(63A),	Ghosh Para Road,	Barrackpore	Kolkata	North 24 Parganas	West Bengal	East	700120
Omega Hospitals Pvt Ltd	Mahaveera Circle,	-	Kankanady	Mangalore	Dakshina Kannada	Karnataka	South	575002
Thind Eye Hospital	701-L,	Mall Road,	Model Town	Jalandhar	Jalandhar	Punjab	North	144003
Leelawati Hospital	No.9 Inder Nagar,Near Arya Chowk,	Police Line Road,	Inder Nagar	Ambala	Ambala	Haryana	North	134003
PRKM Modern Hospital	Opposite Government College,	Suthari Road,	Suthari Road	Hoshiarpur	Hoshiarpur	Punjab	North	146001
Shri Jai Parkash Hospital	Near Pehowa Chowk,	Ambala Road,	Ambala Road	Kaithal	Kaithal	Haryana	North	136027
Behgal Hospital	S.F.C.11,Phase - 5,	S.A.S Nagar,Near PTL Chowk,	Mohali	Mohali	Rupnagar	Punjab	North	160059
Jeevan Jot Hospital	Peer Khanna Road,	-	Khanna HO	Khanna	Ludhiana	Punjab	North	141401
Indus Super Speciality Hospital	Opposite D.C.Office,	Phase-1,	S.A.S.Nagar	Mohali	Rupnagar	Punjab	North	160055
KMC Hospital	Attavar,	-	Attavar	Mangalore	Dakshina Kannada	Karnataka	South	575001
Peace Health Centre	No.48H/5,South Bypass Road,	Near New Bus Stand,	South Bypass Road	Tirunelveli	Tirunelveli	Tamil Nadu	South	627005
Trilochan Netralaya	Fatak,Budharaja,	-	Sambalpur	Sambalpur	Sambalpur	Odisha	East	768004
Gupta Nursing Home	A 19 New Acc Colony,	Opp MES colony,	Madhaunagar	Katni	Katni	Madhya Pradesh	West	483504
Ozone Multispeciality Hospital	Kedia Plot,	Holy Cross Convent Road,	Akola	Akola	Akola	Maharashtra	West	444002
Gouri Devi Hospital &	National Highway-2,GT	Beside IOC Terminal,	Rajbandh	Durgapur	Bardham	West	East	713212

Research Institute	Road,				an	Bengal		
Jyoti Nursing Home Pvt Ltd	Road No.4,	Opp. SBI Bank,	Vishvakarma Industrial Area	Jaipur	Jaipur	Rajasthan	North	302013
Sairam Hospital	BTM Bye Pass,	-	Jharsuguda	Jharsuguda	Jharsuguda	Odisha	East	768218
Wadgaonkar Eye Hospital	126,	Varad Ganesh Mandir Road,	Samarth Nagar	Aurangabad	Aurangabad	Maharashtra	West	431001
Choudhari Hospital	Near LIC Office,	Shikarkhana Road,	Bijapur	Bijapur	Bijapur(KAR)	Karnataka	South	586104
Mitra Hospital	Mitra Priya,	Old Post Office Road,	Udupi	Udupi	Udupi	Karnataka	South	576102

Office of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 E-mail : bimalokpal.ahmedabad@ecoi.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building ,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
BHOPAL	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 & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
CHENNAI	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	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road,	Delhi

	New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@ecoi.co.in	
GUWAHATI	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
HYDERABAD	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	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry
JAIPUR	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	Rajasthan
ERNAKULAM	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	Kerala, Lakshadweep, Mahe – a part of Pondicherry
KOLKATA	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	West Bengal, Andaman & Nicobar Islands, Sikkim
LUCKNOW	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	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur,

		Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	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	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
PATNA	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
NOIDA	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	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
PUNE	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.

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.carehealthinsurance.com or from any of the Company's offices. Address and contact number of Executive Council of Insurers –

Office of the 'Executive Council of Insurers'
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
Mumbai – 400 054.

Tel : 022-26106889/671/980
Fax : 022-26106949
Email- inscoun@ecoi.co.in

CARE HEALTH INSURANCE LIMITED.

Registered Office Address: 5th floor, 19 Chawla House, Nehru Place, New Delhi – 110 019
Correspondence Address: Care Health Insurance Limited,
Unit No. 604 - 607, 6th Floor, Tower C,
Unitech Cyber Park, Sector-39,
Gurgaon, Haryana – 122001
Contact No.: 1800-500-4488
CIN : U66000DL2007PLC161503
www.careinsurance.com

SERVICE REQUEST FORM
For Change in Occupation / Nature of Job
(Refer Clause 5.2.1 of Policy Terms and Conditions)

PLEASE NOTE :
1. To be filled in by Policyholder in CAPITAL LETTERS only.
2. If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this service request.
3. This form has to be filled in and submitted to the company whenever the nature of job / occupation of any insured covered under the Policy changes subsequent to the issuance of the Policy.

Policyholder Details

Policy No. : |__|__|__|__|__|__|__|__|__|
Name : Mr. / Ms |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(First name) (Last name)

Details of the Insured Persons for whom details are to be updated

Name : Mr. / Ms |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(First name) (Last name)

Occupation : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

DECLARATION

I hereby declare, on my behalf and on behalf of all persons insured, that the above statement(s), answer(s) and / or particular(s) given by me are true and complete in all respects to the best of my knowledge and that I am authorized to provide / request for updation of the details on behalf of Insured Persons.

Place : |__|__|__|__|__|__|__|__|
Date : |__|__|/|__|__|/|__|__|__|__| (DD/MM/YYYY)
Signature of the Policyholder : ____
(On behalf of all the persons insured under the Policy)

Note: *The Company shall update its record with respect to the information provided above. Subsequently, the Company may review the risk involved and may alter the coverage and / or premium payable accordingly.*