Edelweiss | GENERAL INSURANCE

POLICY WORDING

YOUR POLICY IN DETAIL

Group Corona Policy, Edelweiss General Insurance Company Limited

POLICY WORDINGS

1. PREAMBLE

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

2. OPERATIVE CLAUSE

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of Covid at a Hospital or given Home Care Treatment (if opted) following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify medically necessary expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during the Policy Period shall be the Sum Insured (Individual or Floater) opted and specified in the Schedule.

3. DEFINITIONS

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

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

3.2. Associate medical expenses: means proportionate deductions of the medical expenses when a higher room category is chosen than the category that is eligible as per terms and conditions of the policy. Proportionate deduction 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.

Associate Medical expenses applicable to below categories/ Expenses incurred during Hospitalization-

a) Room Rent

b) Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;

c) Medical Practitioners' fees,

d) Physiotherapy

e) Operation theatre charges;

This shall not apply to the below categories:

a) Cost of pharmacy and consumables, b. Cost of implants and medical devices, c) Cost of diagnostics, d) ICU Charges

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

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

a. Central or State Government AYUSH Hospital or

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

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

i. Having at least 5 in-patient beds;

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

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

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

3.5. Cashless Facility means a facility extended by the insurer to the insured where the payments , of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

3.6. Company (also referred as We/Us/EGIC) means Edelweiss General Insurance Company Limited.

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

3.8. COVID: For the purpose of this Policy, Coronavirus Disease means COVID-19 as defined by the World Health Organization (WHO) and caused by the virus SARS-CoV2.

3.9. Day Care Treatment means medical treatment, and/or surgical procedure which is :
i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
ii. which would have otherwise required a hospitalization of more than twenty-four hours.
iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.10. Disclosure to information norm: The policy shall be void and all premiums 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.

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

3.12. Family means, the Family that consists of the proposer and any one or more of the family members as mentioned below:
i. Legally wedded spouse.
ii . Parents and Parents-in-law.
iii. Dependent Children (i.e. natural or legally adopted) between the day 1 of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage
iv. Siblings

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

3.14. Group: Group means any association of persons who assemble together with a commonality of purpose or for engaging in a common economic activity, like employees of a company. Non-employer-employee groups, like employee welfare associations, holders of credit cards issued by a specific company, customers of a particular business where insurance is offered as an add-on benefit, borrowers of a bank, professional associations or societies. However, an association of persons coming together with the main purpose of availing an insurance cover will not qualify to be a group for the purpose of this Policy

3.15. Health care worker for the purpose of this policy shall mean doctors, nurses, midwives, dental practitioners and other health professionals including laboratory assistants, pharmacists, physiotherapists, technicians and people working in hospitals .

3.16 Home Care Treatment means treatment availed by the Insured Person at home for Covid on positive diagnosis of Covid in a Government authorized diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home provided that:

a) The Medical practitioner advices the Insured person to undergo treatment at home.
b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

3.17. Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

For the purpose of this policy any other set-up designated by the Government as hospital for the treatment of Covid shall also be considered as hospital.

3.18. Hospitalization means admission in a hospital for a minimum period of twenty-four (24) hours consecutive 'In-patient care' provided it will not include procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

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

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

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

sophisticated and intensive than in the ordinary and other wards.

3.22. ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical suppo1t services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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

3.24. Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

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

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

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

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

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

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

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

3.31. 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.

3.32. 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:

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

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

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

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

3.36. Police Personnel: Police personnel refers to any person who is employed, deputed and/or authorized by the state or central government for maintaining the law and order and assist in the criminal justice system for preservation of public order and tranquillity, promotion of the public health, safety, and morals, and the prevention, detection, and punishment of crimes in any particular village, town, city, or any area within India and includes permanent, full time police officers and other support staff so employed as such.

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

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

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

3.40. Sum Insured means the pre-defined limit specified in the

Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Period.

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

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

3.43. Waiting Period means a period from the inception of this Policy during which Covid is not covered.

4. Base Cover:
The cover listed below is in-built Policy benefit and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

Our total liability under the base covers and optional covers shall not exceed the base Sum Insured as opted by the Insured in individual policy and for family under floater policy

4.1. Covid Hospitalization Cover
The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy period for the treatment of Covid on Positive diagnosis of Covid in a government authorized diagnostic centre including the expenses incurred on treatment of any comorbidity and pre-existing diseases along with the treatment for Covid up to the Sum Insured specified in the policy schedule, for,
i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital/ Nursing Home.
ii. Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, ventilator charges, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, PPE Kit, gloves, mask and such similar other expenses.

Note: Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible.

4.2. AYUSH Treatment
The Company shall indemnify medical expenses incurred for inpatient care treatment for Covid on Positive diagnosis of COVID test in a government authorized diagnostic centre including the expenses incurred on treatment of any comorbidity and pre-existing diseases along with the treatment for Covid under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during the Policy Period up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

Covered expenses shall be as specified under Covid Hospitalization Expenses (Section 4.1)

4.3. Pre Hospitalization
The company shall indemnify pre-hospitalization/home care treatment medical expenses incurred, related to an admissible hospitalization/home care treatment (if opted), for the period of 30 days as specified in the Schedule immediately prior to the date of admissible hospitalization/home care treatment covered under the policy.

4.4. Post Hospitalization
The company shall indemnify post hospitalization/ home care treatment medical expenses incurred, related to an admissible hospitalization/ home care treatment (if opted), , for the period of 60 days as specified in the Schedule immediately from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

5. Optional cover:
The cover listed below is Optional Policy benefit and shall be available to Insured Persons in accordance with the terms set out in the Policy, if the listed cover is opted. The sum inured applicable would be within the base sum insured

5.1. Hospital Daily Cash: The Company shall pay the Insured Person, the fixed amount specified in policy schedule per day for each 24 hours of continuous hospitalization for which the Company has accepted a claim under Section 4.1 Covid Hospitalization Cover.
The benefit shall be payable maximum up to 15 days during a policy period in respect of every insured person

5.2 Home Care Treatment:
By Opting this cover, we will cover home care treatment upto the amount specified in policy schedule.
Home Care Treatment means Treatment availed by the Insured Person at home for Covid on positive diagnosis of Covid in a Government authorized diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:
a) The Medical practitioner advices the Insured person to undergo treatment at home.
b) There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through

the duration of the home care treatment.
c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
d) Insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility shall be offered under homecare expenses subject to claim settlement policy disclosed in the website.
e) In case the insured intends to avail the services of non-network provider, claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.

In this benefit, the following shall be covered if prescribed by the treating medical practitioner and is related to treatment of COVID,
a. Diagnostic tests undergone at home or at diagnostics centre
b. Medicines prescribed in writing
c. Consultation charges of the medical practitioner
d. Nursing charges related to medical staff
e. Medical procedures limited to parenteral administration of medicines
f. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer
g. PPE Kits, Gloves, Mask

5.3 Institutional Quarantine:
By Opting this cover we will cover upto the amount specified in the policy schedule on indemnity basis if the Insured Person is institutional Quarantined during the Policy Period provided that such Quarantine is necessarily due to diagnosis of COVID-19 in government authorised quarantine centre, for a maximum of fourteen continuous Quarantine days.

The following shall be covered if prescribed by the treating medical practitioner and is related to treatment of COVID,
a. Room rent charges
b. Diagnostic tests undergone at home or at diagnostics centre
c. Medicines prescribed in writing
d. Consultation charges of the medical practitioner
e. Nursing charges related to medical staff
f. Medical procedures limited to parenteral administration of medicines
g. Cost of Pulse oximeter, Oxygen cylinder and Nebulizer
h.PPE Kits, Gloves, Masks

5.4 Ambulance Cover –
By opting this cover , we will pay the cost of Road Ambulance charges upto the amount specified in the policy schedule per hospitalization for the Ambulance services offered by a Hospital or by an Ambulance service provider, provided that the Ambulance is availed only in relation to Covid Hospitalization. This also includes the cost of the transportation of the Insured Person from a Hospital to the another Hospital as prescribed by a Medical Practitioner

5.5 First fifteen days Waiting Period waiver
First Fifteen Days Waiting Period (clause 7.1) shall be waived only if the optional cover for first fifteen waiting period waiver is specifically opted and is specified in the Schedule to this Policy

5.6 No Pre- Hospitalization
By opting this cover, we shall not be liable to make any claim expenses incurred towards Pre- Hospitalization expenses.

5.7 No Post- Hospitalization
By opting this cover, we shall not be liable to make any claim expenses incurred towards Post- Hospitalization expenses.

6. Discount Covers –
6.1 Room Rent Capping - By opting this cover policy schedule will specify the eligibility of room rent per day applicable for the insured under the policy.
If the actual room rate is more than the policy's per day limit, then associated medical expenses will be paid in the same proportion of the difference between the approved room rate and the actual room rate.

6.2 ICU capping-
By opting this cover policy schedule will specify the eligibility of ICU charges per day applicable for the insured under the policy.
If ICU charges are more than policy's per day limit then we will deduct only excess amount charged for ICU.

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

7.1. First Fifteen Days Waiting Period
Expenses related to the treatment of Covid within 15 days from the policy commencement date shall be excluded.

This exclusion will not be applicable if first fifteen days waiting period waiver option (5.5) is specifically opted

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

8.1. Investigation & Evaluation (Code- Exc104)
Expenses related to any admission primarily for diagnostics and evaluation purposes. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

8.2. Rest Cure, rehabilitation and respite care (Code-Exc105)

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.

8.3. Dietary supplements and substances that can be purchased without prescription, including Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or Home care treatment.

8.4. Unproven Treatments:

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. However, treatment authorized by the government for the treatment of COVID shall be covered.

8.5. Any expenses incurred on Day Care treatment and OPD treatment

8.6. Diagnosis /Treatment outside the geographical limits of India

8.7. Testing done at a Diagnostic centre which is not authorized by the Government shall not be recognized under this Policy

8.8. All covers under this Policy shall cease if the Insured Person travels to any country placed under travel restriction by the Government of India.

9. CLAIM PROCEDURE

9.1. Procedure for Cashless claims:

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

9.2. Procedure for reimbursement of claims:

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

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

9.3. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA as under:

i. Within 24 hours from the date of emergency hospitalization/cash less home care treatment.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

9.4. Documents to be submitted:

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

Benefits	Claims Documents Required
1. Covid Hospitalization Cover	i. Duly filled and signed Claim Form ii. Copy of Insured Person's passport, if available (All pages) iii. Photo Identity proof of the patient (if insured person does not own a passport) iv. Medical practitioner ' s prescription advising admission v. Original bills with itemized break-up vi. Payment receipts vii. Discharge summary including complete medical history of the patient along with other details. viii. Investigation reports including Insured Person's test reports from Authorized diagnostic centre for COVID ix. OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable x. Sticker/Invoice of the Implants, wherever applicable. xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines xiii. Legal heir/succession certificate, wherever applicable xiv. Any other relevant document required by Company/TPA for assessment of the claim.
2. Home Care treatment expenses	i. Duly filled and signed Claim Form ii. Copy of Insured Person's passport, if available (All pages) III. Photo Identity proof of the patient (if insured person does not own a passport) IV. Medical practitioners' prescription advising hospitalization V. A certificate from medical practitioner advising treatment at home or consent from the insured person on availing home care benefit. vi. Discharge Certificate from medical practitioner specifying date of start and completion of home care treatment. vii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

Note:

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

9.5. 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.

9.6. Services Offered by TPA

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

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

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

9.7. Payment of Claim

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

10. GENERAL TERMS &CONDITIONS

10.1. Disclosure of Information

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

10.2. 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.

10.3. Records to be maintained

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

10.4. Complete Discharge

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

10.5. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

10.6. Territorial Limit

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

10.7. Multiple Policies

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

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

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

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

10.8. 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 thereat: 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 the policy which are found fraudulent later under this policy 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.

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, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

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

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

(c) any other act fitted to deceive; and

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

The company shall not repudiate the policy on the ground of

fraud, if the insured person/ beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer.

10.9. Cancellation

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

Refund Percentage	
Cancellation period	**1 Year Policy**
Up to 1 Month	80%
Up to 3 Months	60%
Up to 6 Months	40%
Up to 9 Months	20%
Up to 12 Months	NIL

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

10.10. Automatic change in Coverage under the policy

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

In the case of demise of the insured person. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

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

10.11. Territorial Jurisdiction

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

10.12. Arbitration

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

10.13. Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India . The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any).

10.14. Terms and conditions of the Policy

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

10.15. 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 Ce1tificate/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.

10.16. Discounts/Loading

1. Healthcare staff (Hospital entity / any association of medical consultant as proposer)- 5 %
2. Group Discount

No of persons insured under the Group Policy	Group Discount %
Up to 25	0%
26 to 1,000	0% to 15%
1,001 to 5,000	15% to 30%
Above 5,000	30% to 40%

A maximum of 70% discount and 200% loading would be applicable subject to proposal type and underwriting criteria.

10.17. Free Look Period

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

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

10.18. Renewal of Policy

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

i the company shall endeavour 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 15 Days for instalment premium and 30 days for single premium to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

iii. No loading shall apply on renewals based on individual claims experience.

10.19. Payment in Instalments (Wherever applicable)

The Insured person can choose to pay Premium for this Policy on any one of the following basis:

i. Single premium

ii. Instalment premium

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

10.20. Withdrawal of Product

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

10.21. 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.

11. REDRESSAL OF GRIEVANCE

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

Website: www.edelweissinsurance.com
Toll free: 1800120216216 / 180012000
E-mail: grievance@edelweissinsurance.com
Courier: 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai 400 070

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 1800120216216 / 180012000.

For updated details of grievance officer, kindly refer the link...
https://www.edelweissinsurance.com/documents/20143/1081704/GRO+DETAILS+05-06-2020.pdf/d1c5e1b6-0acc-2e05-f14b-3c5cca0c0797?t=1591374023226

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

Insurance Ombudsman -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. The contact details of the Insurance Ombudsman offices have been provided as Annexure- B.

Grievance Mechanism Process
Any Grievance of the Complainant sent in a written communication to the Company at any of the touch points as mentioned, shall be addressed within 14 days of the receipt of the complaint.
Escalation Matrix:

Step 1
Call: 180012000
Email: support@edelweissinsurance.com

Step 2
If the response is not as per Complainant's expectations he/she may contact the Grievance Cell at the below touchpoints:
- Email: grievance@edelweissinsurance.com
- Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

Step 3
If the response is not as per Complainant's expectations he/she may contact the Company's Grievance Redressal Officer at:
- Email: grievanceofficer@edelweissinsurance.com
- Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

Step 4
If the Complainant is not still not satisfied with the response or does not receive a response from the Company within 14 days, the Complainant may approach the Grievance Cell of the IRDAI on the following contact details:
- IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255; Email ID: complaints@irda.gov.in
- Register online at: http://www.igms.irda.gov.in/
- Address for communication for complaints by fax/paper: Consumer Affairs Department, Insurance Regulatory and Development Authority of India Sy. No. 115/1, Financial District, Nanakramguda, Gachibowli Hyderabad - 500032

Step 5
If the complaint/grievance has still not been resolved, the Complainant may approach the Office of the Insurance Ombudsman established by the Central Government of India as per Rule 13 and Rule 14 of the Insurance Ombudsman Rules, 2017 ('Ombudsman Rules').
The following complaints can be lodged with the Insurance Ombudsman:
1. Any partial or total repudiation of claims by an insurer;
2. Any dispute in regard to premium paid or payable in terms of the policy;
3. Any dispute on the legal construction of the policies in so far as such disputes relate to claims;
4. Delay in settlement of claims;
5. Non-issue of any insurance document to customers after receipt of premium.

Manner in which complaint is to be made Rule 14 of the Ombudsman Rules:-
1 Any person who has a grievance against the Company, may himself or through his legal heirs make a complaint in writing to the Ombudsman within whose jurisdiction the branch or office of the Company complained against is located.
2. The complaint shall be in writing duly signed by the complainant or through his legal heirs and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against which the complaint is made, the fact giving rise to the complaint.
3. No complaint to the Ombudsman shall lie unless:
- the complainant had before making a complaint to the Ombudsman, made a written representation to the Company/insurer named in the complaint and either insurer had rejected the complaint or the complainant had not received any reply within a period of one month after the insurer concerned received his representation or the complainant is not satisfied with the reply given to him by the insurer;
- the complaint is made not later than one year after the insurer had rejected the representation or sent his final reply on the representation of the complainant; and
- the complaint is not on the same subject matter for which any

proceedings before any court or Consumer Forum or arbitrator is pending or was so earlier.

You may refer to the ECOI website at http://www.ecoi.co.in/ombudsman.html for the offices of the Ombudsman or refer to the details below.
Mentioned below are the contact details of the Offices of Ombudsman:
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.edelweissinsurance.com or from any of the Company's offices. Address and contact number of Governing Body of Insurance Council -
Office of the 'Governing Body of Insurance Council' Secretary General/Secretary,
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz (W), Mumbai - 400 054.
Tel: 022-26106245/889/671 Fax: 022-26106949
Email - inscoun@ecoi.in

11. TABLE OF BENEFITS

Name	Group Corona Policy, Edelweiss General Insurance Company LTD
Product Type	Individual/ Floater
Category of Cover	Indemnity/Benefit
Sum insured	₹25,000, 50,000/- (Fifty Thousand) to ₹5,00,000/- (Five Lakh) (in the multiples of fifty thousand) On Individual basis - SI shall apply to each individual family member On Floater basis - SI shall apply to the entire family
Policy Period	1 year including waiting period (if applicable).
Eligibility	Policy can be availed by any Group wherein the age of the insured is from day 1 to 100 years
Covid Hospitalization cover	Medical Expenses of Hospitalization for Covid for a minimum period of 24 consecutive hours only shall be admissible
Pre Hospitalization	0 days, 30 days prior to the date of hospitalization/home care treatment
Post Hospitalization	0 days, 60days from the date of discharge from the hospital/completion of home care treatment
Hospital Daily Cash	₹500 , 1,000, 1,500, 2,000 /24 hrs of Hospitalization Maximum upto 15 days
Home Care Treatment	20 K, 50 K, 1Lakh , upto sum insured Home care treatment: Maximum up to 14 days per incident
Institutional Quarantine	20 K, 50 K, 1Lakh , upto sum insured Institutional Quarantine: Maximum up to 14 days per incident
Ambulance Cover	₹2,000, 3,000, 5,000, 10,000 per hospitalization
AYUSH	Medical Expenses incurred for Inpatient Care treatment for Covid under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered upto sum insured during the Policy period as specified in the policy schedule.
Sub Limits (optional)	Room rent- 1%,2%,3%of Sum insured per day ICU Charges- 2%,4%,6% of Sum insured

Addendum to the Policy Wording (to be attached as applicable)

1. Additions/Deletion of Members It is hereby declared and agreed that the Insured Person/s is/are covered under this Policy only till such time they are on rolls of the Insured (Policy Holder). It is further agreed that any addition/deletion of members shall be communicated to the Insurer in writing within a reasonable time from the date of joining/ leaving but not later than last day of the succeeding month of joining / leaving the employment. The cover will commence from the joining date for such Insured Person/s (as requested by the Insured and agreed to by the Insurance Company) subject to adequate premium balance maintained with the Insurer for such additions. In case of inadequate premium balance with the Insurer on the day of inclusion of the additional members, the balance premium available as on that date would be reckoned for such members as per the serial number of the list received from the Insured. Where no such premium balance is maintained, the cover for such additions will commence from

the date of receipt of premium by the Insurer. Provided however that the Group Policyholder has intimated the joining of the said Insured person to the group. Refund on deletion of members will be effected only for such members who have not preferred any claims under the Policy. Dependents of Primary members shall be declared at the inception of the Policy. Any mid-term inclusion of dependents will not be allowed except for spouse by marriage, child by birth and for insured persons joining the group during the Policy Period. In case of intimation received beyond the stipulated time period, the risk commencement date for additional members would be from the date of intimation to the Insurer or as otherwise specifically agreed to by the Insurer subject to adequate premium balance. All other terms, conditions, warranties & exclusions of the Policy remain unaltered. The Company may issue multiple group insurance policies in tranches to the Group Organizer, subject to minimum group size and maximum policy term, for providing insurance coverage to the new members on an ongoing basis.

Annexure-A

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

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

Sl. No.	Item
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	SPIROMETRE
36	STEAM INHALER
37	ARMSLING
38	THERMOMETER
39	CERVICAL COLLAR
40	SPLINT
41	DIABETIC FOOT WEAR
42	KNEE BRACES (LONG/ SHORT/ HINGED)
43	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
44	LUMBO SACRAL BELT
45	NIMBUS BED OR WATER OR AIR BED CHARGES
46	AMBULANCE COLLAR
47	AMBULANCE EQUIPMENT
48	ABDOMINAL BINDER
49	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
50	SUGAR FREE TABLETS
51	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
52	ECG ELECTRODES
53	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
54	KIDNEY TRAY
55	OUNCE GLASS
56	PELVIC TRACTION BELT
57	PAN CAN
58	TROLLY COVER
59	UROMETER, URINE JUG

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

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

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

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

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

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

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Annexure B

Ombudsman and Addresses

The contact details of the Insurance Ombudsman offices are as below

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:-**bimalokpal.ahmedabad@ecoi.co.in**	State of Gujarat, Union Territory of Dadra & Nagar Haveli & Union Territory of 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, 1st Phase, Bengaluru-560 078. Tel.:- 080-26652048 / 26652049 Email:- **bimalokpal.bengaluru@ecoi.co.in**	State of Karnataka
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 033. Tel.:- 0755-2769200/201/202, Fax:- 0755-2769203 Email:- **bimalokpal.bhopal@ecoi.co.in**	States of Madhya Pradesh and Chattisgarh
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**	State of Odisha
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**	States of Punjab, Haryana, Himachal Pradesh, Union Territory of Jammu & Kashmir, Union Territory of Ladakh and Union Territory of 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**	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry)
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23232481/23232481 Email:- **bimalokpal.delhi@ecoi.co.in**	State of Delhi
ERNAKULAM Office of the Insurance Ombudsman, 2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulum - 682 015. Tel.:- 0484-2358759/2359338 Fax:- 0484-2359336 Email:- **bimalokpal.ernakulam@ecoi.co.in**	State of Kerala, Union Territory of Lakshadweep and Mahe, a part of Puducherry
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**	States of 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**	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of Puducherry

CONTACT DETAILS	JURISDICTION
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi-II Bldg., Ground Floor, Bhawani Singh Marg, Jaipur - 302005. Tel.:- 0141-2740363 Email:- **bimalokpal.jaipur@ecoi.co.in**	State of Rajasthan
KOLKATA Office of the Insurance Ombudsman, Hindustan Building Annexe, 4th floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.:- 033-22124339 / 22124340, Fax:- 033-22124341 Email:- **bimalokpal.kolkata@ecoi.co.in**	States of West Bengal, Bihar, Sikkim and Union Territory of Andaman and Nicobar Islands
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: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, 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**	State of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Distt: Gautam Budh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email:- **bimalokpal.noida@ecoi.co.in**	State of Uttarakhand 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, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
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**	States of Bihar and Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Building, 3rd Floor, CTS Nos. 195 to 198, NC Kelkar Road, Narayan Peth, Pune - 411 030 Tel: 020 -41312555 Email:- **bimalokpal.pune@ecoi.co.in**	State of Maharashtra, Area of Navi Mumbai and Thane, excluding Mumbai Metropolitan Region