CIN No. U66010RJ2006PLC029979
IRDA Registration Number: 137

Shriram General insurance Co. Ltd.

IN PARTNERSHIP WITH THE **Sanlam** GROUP
Regd.&Corpt. Office:E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022
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Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

Shri Hospital Daily Cash Benefit Insurance– Policy Wording

1. PREAMBLE

SHRIRAM General Insurance Company Limited (We, Our or Us) will provide the insurance described in this Policy and any endorsements thereto for the Insured Period as defined in this Policy, to the Insured Persons detailed in the Policy Schedule and in reliance upon the statements contained in the Proposal and Declaration Form filled and signed by the Policyholder, which shall be the basis of this Policy and are deemed to be incorporated herein in return for the payment of the required premium when due and compliance with all applicable provisions of this Policy.
The insurance provided under this Policy is only with respect to such and so many of the benefits as are indicated by a specific amount set opposite in the Policy Schedule.

2. OPERATIVE CLAUSE

If any claim arising as a result of an Illness or Injury that occurred during the Policy Period becomes payable, then We shall pay the Benefits as listed below in accordance with terms, conditions and exclusions of the Policy.

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.

2.1 **We, Us, Our/Ours** means the Shriram General Insurance Company Limited.

2.2 **You, Your, Yourself means** the Insured Person shown in the Schedule.

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

2.4 **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.5 **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken\

2.6 **AYUSH Treatment** refers to hospitalization treatments given Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

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

a. Central and State Government AYUSH Hospital, or
b. Teaching hospitals attached to AYUSH Colleges recognized by Central Government/Council of Indian Medicine/Central Council of Homeopathy, or
c. AYUSH Hospitals standalone or co-locted with in-patient healthcare facility of recognized system of medicine, registered with local authority where applicable, and is under the supervision of qualified registered AYUSH Medical Practitioner and must comply with all the following creation:
   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 theater where operation procedure are to be carried out.
   iv. Maintains daily records of patients and makes these accessible to the Company's authorized representative.

2.8 **AYUSH Day Care Centre** means and include Community Health Center(CHC), Primary Health Center(PHC), Dispensary, Clinic, Policlinic or any such health center which is registered with local authorities where applicable and having facility for carrying out treatment procedure and medical or surgical/para- surgical interventions or both the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient service must comply with all the following criterion.

i. Having qualified AYUSH Medical Practitioner in charge round the clock
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theater where operation procedure are to be carried out .
iii. Maintains daily records of patients and makes these accessible to the Insurance Company's authorized representative.

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

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

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

a. Internal Congenital Anomaly
Congenital anomaly which is not in the visible and accessible parts of the body.

b. External Congenital Anomaly
Congenital anomaly which is in the visible and accessible parts of the body.

2.12 **Day** means a continuous period of 24 hours.

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

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

2.14 **Day Care Treatment** means medical treatment, and/or surgical procedure which is

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours.
iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

2.15 **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

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

2.17 **Dependent Child** refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

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

2.19 **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.

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

- Self
- Spouse
- Children (including unmarried children, step children or legally adopted children, who are financially dependent and aged between 91 days and 25 years).
- Parents or and parents-in-law

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

2.22 **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 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 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.

2.23 **Hospitalization:** means admission in a hospital for a minimum period of 24 consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

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

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

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

2.26 **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.

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

2.28 **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.

2.29 **Maternity expenses mean**

a. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b. expenses towards lawful medical termination of pregnancy during the policy period.

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

2.31 **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 license.

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

2.32 **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.

2.33 **Migration** means**,** the right accord to health insurance policyholder (including all the member 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.

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

2.35 **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.

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

2.37 **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.

2.38 **Policy period/ Policy tenure** mean period as mentioned in the schedule for which the Policy is issued

2.39 **Policy Schedule** means the Policy Schedule attached to and forming part of Policy.

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

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

2.42 **Proposal form** means a form to be filled in by the prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

2.43 **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.

2.44 **Renewal:** Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

2.45 **Sum Insured** means the amount specified in the Policy Schedule, which We will pay for claims made by You under the Policy Year in respect of the Insured Person(s).

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

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

2.48 **Unproven/ Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India. is treatment experimental or unproven.

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4. Scope of Coverage

The Company hereby agrees to pay in respect of an admissible claim, any or all of the following covers subject to the Sum Insured, limits, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.

4.1. Basic Plan

I. Sickness Daily Hospital Cash Benefit

During the period stated in the Schedule, if the insured person shall contract any disease or suffer from any illness and if such disease / illness shall, upon the advice of a duly Qualified Medical Practitioner, require admission of the insured Person as an In-patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay to the Insured Person, Daily Hospital Cash amount mentioned in the schedule for each consecutive 24 hours of hospitalization subject to maximum number of days stated in the Schedule.

Deductible - 1- day deductible is applicable on every hospitalization.

II. Accident Hospital Cash Benefit

During the period stated in the Schedule, if the insured person shall sustain bodily injury due to accident and if such accident shall, upon the advice of a duly Qualified Medical Practitioner, require admission of the insured Person as an In-patient in any Hospital in India for the purpose of medical /surgical treatment, then the Company will pay to the Insured Person, 2 times of Daily Hospital Cash amount mentioned in the schedule for each consecutive 24 hours of hospitalization subject to maximum number of days stated in the Schedule.

Deductible - Not Applicable

III. Intensive Care Unit (ICU) Benefit

During the policy period stated in the schedule If the insured person shall, upon the advice of a duly Qualified Medical Practitioner, require admission in ICU for the purpose of treatment of Sickness/Accident /Injury, then We will pay 2.5 times of the Daily Hospital Cash amount for each consecutive 24 hours that the Insured Person is admitted in an Intensive Care Unit, subject to maximum of 15 days per Policy Year. Whenever Intensive Care Unit benefit is admissible under the Policy, We will not pay for Daily Hospital Cash benefit in I or II above for the period when the Insured Person is in Intensive Care Unit.

Deductible - 1- day deductible is applicable on every hospitalization except accidental hospitalization.

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4.2. Advance Plan

This is an addition to basic plan as specified in 4.1

I. Convalescence Benefit:

If the Insured Person is Hospitalized in India during the Policy Period for Medically Necessary treatment of an Illness Or an Injury that occurred during the Policy Period and the continuation of such Hospitalization is Medically Necessary for at least 15 consecutive days, then will pay a lump sum amount equal to 5 times of the Daily Cash Benefit amount specified in the Policy Schedule.

This benefit is payable in addition to basic plan 4.1 only if there is an admissible claim under same.

For Individual Policy: This benefit is available only once during the Policy tenure for per Insured Person.

Deductible - Not Applicable

II. Child Birth Hospital Cash

During the period stated in the Schedule the insured person shall, upon the advice of a duly Qualified Medical Practitioner, require admission of the Insured Person as an In-patient in any Hospital in India for the purpose of Child Delivery, then the Company will pay to the insured person Daily Hospital Cash amount stated in the schedule subject to maximum number of days stated in the schedule.

Special Condition:

1. The benefit under this cover is payable after waiting period of 2 years from date of addition of spouse in the policy period subject to both self and spouse are covered.
2. This cover is available for maximum of 2 child for life time.

Deductible - Not Applicable

III. Compassionate Benefit

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment of an Injury due to an Accident that occurred during the Policy Period and the Insured Person dies during the course of such Hospitalization, We will pay the Nominee a lump sum amount equal to 10 times of the Daily Hospital Cash Benefit amount specified in the Policy Schedule.

This benefit is payable in addition to basic plan 4.1 only if there is an admissible claim under same.

Deductible - Not Applicable

5. Optional Cover

Day Care Treatment Benefit

If the Insured Person requires and avails a Medically Necessary Day Care Treatment (as defined under Annexure I below) during the Policy Period, We will pay a lump sum benefit amount which is the lower of 5 times the Daily Cash Benefit specified in the Policy Schedule or Rs.25,000 to the Insured Person for such Day Care Treatment provided the Insured Person is admitted in the Hospital for less than 24 hours. The benefit under this Section shall be available for a maximum of 1 Day Care Treatments per Policy Year. In case of Cataract, coverage is limited to 1 surgery in a Policy year.

6. Specific Exclusion - Waiting Period Applicable To Basic Plan And Advance Plan

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following waiting periods. All the waiting periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

6.1. Pre-existing Diseases (Code - Excl 01)

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

6.2. Specified disease/procedure waiting period - Two Years Exclusions (Code - Excl 02)

a. Expenses related to the treatment of the below listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific disease/procedures -
   i. Cataract,
   ii. Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids,
   iii. Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Inter-vertebral discs(other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylolisthesis,
   iv. Varicose Veins and Varicose Ulcers,
   v. Stones in the urinary uro-genital and biliary systems including calculus diseases,
   vi. Benign Prostate Hypertrophy, all types of Hydrocele, Congenital Internal Anomaly,
   vii. Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Haemorrhoids and any abscess related to the anal region,
   viii. Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery.
   ix. Gastric and Duodenal ulcer, any type of Cysts/ Nodules/ Polyps/ internal tumours/ skin tumours, and any type of Breast lumps(unless malignant), Polycystic Ovarian Diseases,
   x. Any surgery of the genito-urinary system unless necessitated by malignancy.

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6.3. First 30 Days Waiting Period (Code - Excl 03)

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

7. General Exclusion [Applicable for Basic Plan and Advance Plan]

The Company shall not be liable for Hospital Cash Amount under this policy if the hospitalization is directly or indirectly for

7.1 Investigation & Evaluation (Code – Excl 04)

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.

7.2 Rest Cure, rehabilitation and respite care- (Code- Excl 05)

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

7.3 Obesity/ Weight Control (Code- Excl 06)

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

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

7.4 Change-of-Gender treatments: (Code- Excl 07)

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

7.5 Cosmetic or plastic Surgery: (Code- Excl 08)

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

7.6 **Hazardous or Adventure sports: (Code- Excl 09)**
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7.7 **Breach of law: (Code- Excl 10)**
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

7.8 **Excluded Providers (Code – Excl 11) -**
Expenses incurred towards treatment in any hospital or by an Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

7.10 Treatments received in health 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 – Excl 13)**

7.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code-Excl 14**)

7.12 **Refractive Error (Code – Excl 15) -**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

7.13 **Unproven Treatments (Code – Excl 16) -**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

7.14 **Sterility and Infertility: (Code- Excl 17)**
Expenses related to sterility and infertility. This includes:

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

7.15

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

7.16 Intentional self-injury
7.17 Circumcision, Preputioplasty, Frenuloplasty, Preputial Dilatation and Removal of SMEGMA
7.18 Congenital External Condition / Defects / Anomalies
7.19 Venereal Disease and Sexually Transmitted Diseases (other than HIV)
7.20 Injury/disease directly or indirectly caused by or arising from or attributable to war, terrorism, invasion,act

of foreign enemy, warlike operations (whether war be declared or not)

7.21 Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

7.22 High Intensity Focused Ultra Sound, Uterine Fibroid Embolisation, Balloon Sinoplasty,Enhanced External Counter Pulsation Therapy and related therapies, Chelation therapy, Deep Brain Stimulation, Hyperbaric Oxygen Therapy, Rotational Field Quantum Magnetic Resonance Therapy, VAX-D, Low level laser therapy, Photodynamic therapy and such other therapies similar to those mentioned herein under this exclusion.

7.23 Stem cell Therapy, Chondrocyte Implantation, Procedures using Platelet Rich plasma and Intra articular injection therapy.

7.24 Oral Chemotherapy, Immuno therapy and Biologicals, except when administered as an inpatient, when clinically indicated and hospitalization warranted.

7.25 Inoculation or Vaccination (except for post–bite treatment and for medical treatment for therapeutic reasons.

7.26 Dental treatment or surgery unless necessitated due to accidental injuries and requiring hospitalization. (Dentalimplants are not payable).

7.27 Medical and / or surgical treatment of Sleep apnea, treatment of endocrine disorders.

7.28 Cochlear implants and procedure related hospitalization expenses

8. Condition(s)

8.1. The premium payable under this policy shall be payable in advance. No receipt of premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance of fulfillment of the terms, provision, conditions and endorsements of this policy by the Insured Person/s, in so far as they relate to anything to be done or complied with by the Insured Person/s, shall be a condition precedent to any liability of the Company to make any payment under this policy.

No waiver of any terms, provisions, conditions, and endorsements of this policy shall be valid unless made in writing and signed by an authorized official of the Company.

8.2. **Modification of the terms of the policy**
The Company reserves the right to modify the policy terms and conditions or modify the premium of the policy with the prior approval of the Competent Authority. In such an event the insured will be intimated three months in advance.

8.3. **Withdrawal of the policy**

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

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Toll Free: 1800-103-3009, 1800-300-30000, ISO/IEC 27001:2013 certified

8.4. **Free Look Period**

At the time of inception of the policy, the Insured will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the policy if not acceptable. In such a case, the premium refund shall be as follows :

If the Insured has not made any claim during the free look period, the Insured shall be entitled to –

a. A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured persons and the stamp duty charges and any policy administrative charges or
b. Where the risk has already commenced and the option of return of the policy is exercised by the policy holder, a deduction towards the proportionate risk premium for period on cover or
c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.
d. Free look period shall not be applicable at the time of renewal.

8.5. **Disclosure to information norms**

The policy shall become void and all premium paid hereon shall be forfeited to the Company, in the event of nondisclosure of any material fact and/or misrepresentation, fraud, moral hazard, misdescription as declared in the proposal form and/or claim form at the time of claim.

8.6. **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.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

8.7. **Migration**

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying formigration 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.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

8.8. **Policy Termination**:

The insurance under this policy with respect to each relevant Insured Person shall expire immediately on the earlier of the following events:

a. Upon the death of the Insured Person.
b. Upon exhaustion of the Hospital Cash amount chosen.
c. Upon exhaustion of the Maximum number of days per year chosen.

8.9. **Renewal**:

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.

8.10. **Important Note**

Where the policy is issued for more than 1 year, the benefits under the policy is for each of the year, without any carry over benefit thereof.

8.11. **Policy disputes**

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

8.12. **Notices**

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile/email to E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur (Rajasthan) – 302022
Phone: +91-141-3928400, 3951111, Fax: +91-141-2770692, 2770693
Website: www.shriramgi.com, E-mail: customer.feedback@shriramgi.in. Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

8.13. **Customer Service**

If at any time the Insured Person requires any clarification or assistance, the insured may contact the offices of the Company at the address specified, during normal business hours.

8.14. **Cancellation**

We may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact by sending written notice to the insured at his/her last known address at least 15 days in advance in that case we shall refund pro-rata premium for the unexpired portion of the policy on the date of cancellation, provided no claim has occurred till the date of cancellation.

The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this policy, in which case the Company shall retain the premium for the period this Policy has been in force at the Company's short period scales.

Period on risk	**% of Annual Premium refunded**		
	1 Year Policy	2 Year Policy	3 Year Policy
Upto 1 month	70%	75%	80%
Exceeding 1 month and upto 3 months	55%	70%	70%
Exceeding 3 months and upto 6 months	30%	55%	65%
Exceeding 6 months and upto 12 months	Nil	30%	45%
Exceeding 12 months and upto 18 months		10%	30%
Exceeding 18 months and upto 24 months		Nil	10%
Exceeding 24 months and upto 30 months			5%
Exceeding 30 months			Nil

8.15. **Refund of premium on death of Insured**

In the event of death of insured in the middle of policy year/during the course of policy period when no claim is paid or in the process to be paid during the policy period, premium shall be refunded on pro-rata basis for balance policy period.

Note - Refund of premium will be calculated from the date of demise subject to

a. Submission of death certificate
b. Intimation for refund should be within 30 days from date of demise of insured.

8.16. **Claims Procedure**

a. You or someone claiming on Your behalf must inform Us in writing immediately within 48 hours of hospitalization in case of emergency hospitalization and 48 hours prior to hospitalization in case of planned hospitalization.
You can intimate Us through E-mail, Fax, Telephone or at our website.

b. You or someone claiming on Your behalf must promptly and in any event within 7 days of discharge from a Hospital give Us the necessary documents along with all original supporting documentation, including but not limited to the following, and other information We ask for, to investigate the claim for Our obligation to make payment for it.

Note: Conditions **a is** precedent to admission of liability under the policy. However, the Company will examine and relax the time limit mentioned in these conditions depending upon the merits of the case.

The Insured Person/s shall submit to the Company: -

a. Duly completed claim form, and
b. Discharge Summary from the hospital
c. Hospital Main bill with breakup details.
d. Aadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)

The Company shall pay interest as per Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations, 2017, in case of delay in payment of an admitted claim under the Policy.

8.17. Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or diseases requiring Hospitalization when and as often as the same may reasonably be required on behalf of the Company.

8.18. You must take reasonable steps or measures to minimize the quantum of any claim that may be made under this Policy.

8.19. **Claims Payment**

a) We shall be under no obligation to make any payment under this Policy unless We have been provided with the documentation and information We have requested to establish the circumstances of the claim or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.
b) We will only make payment to You under this Policy. Your receipt shall be considered as a complete discharge of Our liability against any claim under this Policy.
c) In the event of Your death, We will make payment to the Nominee (as named in the Schedule). No assignment of this Policy or the benefits there under shall be permitted.

8.20. **Settlement of Claims**

a) Our Medical Practitioners will scrutinize the claims and flag the claim as settled/ rejected/ pending within the period of 30 days of the receipt of the last necessary documents.
b) In case of '**pending'** claims, We will ask for submission of incomplete documents.
c) '**Rejected'** claims will be informed to the Insured Person in writing with reason for rejection.

d) In the circumstances where a claim warrant an investigation in Our opinion, We 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, We shall settle the claim within 45 days from the date of receipt of last 'necessary' document.

e) In the cases of delay in the payment of a '**settled'** claim, We 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 which is 2% above the bank rate.

8.21. All claims under this policy shall be payable in Indian currency.

8.22. All treatments under this policy shall have to be taken in India.

8.23. **Fraud**

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

ii. 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.

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

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

iv. 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.

8.24. **Compliance with policy provisions**

Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

8.25. **Examination of Records**

We may examine Your records relating to the insurance under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy

8.26. **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.

8.27. **Legal actions**

Without prejudice to Uniform Provision 26 above, no action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) Days after written evidence has been furnished in accordance with the requirements of this Policy. If no evidence has been furnished within one (1) year of the date upon which it should have been furnished then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

If We disclaim liability to You for any claim, and if You do not notify Us in writing within one (1) year from the date of receipt of the notice of such disclaimer that You do not accept such disclaimer and intend to recover this claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

8.28. **Endorsement (Change in Policy)**

i. This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir immediate family member Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break. The policyholder may be changed during the Policy Period only in case of his/her demise him/her moving out of India.

8.29. **Change of Sum Insured**

The Sum Insured can be changed (increased / decreased) only at the time of Renewal subject to the underwriting norms and acceptability criteria of the Policy.

If You increase the sum insured, the case may be subject to health check-up.

In case of increase in the Sum Insured, the waiting periods will apply afresh in relation to the amount by which the Sum Insured has been enhanced. The quantum of increase shall be at Our discretion and subject to Our underwriting guidelines. Additional premium if any, shall be charged as per terms and conditions of the Policy.

8.30. **Terms and condition 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.

8.31. **Nomination**

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

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8.32. **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.

8.33. **Complete discharge**

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative 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.

8.34. **Relief under Section 80-D**

Insured Person is eligible for relief under Section 80-D of the IT Act in respect of the amount paid for Health Section by any mode other than cash.

8.35. **Governing Law**

The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

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9. Redressal Of Grievance

Welcome to Shriram General Insurance and Thank You for choosing us as your insurer.

Please read your Policy and Schedule. The Policy and Policy Schedule set out the terms of your contract with us. Please read your Policy and Policy Schedule carefully to ensure that the cover meets your needs.

We do our best to ensure that our customers are delighted with the service they receive from us. If you are dissatisfied we would like to inform you that we have a procedure for resolving issues. Please include your Policy number in any communication. This will help us deal with the issue more efficiently. If you don't have it, please call your Branch office.

First Step Initially, We suggest you to contact the Branch Manager / Regional Manager of the local office which has issued the Policy. The address and telephone number will be available in the Policy.

Second Step Naturally, We hope the issue can be resolved to your satisfaction at the earlier stage itself. But if you feel dissatisfied with the suggested resolution of the issue after contacting the local office, please e-mail or write to Grievance Cell, HO, headed by a senior executive which will be directly under the control of the MD at the below mentioned address:

Contact Person: Chief Compliance and Grievance Officer
Contact Address: Shriram General Insurance Co. Ltd.
E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur – 302022
Grievance Cell No: 1800-103-3009, 1800-300-30000
E-mail ID: md@shriramgi.com
Fax No.: 91-141-2770693
You can also reach us by email or register their complaints on the website of the Company.

In case your complaint is not fully addressed by the Company, You may use the Integrated Greivance Management System (IGMS) https://igms.irda.gov.in For registration please visit IRDAI website www.irda.gov.in.

The contact details of the ombudsman offices are mentioned below. However, We request you to visit https://www.shriramgi.com for updated details.

Grievance Redressal Cell for Senior Citizens
Our customers who are above 60 years of age we have created special cell to address any health insurance related grievances.
Our senior citizen customers can reach us through the below dedicated channels to enable us to service them promptly.
Grievance Cell No: 1800-103-3009, 1800-300-30000
Exclusive Email address: seniorcitizen@shriramgi.com
In case your complaint is not fully addressed by the Company, You may use the Integrated Greivance Management System (IGMS) https://igms.irda.gov.in For registration please visit IRDAI website www.irda.gov.in.

The contact details of the ombudsman offices are mentioned below. However, We request you to visit https://www.shriramgi.com for updated details.

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The contact details of the Insurance Ombudsman offices are as below

Office Location	**Contact Details**	**Jurisdiction of Office Union Territory,District)**
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@cioins.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@cioins.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@cioins.co.in	Madhya Pradesh, Chattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.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@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & 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@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
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@cioins.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 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.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@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
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@cioins.co.in	West Bengal, Sikkim, Andaman & 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@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, 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@cioins.co.in	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 Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.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.
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
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@cioins.co.in	Maharashtra,Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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Annexure – I
List of Day Care Treatments covered under Day Care Treatment Benefit are as follows:

1. Cataract
2. Lithotripsy/ Nephrolithotomy for renal calculus
3. Coronary angiography
4. Haemodialysis
5. Parenteral Chemotherapy
6. Manipulation of dislocation under GA
7. Radiotherapy
8. Cystoscopy under GA
9. Therapeutic curettage
10. Surgery for ligament tear

Insured person is eligible for a claim in-respect of the above said day care treatments only for one time in a policy year.