SENIOR CITIZEN HEALTH INSURANCE POLICY WORDING

To help You understand Your Policy, the following words and phrases used anywhere within the Policy have specific meanings, which are set out in this section. To enable You recognize the defined words and phrases, We have shown them in Italics wherever they appear in Your Policy.

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.

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

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

Ambulance means any vehicle used solely for Your conveyance if You are injured from the Accidental location or Your residential place or Hospital to any Hospital in emergency cases.

Any One Illness means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.

Alternative Treatment means forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

AYUSH Hospital - 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.

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

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

Company means "Universal Sompo General Insurance Company Limited."

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

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

a) **Internal Congenital Anomaly**: means which is not in the visible and accessible parts of the body
b) **External Congenital Anomaly**: means which is in the visible and accessible parts of the body

Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

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

Daily Allowance is the amount specified as such in the Schedule

Day Care Centre means any institution established for Day Care Treatment of Illness and/or 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

- has qualified nursing staff under its employment;
- has qualified Medical Practitioner/s in charge;
- has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

maintains daily records of patients and will make these accessible to the insurance Company's authorized personnel

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.

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

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

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

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

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

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.

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

Hospital means any institution established for in-patient care and Day Care Treatment of Illness and/or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the

enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- has qualified Medical Practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

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

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.

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.

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.

a) **Acute Condition** is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/Illness/Injury which leads to full recovery.
b) **Chronic condition** is defined as a disease, Illness, or Injury that has one or more of the following characteristics

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

Insured means the individual whose name is specifically appearing in the Schedule herein after referred as "You"/"Your"/"Yours"/"Yourself".

Insured Persons means the individual(s) whose name is/are appearing in the Schedule and shall include his/her spouse, dependent children and/ or parents

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 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.

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 support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

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.

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

Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

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

- is required for the medical management of the Illness or Injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner,
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Network Provider means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured on payment by a cashless facility.

Nominee means the person(s) nominated by the Insured Person to receive the insurance benefits under this Policy payable on his/her death.

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

Notification of Claim is the process of notifying a claim to the insurer or TPA through any of the recognized modes of communication.

Out-Patient (OPD) Treatment is one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Policy means Our contract of insurance with the Insured providing cover as detailed in this document.

Policy Period means the Policy Period as set out in the Schedule for which the insurance cover will remain valid.
Policy Year means a year following Policy Period Start Date and its subsequent annual anniversary.

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

Pre- Existing Diseases means any condition, ailment or Injury or disease:

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

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

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

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

- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required and
- The inpatient Hospitalization claim for such Hospitalization is admissible by the insurance Company.

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

Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include associated Medical Expenses.

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 all waiting periods.

Sum Insured means the sum as mentioned in the Schedule against the respective benefit(s) which represents Our maximum liability for any or all claims under this Policy during the Policy Period.

Service Providers means any person, institution or organisation that has been empanelled by the Company to provide services to the Insured Person specified in the Policy.

Schedule means Schedule attached to and forming part of this Policy mentioning the details of the Insured/Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy would be payable

Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

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.

You/Your/Yours/Yourself means the person(s) that We insure and is/are specifically named as Insured in the Schedule.

We/Our/Ours/Us means Universal Sompo General Insurance Company Limited.

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.

War means war, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

What will We Pay? (Scope of Cover)

SECTION A – HOSPITALISATION (Base Cover)

1. In-patient Treatment

We hereby agree subject to terms, conditions and exclusions herein contained or otherwise expressed hereon that, if during the Policy Period, You require Hospitalization for any Illness or Injury on the written advice of a Medical Practitioner, then We will indemnify the Medical Expenses so incurred by You as per below heads

Hospitalisation Benefits		Limits
A	i)Room, Boarding expenses a provided by the Hospital/Nursing Home ii)If admitted in IC Unit	i) Up to 1% of Sum Insured or actuals whichever is less per day ii) Up to 2% of Sum Insured or actuals whichever is less per day Overall limit:25% of the S.I. per illness/ injury or actuals whichever is less
B	Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees, Nursing Expenses	Up to 25% of Sum Insured per illness/ Injury or actuals whichever is less
C	Anaesthesia, Blood, Oxygen, OT charges, Surgical appliances(any disposable surgical consumables subject to upper limit of 7% of Sum Insured), Medicines, drugs, Diagnostic material & X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of pacemaker, artificial limbs, Cost of stent & implants	Up to 50% of Sum Insured per illness/Injury or actuals whichever is less

Hospitalization expenses of person donating an organ during the course of organ transplant will also be payable subject to the sub limits under "C" above applicable to you.
However, our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

2. Day Care Procedures/ Treatment

We hereby agree subject to terms, conditions and exclusions herein contained or otherwise expressed hereon that, if during the Policy Period, You require Hospitalization as an inpatient for less than 24 hours in a Hospital (but not in the outpatient department of a Hospital) on the written advice of a Medical Practitioner, then We will pay You for the Medical Expenses incurred for undergoing such Day Care Procedure/Treatment or surgery, (as is mentioned in the list of Day Care Procedures/Treatments annexed to this Policy).

However, Our total liability under this cover for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

3. Pre-Hospitalization and Post-Hospitalization Expenses

We hereby agree subject to the terms, conditions and exclusions herein contained or otherwise expressed hereon that, We will compensate You for the relevant Medical Expenses incurred by You in relation to:

- Pre-hospitalization Medical Expenses incurred by You for a 30-day period immediately before Your date of Hospitalization; and
- Post-hospitalization Medical Expenses incurred by You for a 60-day period immediately after the date of discharge from the Hospital, provided that Your Hospitalization falls within the Policy Period and We have accepted Your Claim under "In-patient Treatment" or "Day Care Procedures" section of the Policy.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

4. Domiciliary Hospitalization

We hereby agree subject to the terms, conditions and exclusions herein contained or otherwise expressed here on that, We will compensate You for expenses incurred on availing medical treatment at home on recommendation of a Medical Practitioner, which would otherwise have required hospitalisation.

The cover under this Section will be available up to a maximum of 50% of Sum Insured opted by You or actual amount incurred whichever is less.However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

5. Cost of Health Check-up

We hereby agree subject to the terms, conditions and exclusions herein contained or otherwise expressed here on that, We will provide for payment to You for the charges incurred for medical check-up once in a block of every 3 years up to 1.25% of the average Sum Insured or the actual charges incurred whichever is less provided there were no claims reported in this Section of the Policy during the said 3 years block period. In case, of floater policies, the above limit of 1.25% of average Sum Insured for the three years is for the two Insured Persons covered under the Policy.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

6. Daily Allowance

We hereby agree, subject to the terms, exclusions and conditions herein contained or otherwise expressed hereon, to pay You 0.1% of Sum Insured or Rs 250 whichever is less, as a Daily Allowance, for each continuous and completed period of 24 hours of Hospitalisation subject to a maximum of Rs 2500 under the Policy.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

7. Ambulance Charges

We hereby agree, subject to the terms, exclusions and conditions herein contained or otherwise expressed hereon, to reimburse You for the expenses incurred for transportation by ambulance to the nearest Hospital/ Nursing Home for treatment of the disease/ illness/ injury necessitating Your admission to Hospital/ Nursing Home up to 1% of Sum Insured or Rs 1500 or actual amount incurred in such transportation whichever is less.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

8. Expenses of Accompanying Person

We hereby agree, subject to the terms, exclusions and conditions herein contained or otherwise expressed hereon, to reimburse You for the expenses incurred by the person who is accompanying You at the Hospital/ Nursing Home whilst You are being hospitalized. These expenses comprise of expenses on food, additional bed charges for such accompanying person being charged by the Hospital/ Nursing Home.

The cover under this Section will be available up to a maximum of 1% of Sum Insured opted by You or the actual amount incurred whichever is less.However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

9. Cumulative Bonus

Sum insured under the Policy shall be progressively increased by 5 % in respect of each claim free year of insurance subject to maximum accumulation of 10 claim free years of insurance. In case of claim under this section, the increased percentage will be reduced by 5% of Sum Insured at the next renewal. However, the basic Sum Insured will be maintained and will not be reduced. A claim under Section B- Critical Illness, if available under the Policy, shall not affect Your right to the Cumulative Bonus under this Section of the Policy.

10. Sublimit

Notwithstanding anything to the contrary in the Policy and subject to the Sum Insured Our maximum liability to make payment for the Medical Expenses incurred during any Hospitalisation (including its related Pre and Post Hospitalization expenses if applicable) due to the below mentioned Surgeries / Medical Procedures or any medical treatment pertaining to an Illness / Injury shall be limited as per the table below:

Cataract per eye	Rs 10,000
Other Eye Surgery	Rs 15,000
Surgeries for Tumor/ Cysts/ Nodule/ Polyp	Rs 20,000
Stone in Urinary System	Rs 20,000
Hernia Related	Rs 20,000
Appendisectomy	Rs 20,000
Knee Ligament Reconstruction Surgery	Rs 40,000
Hysterectomy	Rs 20,000
Fissures/ Piles/ Fistula	Rs 15,000
Spine and Verebrae related	Rs 40,000
Cellulites/ Abscess	Rs 15,000

For the purpose of applicability of the said sub-limits, multiple Hospitalizations pertaining to the same Illness or medical procedure / surgery occurring within a period of 45 days from the date of discharge of the first Hospitalization shall be considered as one Hospitalization.
Besides the above mentioned, no other sublimit for any major surgery or procedure shall be applicable under the Policy.

SECTION B – CRITICAL ILLNESS (Optional Cover)

What will We pay? (Scope of Cover-)

We agree, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, general exclusions stated in the Policy, to pay such Sum Insured as mentioned against Section B in the Schedule to this Policy, on the occurrence of any of the below mentioned Critical Illnesses and/ or undergoing of the below mentioned Surgical Procedure that You/ Your Spouse may suffer from or undergo provided that

- In the event of a claim, the Critical Illness have to be diagnosed by a Medical Practitioner, supported by radiological, histological and laboratory evidence acceptable to Us and to be reconfirmed by a Medical Practitioner appointed by Us.
- We shall compensate You/ Your Spouse only once in respect of any particular Critical Illness/ Surgical Procedure mentioned as covered in the Schedule.
- Cover under this policy shall cease upon payment of the compensation on the happening of a Critical Illness and/ or undergoing of listed Surgical Procedure and no further payment will be made for any consequent disease or any dependent disease.
- You should survive for 30 days post diagnosis of such Critical Illness to be able to make a claim under the Policy.

Specified Critical Illnesses and Surgical Procedures

1. Cancer of specified severity

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded:

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. All tumors in the presence of HIV infection.

2. Open Chest CABG

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

3. Kidney Failure requiring regular dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

4. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and

embolization from an extra cranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

Exclusion

- Transient ischemic attacks (TIA)
- Traumatic Injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions

5. Major Organ /Bone Marrow Transplant

The actual undergoing of a transplant of:

- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

6. Multiple Sclerosis with persisting symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

What will We not pay for? (Specific Exclusions)

1. Any Illness, sickness or disease , other than specified as Critical Illness, as mentioned in the policy schedule, or
2. Any Critical Illness of which, the signs or symptoms first occurred prior to or within Ninety (90) days following the Policy Issue Date or the last Commencement Date, whichever is later, or
3. Any Critical Illness based on a diagnosis made by You or Your immediate family member or anyone who is living in the same household as You or by a herbalists, acupuncturist or other non-traditional health care provider.

SECTION C - 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:

1. Pre-Existing Diseases (Code- Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage, as may be the case 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 under the policy, then waiting period for the same would be reduced to the extent of prior coverage.

List of specific diseases/procedures:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy unless because of malignancy
- All types of Hernia, Hydrocele
- Fissures and/or Fistula in anus, hemorrhoids/piles
- Arthritis, gout, rheumatism and spinal disorders
- Sinusitis and related disorders
- Stones in the urinary and billiary systems
- Dilatation and curettage , Endometriosis
- All types of Skin and internal tumors/ cysts /nodules/ polyps of any kind including breast lumps unless malignant
- Dialysis required for chronic renal failure
- Surgery on tonsils, adenoids and sinuses
- Gastric and Duodenal erosions & ulcers
- Deviated Nasal Septum
- Varicose Veins/ Varicose Ulcers
- Joint replacements unless due to accident

3. First Thirty Days Waiting Period (Code- Excl03)

- **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 is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

SECTION D - 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:

A. Investigation & Evaluation(Code- Excl04)

- **a)** Expenses related to any admission primarily for diagnostics and evaluation purposes.
- **b)** Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

B. Rest Cure, Rehabilitation and Respite Care (Code- Excl05)

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

C. Obesity/ Weight Control (Code- Excl06)

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

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMl);
   - **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

D. Change-of-Gender Treatments: (Code- Excl07)

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

E. Cosmetic or plastic Surgery: (Code- Excl08)
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

F. Hazardous or Adventure sports: (Code- Excl09)
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

G. Breach of law: (Code- Excl10)
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

H. Excluded Providers: (Code-Excl11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

J. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

K. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code-Excl14)**

L. Refractive Error:(Code- Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

M. Unproven Treatments:(Code- Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness. any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

N. Sterility and Infertility: (Code- Excl17)
Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy
(iv) Reversal of sterilization

O. Maternity Expenses (Code – Excl 18):

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.

P. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

Q. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

R. Treatment taken outside the geographical limits of India

S. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

SECTION E - CLAIMS PROCEDURE

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.

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.

SI No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care 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. Notification of Claim

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

i Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

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

4. Documents to be submitted:

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

i. Duly Completed claim form

ii. Photo Identity proof of the patient

iii. Medical practitioner's prescription advising admission

iv. Original bills with itemized break-up

v. Payment receipts

vi. Discharge summary including complete medical history of the patient along with other details.

vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner

viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).

ix. Sticker/Invoice of the Implants, wherever applicable.

x. MLR(Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever 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.

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

5. Payment of Claim

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

6. Position after claim

i.In cases of claim under Section A- Hospitalization ,

For Individual Policies: We shall reduce the Sum Insured in respect of Insured Person to whom such sum shall become payable, by the amount admissible under the claim and paid by Us.

For floater Policies: the floater Sum Insured shall be reduced by the amount admissible and paid by Us irrespective of which of the Insured Person(s) claimed under the Policy.

ii. In case of a claim under Section B- Critical Illness cover, on admissibility and payment of a claim by Us, We shall delete the name of the Insured Person in respect of whom such sums shall become payable by passing an endorsement to this effect and that person shall be no longer be covered under the Section B- Critical Illness cover and consequently no further benefit under the section shall accrue to such Insured Person. We shall however, continue to cover the said Insured Person for the risks covered under Section A- Hospitalisation

iii. We shall have no liability under the Policy, once the Sum Insured (Maximum Limit of Liability), as stated in the Policy Schedule with respect to any of the Sections, is exhausted by You or Your Spouse

SECTION F – DISCOUNT AND LOADING

1. **Long Term Policy Discount**- Policy terms 1 year to 3 years are available under the policy. The following discounts will be offered if the Policy is taken by paying the

appropriate premium for 2 years/ 3 years at once. No installment facility in payment of premium is available to you if you choose to opt for a long term policy,

Duration of policy	Premium to be charged
2 years	2 year premium in advance less 10% discount
3 years	3 year premium in advance less 15% discount

2. **Family discount:** A family discount of 10% shall be applicable on hospitalisation premium when an individual opts for covering his/ her spouse under the policy on individual Sum Insured basis. This discount shall not be applicable when Your Spouse is covered under the Policy on Floater Sum Insured basis.
3. **Loading based on location:** We may load premium up by 10% if You are a resident of any one for the Tier 1 cities viz. Delhi/NCR, Mumbai, Bengaluru, Chennai, Pune, Hyderabad, Kolkata, Ahmedabad.
4. **Health status loading:** We may load premium up to 100% as under the policy depending on Your health status.

Health Status Indicators					
S.N.	**Health Indicators**		**Normal**	**Borderline Level**	**High**
1	**Blood Sugar Levels**		99 mg and lower	100-125 mg	126 mg and higher
2	**Blood Pressure**	**Systolic**	Below 130	130-139	140 or higher
		Diastolic	Below 80	80-89	90 or higher
3	**Cholesterol Level (mg/dL)**		Below 200	200-239	240 or higher
4	**Body Mass Index**		18.5-24.9	25-29.9	30 or higher
5	**Any disease co-existing with any of the above**				

Health Status Loading	**Loading**
For Normal conditions and no co-existing disease at time of proposal	Nil
For any One Borderline Level Condition	20%
For any One Borderline condition with a co-existing disease or any Two Borderline Level conditions	30%
For any Two Borderline Level Condition with a co-existing disease	40%
For all three Borderline Level Condition	50%
For any one High condition or all three Borderline Level Conditions with a co-existing disease	60%
For two or more high conditions	100%

5. **Floater extension loading:** A loading of 40% shall be applied on premium for Section A- Hospitalisation when the cover under section A of the policy is extended to spouse of the primary insured. Sum Insured under the section, then shall be available on floater basis.

   We will inform You about the applicable risk loading through a counter offer letter. You have to revert to Us with consent and additional premium (if any) within 15 days of issuance of such counter letter. In case, You neither accept the counter letter from Us nor

revert to Us within 15 days, We shall cancel Your application and refund the premium within next 7 days.

6. Medical Examination

We may ask You or Your spouse (if proposed for insurance under the Policy) to undergo below mentioned medical tests for purpose of consideration of Your proposal on basis of Your medical conditions/ health status declaration in the Proposal Form.

S. No	List of Medical tests	Sum Insured limits
1	Complete Blood Sugar, Urine, Routine Blood Group, ESR, Fasting Blood, Glucose, S Cholesterol, SGPT, Creatinine	Rs 1,00,000
2	Complete Blood Sugar, Urine, Routine Blood Group, ESR, Fasting Blood, Glucose, S Cholesterol, SGPT, Creatinine, ECG	Rs 2,00,000 and Rs 3,00,000
3	Complete Blood Sugar, Urine, Routine Blood Group, ESR, Fasting Blood, Glucose, S Cholesterol, SGPT, Creatinine, ECG, Lipid Profile, Stress test or 2D Echo, Kidney Function Test Complete Physical test by a physician	Rs 4,00,000 and 5,00,000

It is agreed and understood that details in the table above, including the list of medical tests is indicative and We reserve the right to add, to modify or amend these details.

If your proposal is accepted by Us, then 50% of the costs incurred in conducting the above mentioned medical tests shall be reimbursed by Us.

We may waive Medical Examination for You or Your spouse under the Policy

- If You or Your spouse have been continuously covered under a health insurance policy from Us or any other insurers for a period of three years and have had no claims under the policy.

7. Region of Cover

We shall pay for treatment confined to the Hospitals in India only. All benefits under the Policy shall be come payable when incurred in India.

8. Sum Insured Enhancement – Sum Insured can be enhanced only upon renewal, subject to

a) No claim under the previous policy with Us
b) Our underwriter's approval.

SECTION G – GENERAL CONDITIONS

i. Disclosure of Information

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

ii. 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.

iii. 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 to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

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 or reject 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 to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

iv. 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.

v. Multiple Policies

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

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

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

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

vi. Fraud

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

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

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

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

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

vii. Cancellation

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

Cancellation Period						
Cover Period	**Within 1 month**	**From 1 month to 3 months**	**From 3 month to 6 months**	**From 6 months to 1 year**	**During 2nd Year**	**During 3rd Year**
1 year	75%	50%	25%	0%	NA	NA
2 year	75%	65%	50%	25%	0%	NA
3 year	75%	70%	60%	45%	11%	0%

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

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

viii. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently 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 www.universalsompo.com

ix. 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 www.universalsompo.com

x. Renewal of Policy

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

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

xi. Withdrawal of Policy

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

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

xii. 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.

xiii. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

xiv. 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;

xv. Redressal of Grievance

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

Universal Sompo General Insurance Co. Ltd.
Express IT Park, Plot No. EL - 94, T.T.C. Industrial Area, M.I.D.C., Mahape,
Navi Mumbai-400710
Website: www.universalsompo.com
Toll free: 1800-200-5142
E-mail: contactus@universalsompo.com
Fax : (022) 39171419

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 grievance@universalsompo.com

For updated details of grievance officer, kindly refer the link www.universalsompo.com

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

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

xvi. Nomination:

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

ANNEXURE-A

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

List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -		
Serial no	Toiletries/ cosmetics/ personal comfort or convenience items	
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable

10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable
36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable

46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures may be considered
Items specifically excluded in the policies		
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
69	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
70	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
71	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified

Items which form part of hospital services where separate consumables are not payable but the service is		
72	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
73	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
74	MICROSCOPE COVER	Payable under OT Charges, not payable separately
75	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not payable separately
76	SURGICAL DRILL	Payable under OT Charges, not payable separately
77	EYE KIT	Payable under OT Charges, not payable separately
78	EYE DRAPE	Payable under OT Charges, not payable separately
79	X-RAY FILM	Payable under Radiology Charges, not as consumable
80	SPUTUM CUP	Payable under Investigation Charges, not as consumable
81	BOYLES APPARATUS CHARGES	Part of OT Charges, not separately
82	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
83	ANTISEPTIC OR DISINFECTANT LOTIONS	Not Payable-Part of Dressing Charges
84	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
85	COTTON	Not Payable-Part of Dressing Charges
86	COTTON BANDAGE	Not Payable- Part of Dressing Charges
87	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
88	BLADE	Not Payable
89	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU chatges
90	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
91	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
92	URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE		

93	LUXURY TAX	Actual tax levied by government is payable. Part of room charge for sub limits
94	HVAC	Part of room charge not payable separately
95	HOUSE KEEPING CHARGES	Part of room charge not payable separately
96	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
97	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
98	SURCHARGES	Part of Room Charge, Not payable separately
99	ATTENDANT CHARGES	Not Payable - Part of Room Charges
100	IM IV INJECTION CHARGES	Part of nursing charges, not payable
101	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
102	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
103	BLANKET/WARMER BLANKET	Not Payable- part of room charges
ADMINISTRATIVE OR NON-MEDICAL CHARGES		
104	ADMISSION KIT	Not Payable
105	BIRTH CERTIFICATE	Not Payable
106	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
107	CERTIFICATE CHARGES	Not Payable
108	COURIER CHARGES	Not Payable
109	CONVENYANCE CHARGES	Not Payable
110	DIABETIC CHART CHARGES	Not Payable
111	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
112	DISCHARGE PROCEDURE CHARGES	Not Payable
113	DAILY CHART CHARGES	Not Payable
114	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
115	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
116	FILE OPENING CHARGES	Not Payable
117	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
118	MEDICAL CERTIFICATE	Not Payable
119	MAINTAINANCE CHARGES	Not Payable
120	MEDICAL RECORDS	Not Payable

121	PREPARATION CHARGES	Not Payable
122	PHOTOCOPIES CHARGES	Not Payable
123	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
124	WASHING CHARGES	Not Payable
125	MEDICINE BOX	Not Payable
126	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
127	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES		
128	WALKING AIDS CHARGES	Not Payable
129	BIPAP MACHINE	Not Payable
130	COMMODE	Not Payable
131	CPAP/ CAPD EQUIPMENTS	Device not payable
132	INFUSION PUMP - COST	Device not payable
133	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
134	PULSEOXYMETER CHARGES	Device not payable
135	SPACER	Not Payable
136	SPIROMETRE	Device not payable
137	SPO2 PROBE	Not Payable
138	NEBULIZER KIT	Not Payable
139	STEAM INHALER	Not Payable
140	ARMSLING	Not Payable
141	THERMOMETER	Not Payable (paid by patient)
142	CERVICAL COLLAR	Not Payable
143	SPLINT	Not Payable
144	DIABETIC FOOT WEAR	Not Payable
145	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
146	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
147	LUMBO SACRAL BELT	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
148	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
149	AMBULANCE COLLAR	Not Payable
150	AMBULANCE EQUIPMENT	Not Payable
151	MICROSHEILD	Not Payable

152	ABDOMINAL BINDER	Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION		
153	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\DETTOL\SAVLON\ DISINFECTANTS ETC	Payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
154	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
155	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
156	SUGAR FREE TABLETS	Payable -Sugar free variants of admissible medicines are not excluded
157	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
158	DIGESTION GELS	Payable when prescribed
159	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
160	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
161	HIV KIT	Payable - payable Pre-operative screening
162	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
163	LOZENGES	Payable when prescribed
164	MOUTH PAINT	Payable when prescribed
165	NEBULISATION KIT	If used during hospitalization is payable reasonably
166	NOVARAPID	Payable when prescribed
167	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
168	ZYTEE GEL	Payable when prescribed
169	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE		
170	AHD	Not Payable - Part of Hospital's internal Cost
171	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
172	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost

OTHERS		
173	VACCINE CHARGES FOR BABY	Not Payable
174	AESTHETIC TREATMENT / SURGERY	Not Payable
175	TPA CHARGES	Not Payable
176	VISCO BELT CHARGES	Not Payable
177	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
178	EXAMINATION GLOVES	Not payable
179	KIDNEY TRAY	Not Payable
180	MASK	Not Payable
181	OUNCE GLASS	Not Payable
182	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
183	OXYGEN MASK	Not Payable
184	PAPER GLOVES	Not Payable
185	PELVIC TRACTION BELT	Should be payable in case of PIVD requiring traction as this is generally not reused
186	REFERAL DOCTOR'S FEES	Not Payable
187	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable
188	PAN CAN	Not Payable
189	SOFNET	Not Payable
190	TROLLY COVER	Not Payable
191	UROMETER, URINE JUG	Not Payable
192	AMBULANCE	Payable-Ambulance from home to hospital or inter hospital shifts is payable/ RTA as specific requirement is payable
193	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
194	URINE BAG	Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs
195	SOFTOVAC	Not Payable
196	STOCKINGS	Essential for case like CABG etc. Where it should be paid.

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

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)

2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

SI 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

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES- DIET

	CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

ANNEXURE B

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	**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
Karnataka.	**BENGALURU** Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh Chattisgarh.	**BHOPAL** Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Orissa.	**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
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	**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

Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	**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
Delhi.	**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@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**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
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	**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
Rajasthan.	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala, Lakshadweep, Mahe-a part of Pondicherry.	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340, Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow,	**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

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.	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	**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 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.	**NOIDA** Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand.	**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
Maharashtra, Area of Navi Mumbai and Thane	**PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan

excluding Mumbai Metropolitan Region.	Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in

EXTENSION WORDINGS

Extension: Floater Benefit:

Floater Benefit means that the aggregate Sum Insured under Section A, as specified in the Policy Schedule, is available to You or Your spouse, as covered under this Policy at the Policy Period Start Date, for any Claim made in aggregate during each Policy Year of the Policy Period.

It is hereby declared and agreed that notwithstanding anything to the contrary in the Policy, We will pay You or Your spouse, for any Claim subject to the Sum Insured, made in aggregate by You or Your spouse under the Floater Benefit, provided such Claim is admissible under the Policy.

Subject otherwise to the terms, conditions and exclusions of the Policy.