my:health Medisure Prime Insurance

Policy Wording

A. PREAMBLE

The Insured named in the Schedule has, by a Proposal, declaration and/or medical reports which shall be the basis of the contract and shall be deemed to be incorporated herein, applied to L & T General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth.

Subject to the terms, conditions, exclusions, stipulations and definitions contained herein or endorsed or otherwise expressed hereon, if during the **Policy Period**, the Insured/Insured Person shall contract any disease or illness or suffer any injury and is required to undergo treatment by way of i) Hospitalisation in any Hospital/Nursing Home in India (hereinafter called "Hospital") upon the advice of a duly qualified Medical Practitioner, the Company agrees to reimburse to the Insured/Insured Person or his/her nominee, expenses related to such treatment by reimbursement of **Expenses** covered under this Policy, not exceeding the **Sum Insured** (including earned Cumulative Bonus if any) for all claims during such **Policy Period.**

B. DEFINITIONS

Following words and expressions which are defined to bear the same meaning wherever they appear in this Policy:

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

"Any one Illness" will mean continuous period of illness and includes relapse within 45 days from the date of last consultation at the Hospital/Nursing Home where treatment was taken. Occurrence of same illness after a lapse of 45 days as stated above will be considered as fresh illness for the purpose of this policy.

"Congenital External Anomaly" means a condition(s) which is present since birth, in the visible and accessible parts of the body, and which is abnormal with reference to form, structure or position.

"Congenital Internal Anomaly" means a condition(s) which is present since birth, but is internal and not visible or known.

"Co-payment" is a cost sharing requirement under a health insurance policy that provides that the Insured will bear a specific percentage of the admissible costs. A co-payment is applicable on a claim and does not impact the Sum Insured.

"Critical Illness" means following disease/illness:

Cancer (of specific 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 –

- Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
- Any skin cancer other than invasive malignant melanoma
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocyctic leukaemia less than RAI stage 3
- micro-carcinoma of the bladder
- All tumours in the presence of HIV infection.

Coronary Artery Bypass Graft

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.
Excluded are: (1) Angioplasty and/or any other intra-arterial procedures (2) any key-hole or laser surgery.

First Heart Attack (of specific severity)

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis for this will be evidenced by all of the following criteria:

- a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
- new characteristic electrocardiogram changes
- elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

- Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
- Other acute Coronary Syndromes
- Any type of angina pectoris

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.

Multiple Sclerosis

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

- investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
- well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

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

Major Organ 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

Stroke (resulting in permanent symptoms)

Any cerebro-vascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation 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 atleast 3 months has to be produced.

The following are excluded:

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

Aorta Graft Surgery

The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon. The diagnosis to be evidenced by any two of the following:

- Computerised tomography (CT) scan
- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Abdominal ultrasound (for associated abdominal aneursysms)
- Angiography (an x-ray of the blood vessels)

Primary Pulmonary Hypertension

The first diagnosis of a primary pulmonary hypertension (PPH) which results in elevation of blood pressure in the pulmonary artery with no apparent reason and measures greater than 25 mm Hg at rest or 30 mm Hg during exercise. The diagnosis of the condition to be evidenced by:

- Electrocardiogram or X-Ray and
- Echocardiography
- Pulmonary Function test
- High Resolution Computerized Tomography Scan (HRCT-Chest)

Further diagnosis to be evidenced by Cardiac Catheterization or Pulmonary ateriography in case the above are not sufficient to confirm PPH.

"Day Care treatment" means Medical Treatment and/or Surgical Procedure undertaken in a Hospital/Nursing Home/Day Care Centre under General or Local Anaesthesia, on the recommendation of a Medical Practitioner for diseases, illness or injury which require hospitalisation for less than 24 hours due to advancement in technology. This excludes all procedures or treatment taken in an Out Patient department.

"Dependent Child" is one who is unmarried, financially dependant on the primary insured or proposer and does not have his/her independent source of income and who is not older than 18 years of age.

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.

"Family Definition for the purpose of family discount includes the Insured, his/her lawfully wedded spouse, dependant children and parents but does not include parent in laws.

"Family for the Purpose of Family Floater" means the Insured, his/her lawful spouse and maximum of two dependent children below the age of 18 years.

"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. Grace Period under this Policy is for a period of 15 days.

"Hospital/Nursing Home" means any institution established for *in - patient care* and *day care treatment* of sickness and / or injuries and which has been registered as a hospital 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 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;
- has qualified nursing staff under its employment round the clock;
- 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 will make these accessible to the respective Insurance company's authorized personnel and is not, a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel, health spa, massage center or any similar establishment.

"Hospitalisation Expenses" mean expenses for treatment as In Patient in a Hospital for a minimum period of 24 hours (except in respect of Day Care Treatment), as admissible under this Policy, under following heads or otherwise expressly covered under this Policy:-

1. Hospital (Room & Boarding and Operation Theatre) charges,
2. Fees of Surgeon, Anesthetist, Nurse, Specialists.
3. Cost of diagnostic tests, medicines, blood, oxygen and internal appliances like pacemaker as long as these are Medically Necessary.

"Illness" means sickness or disease first diagnosed during the Policy period for which immediate treatment by a Medical Practitioner is necessary.

"Injury" means physical injury caused by unintended means during the Policy period.

"In-patient" means an Insured/Insured Person who is admitted to Hospital/Nursing Home and stays for at least 24 hours for the sole purpose of receiving treatment.

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

"Insured/Insured Person" means the person(s) named in the Schedule to this Policy, having a place of residence in India, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

"Medical Charges" mean reasonable charges unavoidably incurred by the Insured/Insured Person for the medical treatment of disease, illness or injury the subject matter of the claim as an In-patient in a Hospital/ Nursing Home, and includes the costs as defined under Hospitalisation and Pre & Post Hospitalisation Expenses.

"Medical Practitioner" A Medical practitioner is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence, provided that this person is not the Insured himself or a member of the Insured/Insured Person's family.

"Medically Necessary" treatment means any treatment, tests, medication, or stay in a Hospital/Nursing Home 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.

"New Born Baby" mean those babies born to the Insured and his/her lawfully wedded spouse during the Policy Period Aged between 1 day and 90 days.

"Network Hospital" means all such Hospitals in which Cashless facility may be availed by the Insured/Insured Person for treatment as provided herein. The list of Network Hospitals shall be available with the Company/TPA and subject to amendment from time to time.

"Non - Network" Any *hospital*, day care centre or other provider that is not part of the *network.*

"Policy" means this policy document including the summary sheet, the Proposal Form, including endorsements and the Schedule as amended from time to time.

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

"Proposal Form" means the proposal and any other information given by the Insured to the company prior to the inception of the Policy which forms the basis of this Contract of Insurance.

"Post-hospitalisation expenses" mean relevant medical expenses incurred during a period up to 90 days after hospitalisation for treatment of disease, illness or injury sustained and considered as part of a claim for hospitalisation admissible under this Policy.

"Pre-existing condition" means any disease/illness/injury or related condition for which Insured/Insured Person had signs or symptoms, and / or diagnosed, and / or received medical advice/ treatment, within 48 months prior to the first Policy taken from the Company.

"Pre-hospitalisation expenses" mean relevant medical expenses incurred during a period up to 60 days prior to hospitalisation for treatment of disease, illness or injury sustained and considered a part of a claim for Hospitalisation admissible under this Policy.

"Qualified Nurse" Qualified nurse is 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 among comparable providers only, taking into account the nature of the illness / injury involved .

"Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

"Sum Insured" means, subject to terms, conditions and exclusions of this Policy, i) the Sum Insured representing the Company's maximum liability for any or all claims during the Policy Period specified in the Schedule to this Policy separately in respect of the Insured/ Insured Person.

In case of two year policies, the Sum Insured specified on the Policy is the limit for the first year. These limits will lapse at the end of the first year and the fresh limits up to the full Sum Insured as opted, will be available for the second year.

Where the Policy is obtained on Floater basis, the Sum Insured as specified in the Schedule to this Policy representing the Company's maximum liability for all claims by the Insured and/or all Insured Persons during the Policy Period, without individual limit for each person.

In the event of a claim being admitted under this Policy, the Sum Insured for the remaining Policy Period shall stand correspondingly reduced by the amount of claim paid (including 'taxes') or admitted and shall be reckoned accordingly.

In respect of an admissible claim for treatment of a Critical Illness listed under this Policy, Reimbursement up to twice the available Sum Insured shall be payable.

"Surgery" or "Surgical operation" means manual and/or operative procedures for correction of deformities and defects, repair of injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life, performed in a Hospital/Nursing Home or day care centre by a medical practitioner.

"Third Party Administrator or TPA/Service Provider" means an organisation or institution that is licensed by the IRDA to act as a TPA and engaged for a fee or remuneration to provide Policy and claims facilitation services to the Insured/Insured Person and the Company.

C. SCOPE OF COVER

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

I. Basic Covers

1. Hospitalisation Expenses

2. Pre-Hospitalisation Expenses

3. Post-Hospitalisation Expenses

5. Day Care expenses

6. Critical Illness (Additional Coverage on Reimbursement)

The Policy provides for an additional amount equivalent to the Sum Insured opted under Hospitalisation towards treatment of listed critical illnesses specifically defined above whose signs or symptoms first commence more than 30 days after the commencement of the first Policy with us.

a) First Diagnosis of the below-mentioned Illnesses more specifically described below:
• Cancer (of specific severity)
• Kidney Failure (requiring regular dialysis)
• Multiple Sclerosis
• Primary Pulmonary Arterial Hypertension or
b) Undergoing for the first time of the following surgical procedures, more specifically described below:
• Major Organ Transplant
• Aorta Graft Surgery
• Coronary Artery Bypass Graft
c) Occurrence for the first time of the following medical events more specifically described below:
• First Heart Attack (of specific severity)
• Stroke (resulting in permanent symptoms)
If these diseases are found to be pre-existing at the time of taking the Policy then the relevant waiting period as defined under pre-existing disease shall apply. Where the diagnosed Critical Illness is due to a condition listed under Exclusion 3 below relevant waiting period shall apply.

The additional Sum Insured is exclusive and specific for the treatment of the first occurrence of the above Critical Illness undertaken in a Hospital/Nursing Home as an in-patient and will not be available for other

illnesses/hospitalization. For all other illnesses/hospitalization benefits the limits shall be Sum Insured available under Hospitalisation benefit.
Insured Person(s) diagnosed with a particular Critical Illness listed above during a policy period shall not be entitled to avail the benefits under the same Critical Illness for subsequent renewals. However he may continue to be covered for the remaining critical illnesses.
Coverage offered under this Section is in combination with the hospitalization cover and the cumulative Sum Insured under both sections could be used for any one Critical Illness Event.

7. Benefit for Hospitalisation due to Accident

In the event of the Sum Insured having been exhausted for any reason and the Insured/Insured Person has to subsequently, during the Policy Period, incurred any expenses on hospitalisation solely attributable to any accident, then the Sum Insured shall be reinstated to the extent of the eligible claim amount arising out of such hospitalisation. However such reinstatement shall not exceed the original Sum Insured.
Reinstatement shall be available only once during the Policy period and maximum amount payable under a single claim shall not exceed the Sum Insured opted under the policy in case of a floater and individual Sum Insured in case of individual cover.

8. Maternity Cover

Medical Expenses for the delivery of a child (including caesarean section) and/or Expenses related to a Medically Necessary and lawful termination of pregnancy shall be covered during the Policy limited to maximum 2 deliveries or termination(s) or either during the lifetime of an Insured/Insured Person subject to the following:

a. Maximum liability of the company per delivery or termination will be subject to limits mentioned in the Schedule to this Policy.
b. Coverage is limited to Self and lawfully wedded Spouse, when both are covered under a single Policy either as a family floater or individually.
c. A waiting period of 48 months from the date of issuance of first policy with us, provided that the Policy has been renewed continuously for that particular Insured during the said period without a break. Coverage under a policy as a dependant will not be considered as part of continuous cover.
d. Pre or Post natal Medical Expenses will be covered within the limit of Sum Insured under this benefit. However any pre-post hospitalisation covered under Scope of Cover 2 & 3 above will not be covered under this.
e. Any complication arising out of or as a consequence of maternity/child birth will be covered within the limit of Sum Insured available under this benefit.
f. Coverage shall be restricted to first two children only.

The following expenses are not covered under Maternity Benefit:

a. Medical Expenses in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.
b. Medical Expenses for ectopic pregnancy. However, these expenses will be covered under the (1) Hospitalisation Expenses under of Scope of Cover above.

9. New Born Baby Cover

Coverage for a New Born Baby shall be allowed subject to a valid claim being accepted under Maternity Cover 8 above.

The following will be covered within limit of the Sum Insured available under the Maternity Cover:

a. Medical Expenses towards treatment of the Insured Person's new born baby while the Insured Person is hospitalised as an in-patient for delivery.

b. Charges incurred on the new born baby during and post birth including any complications shall be

covered up to a period of 90 days from the date of birth and within the limit of Sum Insured under Maternity Cover without payment of any additional premium.

c. Reasonable and Customary vaccination expenses of the new born baby till he/she completes 90 days. Where a Policy ends before the new born baby has completed 90 days, then, such vaccinations shall be covered until the expiry of the policy only.

Coverage of the baby beyond 90 days shall be subject to addition of the baby into the policy by way of an endorsement or at the next renewal whichever is earlier on payment of requisite premium.

II. Value Added Covers

Benefits under this Section are Value added covers payable up to the limit of the Sum Insured as specified against each cover in the Schedule to this Policy and shall not exceed the overall limit of Sum Insured under basic Hospitalisation opted by the Insured during the policy period. Benefits under each value added cover shall be available separately to each Insured/Insured Person and available per hospitalisation.

A valid claim should have been admitted under the basic cover of the Policy, for admission of liability under each of the value added covers. Value added covers are part of the policy and available without any extra cost.

Donor Expenses

This Policy provides for reimbursement of expenses incurred towards donor in case of major organ transplant, for the harvesting of the organ provided that:

- The Organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules,
- The Organ donated is for the use of the Insured Person.

Coverage under this section shall not pay for any Pre-Post hospitalization expenses, donor screening, cost of organ or any other medical treatment for the donor consequent on the harvesting.

Hospital Cash

This Policy provides for payment to the Insured / Insured Person of a Daily Hospital Cash Allowance of Rs 1000 per day from day 4 to day 10 provided hospitalization exceeds 3 days continuously.

Ambulance Charges

This Policy provides for reimbursement to the Insured/ Insured Person for expenses incurred towards his / her transportation by ambulance to the Hospital / Nursing Home for treatment of the disease / illness / injury necessitating his / her admission to Hospital / Nursing Home up to a maximum of Rs 1500.

Recovery Benefit

This Policy provides for payment to the Insured / Insured Person of the for a lump sum amount of Rs 10000 in the event his/her hospitalisation for a disease / illness / injury for a continuous period of not less than 10 days.

Expenses on accompanying person

This Policy provides for payment to the Insured / Insured Person for expenses incurred by the accompanying person at the Hospital / Nursing Home up to a maximum of Rs 500 towards treatment of Insured / Insured Person for a disease, illness, injury necessitating his / her hospitalization for a maximum period of 7 days subject to hospitalization exceeding 3 days and such expenses being charged/included as a part of the Main Hospital Bill of the Insured/Insured Person. Coverage will be available from day 4 to day 10. Help

III Additional Features

2 Year Health Check Up

This Policy provides for an all paid Comprehensive Health Check-Up (designed by the Company) for Insured Persons above the age of 45 years at the end of every two continuous policy years. Insured Persons entering the Policy at 43 will be eligible for this check up on 2nd renewal of the policy provided they have attained 46 years of age at the time of such eligibility. Health Check-ups will be arranged by the Company and carried out at the Company's network Hospital/Clinics/Diagnostic Centres.

Note: It is expressly agreed and understood that all expenses covered under the aforesaid Benefits/Value Added Covers shall be calculated at usual, customary and reasonable rates as defined above.

D. EXCLUSIONS

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

1. All pre-existing diseases / illness / injury / conditions as defined in the Policy, until 24 months of continuous covers have elapsed since inception of the first Policy with us.
2. Any disease contracted and/or medical expenses incurred in respect of any disease/illness by the Insured/Insured Person during the first 30 days from the commencement date of the Policy except in case of accidental injuries. This exclusion doesn't apply for Insured/Insured Person having any health insurance indemnity policy in India atleast for 1 year prior to taking this Policy as well as for subsequent renewals with the Company without a break**.**
3. All expenses along with their complications on treatment towards Cataract, Hysterectomy for Menorrhagia or Fibromyoma, Knee Replacement Surgery (other than caused by an accident), Arthritis, Rheumatism, Joint Replacement Surgery (other than caused by accident), Prolapse of Intervertibral discs(other than caused by accident), Varicose Veins and Varicose Ulcers, Hernia, Stones in the urinary uro-genital and biliary systems, Benign Prostate Hypertrophy, Hydrocele, Congenital internal anomoly, Fistula in anus, Piles, Pilonidal sinus, Chronic Suppurative Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps, and any type of Breast lumps, Hypertension and Diabetes and related complications during the first two years(24 months) of continuous operation of this insurance cover.
   Diabetes & Related complications include: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper/Hypoglycemic Shocks.
   Hypertension & Related complications include: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nehpropathy, Internal Bleed/Haemorrhages. If these diseases are pre-existing at the time of proposal or subsequently found to be pre-existing exclusion 1 above shall apply.
4. Any treatment arising from or traceable to pregnancy, childbirth including caesarean section until 48 months of continuous coverage has elapsed since the inception of the first policy with us. However, this exclusion/waiting period will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.
5. Any Domiciliary Hospitalization / Treatment.
6. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder or due to an accident.
7. Genetic disorder and stem cell implantation/surgery.
8. Dental treatment or surgery of any kind unless necessitated due to an accident and requiring minimum 24 hours hospitalization or treatment of irreversible bone disease involving the jaw which cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.
9. Birth control procedures, hormone replacement therapy and voluntary termination of pregnancy

during the first 12 weeks from the date of conception.

10. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for cosmetic purposes or corrective surgeries, contact lenses or hearing aids, vaccinations except post-bite treatment or for new born baby up to 90 days, issue of medical certificates and examinations as to suitability for employment or travel.
11. All expenses arising out of any condition directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III) or Lymphadinopathy Associated Virus (LAV) or Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV and sexually transmitted diseases.
12. Vitamins and tonics unless forming part of treatment for disease, illness or injury and prescribed by a Medical Practitioner.
13. Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and Continuous Peritoneal Ambulatory Dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition, Infusion pump or any other external devices used during or after treatment.
14. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
15. Treatment for developmental problems including learning difficulties eg. Dyslexia, behavioural problems including attention deficit hyperactivity disorder(ADHD)
16. Treatment for general debility, ageing, convalescence, run down condition or rest cure, congenital external anomalies or defects, sterility, infertility including IVF, impotency, venereal disease, puberty, menopause or intentional self-injury, suicide or attempted suicide(whether sane or insane).
17. Certification / Diagnosis / Treatment by a family member or from persons not registered as Medical Practitioners under the respective Medical Councils, or any diagnosis or treatment that is not scientifically recognized or experimental or unproven.
18. Ailment requiring treatment due to use, abuse or a consequence of an abuse of any substance, intoxicat, drug, alcohol or hallucinogen and treatment for de-addiction, or rehabilitation.
19. Any illness or hospitalisation arising or resulting from the Insured/Insured person or any of his family members committing any breach of law with criminal intent.
20. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
21. Prostheses, corrective devices and medical appliances, which are not required intra-operatively for the disease/ illness/ injury for which the Insured / Insured Person was hospitalised.
22. Any stay in Hospital without undertaking any treatment or any other purpose other than for receiving eligible treatment of a type that normally requires a stay in the hospital.
23. Treatment of any mental illness or sickness or disease including a psychiatric condition, disorganization of personality or mind, or emotions or behaviour, Parkinsons or Alzheimer's disease even if caused or aggravated by or related to an Accident or Illness or general debility or exhaustion ("run-down condition").
24. Any cosmetic surgery unless forming part of treatment for cancer or burns, surgery for sex change or treatment of obesity/morbid obesity or treatment/surgery /complications/illness arising as a consequence thereof.
25. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment even if the same requires confinement at a Hospital/Nursing Home.
26. Costs of donor screening.
27. Any form of Non-Allopathic treatment, Naturopathy, hydrotherapy, Ayurvedic, Homeopathy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.
28. Insured/ Insured Persons whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports or involving a naval military or air

force operation.

29. Insured/Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air Charter Company.
30. All expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
31. All expenses directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
32. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and treatment of the disease/illness/injury for which the Insured/Insured Person was hospitalized, Ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of Room expenses.
33. Service charges levied by the hospital, except registration/admission charges.

E. CLAIMS PROCEDURE

It is a condition precedent to the Company's liability that upon the discovery or happening of any disease/illness/injury that may give rise to a claim under this Policy, the Insured/Insured Person shall:-

1. Claim Notification

Give immediate notice to the TPA named in this Policy/Health Card, by calling the Help Line number as specified in the Policy/Health Card, or in writing to the address shown in the Schedule with particulars as below.

Policy Number,

Name of the Insured/Insured Person availing treatment,

Nature of disease/illness/injury,

Name and address of the attending Medical Practitioner/Hospital

Any other relevant information

Intimation of claim must be done at least 72 hours prior to hospitalization in case of planned hospitalization and within 24 hours of hospitalization in case of an emergency hospitalization.

2. Cashless Facility for Hospitalisation

i) The Company may provide Cashless facility for Hospitalisation expenses either directly or through the Third Party Administrator (TPA) if treatment is undergone at a **Network Hospital** by issue of pre-authorisation by the Company or the TPA.

ii) For the purpose of considering pre-authorisation and Cashless facility, the Insured/Insured Person shall submit to the TPA complete information of the disease, illness or injury requiring treatment along with necessary certification from the Medical Practitioner and/or Hospital.

iii) If claim for treatment appears admissible, TPA shall issue pre-authorisation to the Hospital concerned for Cashless facility whereby Hospitalisation expenses shall be paid directly by the Company through the TPA as confirmed in the pre-authorisation.

iv) Cashless facility for hospitalisation will not be available for treatment in non-Network Hospital and may be declined even for treatment at Network Hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such a case, Insured/Insured Person shall bear the expenses and claim reimbursement immediately after discharge from Hospital/Nursing Home in accordance with the stipulations herein.

v) Cashless facility for Hospitalisation benefit shall be limited exclusively to Hospitalisation Expenses incurred for treatment at a Network Hospital for disease, illness or injury which are covered under the Policy and shall not extend to any other Value Added Benefits or otherwise.

3. Claim Processing for Reimbursement

i) The Insured/Insured Person shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 30 days of discharge from Hospital the following:-

- Duly filled claim form(s)
- Original bills, receipts and discharge/card from the Hospital /Medical Practitioner
- Certificate from attending Medical Practitioner providing details of first symptoms and date of occurrence of the disease/illness/injury/surgery along with complete medical history of the Insured/Insured Person.
- Original bills from chemists supported by proper prescription
- Original Investigation test reports and payment receipts
- Medical Practitioner's referral letter advising hospitalisation
- Original bills and receipts for claiming Ambulance charges
- Any additional documents or information's, as may be deemed necessary by the Company or the TPA.

ii) The Insured/Insured Person shall submit to the TPA at his/her own expense, documents pertaining to the post hospitalization claim within 15 days from the date of expiry of post hospitalsation coverage period.

iii) The Insured/Insured Person shall at any time as may be required authorize and permit the TPA and/or the Company or anyone deputed by them in this behalf to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim.

iv) If so requested by the Company or the TPA, the Insured/Insured Person shall submit to medical examination by any Medical Practitioner designated by the Company or the TPA.

The above list is only indicative. The Company may call for additional documents/ information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the assessment of loss. Verification carried out if any will be done by Professional Investigators or member of the Service Provider and costs for such investigations shall be borne by the Company.

Applicable Taxes prevailing at the time of claim will be considered as part of Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Sum Insured opted.

4. TPA to Pay or Reject

The TPA where appointed, shall process and pay the claim or communicate rejection, if a claim is found to be not admissible under this Policy as authorized by the Company. However all decisions shall be the responsibility of the Company.

5. Representation against Rejection

Where rejection is communicated by the TPA, the Insured/Insured Person, may if so desired, represent to the Company within 15 days for reconsideration of the decision.

6. Condition Precedent

Completed claim forms and documents must be furnished to the Company within the stipulated timelines. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if the Insured can satisfy the Company that it was not reasonably possible for the Insured to submit/give proof within such time.

The due intimation, submission of documents and compliance with requirements by Insured/Insured Person as mentioned above shall be essential failing which Company/TPA shall not be bound to entertain a claim.

7. Claims Service Clause

If the Insured notifies a cashless facility request by email, telephone, fax or such other medium to the Company or its representative then within 6 hours of the actual receipt of such a request the Company will respond with:

a) Approval, or
b) Rejection
c) If such request has been notified during office hours(9am to 9 pm) on a working day and the Company fails to either approve or reject or seek further information after the expiry of 6 hours from the actual receipt of the request then the Company shall be liable to pay the Insured for the delay in the following manner:
   i) For delay beyond 6 hours: Rs.1000
   ii) The maximum amounts that the Company shall be liable to pay the Insured for any delay, in respect of a single hospitalization, shall at no time exceed Rs.1000.
d) If such request has been notified after office hours on a working day or at any time during a holiday and the Company fails to either approve or reject or seek further information after the expiry of 8 hours from the actual receipt of the request then the Company shall be liable to pay the Insured for the delay in the following manner:
   i) For delay beyond 8 hours: Rs.1000
   ii) The maximum amounts that the Company shall be liable to pay the Insured for any delay, in respect of a single hospitalization, shall at no time exceed Rs.1000.

2) In case of reimbursement claim, the Company shall communicate its decision on payment within 6 working days after the Insured submits the complete details, information and document requirements in respect of the claim. If the Insured has provided such information and documents as the Company requires and the Company fails to communicate its decision then the Company shall pay Rs. 1000 for a delay beyond 6 days to the Insured. The maximum amounts that the Company shall be liable to pay the Insured for any delay, in respect of a single hospitalization, shall at no time exceed Rs.1000.
3) The Company will not be liable to make any payments under Clause 1 and 2 above in case of any natural event or manmade disturbance which impedes the Company's ability to make a decision or to communicate such decision to the Insured.
4) Any amounts paid under this Clause will not affect the sum insured as specified in the Schedule. That the Company's liability to make payments under this Clause shall at all times be restricted to the amounts specified in Clause 1 and 2 above including the maximum amount specified therein and the Insured shall not be entitled to any sum whatsoever in excess of those amounts. That any payment made under this Clause by the Company will not amount to any admission of liability for a claim notified by the Insured. Service Assurance is applicable only to the first response on a single claim and no subsequent correspondence.

The above compensation shall be paid to the policyholder notwithstanding the Company's obligation to pay interest in cases of delay in settlement of claims, as per Reg. 9(6) of IRDA (PPH) Regulations, **8. Claim Settlement**

Wherever a claim has not been settled within the stipulations of the Claims Service Clause above, the Company after payment of agreed compensation shall within a period of maximum 30 days on receipt of final completed set of documents/investigation reports (if applicable) offer settlement of the claim. In the event that the Company decides to reject a claim made under this policy, the Company shall do so within a period of 30 days of the receipt of the final completed set of documents/investigation reports (if applicable), in accordance with the provisions of Protection of Policyholders' Interest Regulations 2002.

F. General Conditions

1. Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements or misrepresentation, mis-description or non-disclosure of any material particulars or if any

material information had been withheld in the Proposal Form, personal statement, declaration or other documents, or if a claim found to be fraudulent or any fraudulent` means or device is used by the Insured/ Insured Person or any one acting on his/their behalf to obtain a benefit under this Policy.

Material information to be disclosed includes every matter that the Insured/Insured Person knows, or could reasonably be expected to know, that relates to questions in the proposal form and which is relevant to the Company's decision to accept the risk of insurance and if so on what terms. . The Insured must exercise the same duty to disclose those matters to the Company before the renewal, extension, variation, endorsement or reinstatement of the Contract.

2. Observance of Terms and Conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy insofar as they relate to anything to be done or complied with by the Insured / Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy.

3. Reasonable Care

The Insured/Insured Person shall take all reasonable steps to safeguard against any Accident or illnesses that may give rise to any claim under this Policy.

4. Notice of Charge

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

5. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument in writing and signed by the Company shall be deemed to be part of this Policy and shall have effect accordingly.

6. Electronic Transactions

The Insured/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of this Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of section 41 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured/Insured Person.

7. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured/Insured Person's rights or recovery thereof against any person or organization, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured/Insured Person's indemnification, in enforcing or endorsing any rights or remedies, or of

obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. This clause does not apply to benefit sections.

8. Contribution

If there shall be existing any other insurance of any nature whatsoever covering the same Insured/Insured Person whether effected by the Insured/Insured Person or not, then the Company shall not be liable to pay or contribute more than its ratable proportion of any loss or damage. This clause does not apply to benefit sections.

9. Claims falling in two Policy Periods

Where a claim in respect of Hospitalisation commenced during one policy period continues into a new policy (either as a renewal or a fresh cover) and becomes admissible as per the coverage of the policy, the claim will be treated under the Policy where such hospitalization has commenced and payable only upto the limit of Sum Insured available under that policy period.

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10. Co-payment

The principles of co-payment have been incorporated in the product structure based on the zone selected by the customer for availing hospitalisation benefits and the zone in which the actual hospitalisation cost is incurred.
In addition to the foregoing an additional co-payment of 25% of the admissible claim is to be borne by any Insured/Insured Person above 70 years irrespective of the Zone of treatment. Details of the same are given in Para 17(below) of this Policy.

11. Fraudulent Claims

If any claim 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/Insured Person or anyone acting on his / her behalf to obtain any benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons, All sums paid under this Policy shall be repaid to the Company by all Insured Persons who shall be jointly liable for such repayment.

12. Cancellation/Termination

The Company may at any time, cancel this Policy, on grounds of misrepresentation, fraud non disclosure of material fact or non co-operation of the insured, by giving 15 days notice in writing by Registered Post Acknowledgment Due to the Insured/Insured Person at his/their last known address in which case the Company shall not be liable to repay the premium for the unexpired term. The Insured/Insured Person may also give 15 days notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scales.

Period On Risk	Rate Of Premium Refunded
Up to l month	75% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	25% of annual rate
Exceeding six months	Nil

An individual policy with a single Insured shall automatically terminate in case of death of the Policyholder. In case of an individual Policy with multiple Insured Persosn and incase of a floater the Policy shall continue to be in force for the remaining members of the family up to the expiry of current policy period.. The Policy may be renewed on an application by another adult Insured Person under the Policy whenever such is due.

For long term contracts the Company shall from the date of receipt of notice cancel the Policy and retain 15% of the pro-rata premium relating to the balance period.
Eg. 2 Year Policy issued for 730 days.
Cancellation request received on day 395(1 year and 1 month)
The amount refunded will be calculated as follows:
The amount to be refunded will be 15% less than the pro-rata premium for the balance period. 2 year premium Rs 1000. Utilised period 395 days, unutilised period 335. Pro-rata premium for unutilised premium will be Rs 458.9
Refund amount shall be 458.9-15% i.e (458.9 – 68.83) = Rs 390
However, in case of a valid claim having been paid or reported under this Policy, there would be no refund of premium.

Minimum premium of Rs 250 per policy will be retained by the Company towards administrative charges.

13. Free-look Cancellation

A period of 15 days from the date of receipt of the Policy document is available to review the terms and conditions of this Policy. The Insured has the option of cancelling the Policy stating the reasons for cancellation if he has any objections to any of the terms and conditions. The Company shall refund the premium paid after adjusting the amounts spent on Stamp duty charges and proportionate risk premium. Cancellation will be allowed only if there are no claims reported under the Policy. All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy. Free look provision is available for long term contracts but not at the time of renewal of the Policy. Minimum premium shall not apply for free look cancellations.

14. Place/Currency

No claim shall be payable under this Policy for any treatment or expenses outside India. All claims shall be payable in India and in Indian Rupees only.

15. Law Applicable

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy or any claim thereunder.

16. If a claim is rejected or partially settled and is the not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and liability of the Company extinguished and shall not be recoverable thereafter.

17. Zone Classification

Zone I (All India Cover): Mumbai, Thane, Navi Mumbai, Delhi & NCR Regions
Zone II: Chennai, Hyderabad, Bangalore, Pune, Kolkata and Gujarat Regions
Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II
Identification of Zone will be based on the location of the proposed insured persons.
(a) Persons paying Zone I premium can avail treatment all over India without any sub limits.
(b) Persons paying Zone II premium
Can avail treatment in Zone II and Zone III without any sublimits.
Availing treatment in Zone I will have to bear 10% of each and every claim.
(c) Person paying Zone III premium
Can avail treatment in Zone III, without any sublimits.
Availing treatment in Zone II will have to bear 10% of each and every claim.
Availing treatment in Zone I will have to bear 20% of each and every claim.

18. Renewal

1. The Company shall not be bound to give notice that renewal is due.

2. If the Insured desires renewal he/she shall apply to the Company for the same prior to expiry of the Policy Period of Insurance.

3. The Insured/Insured Person shall disclose to the Company in writing of any material change in the health condition, either by way of change in nature of job at the time of seeking renewal of this Policy, irrespective of any claim arising or made and upon such disclosure the Company shall be entitled to modify or vary the terms of insurance and/or premium, if necessary, accordingly. Failure to comply with this Condition would render any renewal voidable at the option of the Company.

4. A 5% increase in Sum Insured will be allowed at the time of renewal, where the Policy is claim free in the expiring year. This cumulative bonus can be accumulated up to a maximum of 50% and will be reduced to 0% in the event of a claim being reported under the policy, however the basic Sum Insured will be maintained at all times.
Where the Policy is issued as a floater, cumulative bonus will be considered for all Insured Persons put together in the Floater.
4. Renewals are deemed to be continuous when received within a period of 15 days from the date of expiry of last policy subject however to the effective policy inception date being reckoned from such period when the renewal premium is received by the Company. Policy would be considered as a fresh policy if there would be break of fifteen or more days between the previous policy expiry date and current policy start date. The Company however shall not be liable for any claim arising out of an ailment suffered or hospitalisation commencing during the period between the expiry of previous policy and date of commencement of subsequent Policy.

5. Any enhanced Sum Insured during subsequent policy renewals will not be available for an illness, diseases, injury already contracted under the preceding policy periods. All Waiting periods as defined in the policy shall apply for this enhanced limit from the effective date of enhancement of such Sum Insured considering such policy period as the first policy with the Company.

6. Where an Insured Person is added to this Policy, either by way of endorsement or at the time of renewal, the pre-existing disease clause, exclusions and waiting periods will be applicable considering such policy period as the first policy with us.

7. A Policy shall be ordinarily renewable unless
   a) any fraud, misrepresentation or suppression by the Insured or on his behalf is found either in obtaining insurance or subsequently in relation thereto or,
   b) the Company has discontinued issue of the particular type of Policy, in which event the Insured shall have the option of renewal under any similar Policy being issued by the Company; provided however, benefits payable shall be subject to the terms contained in such other Policy.

8.

9. The Company reserves its rights to vary the premium from time to time subject to approval of IRDA.

19. Continuity Benefits

For Roll Over Cases (Portability Policies) Continuity benefits shall be offered to all Insured/Insured Persons in accordance to IRDA circular from time to time.

Where the product is offered to the customers of a specific institution, with which the Company has a tie up, continuity of benefits will be provided under the same or similar policies available with the Insurer during such period in the event that such tie-up has been discontinued.

20. Pre-acceptance Medical Tests

All Individuals above the age of 45 years may be required to undergo pre-acceptance medical tests. All Medical reports need to be within 30 days from date of Proposal form and can be conducted at the Company's list of Network Hospitals/Clinics. In case of accepted proposals the Company shall reimburse

100% of pre-acceptance medical test costs. For individuals below 45 years as per the declarations made on the proposal form Medical Tests may be required on a case to case basis.
Medical Tests required for age group 46-55 includes Medical Examination Report, Electrocardiogram, Serum Triglycerides, Fasting Blood Sugar, Serum Creatinine, Urinalysis, SGOT & SGPT.
Medical Tests required for age group 56-65 includes Medical Examination Report, Electrocardiogram, Complete Blood Count, Lipid Profile, Fasting & Post Prandial Blood Sugar, Serum Creatinine, Urinalysis, SGOT, SGPT and GGT.
Based on the evidence from the above reports the Company may call for additional reports on a case to case basis to determine the acceptance of a Proposal. 50% Cost of any additional test shall be borne by the Insurer in case of accepted proposals.

21. Grievances Redressal Procedure
For any grievance related to Delay in settlement or against decision on any claim, Premium, Non-issue or Interpretation of Policy terms, or such other grievances the Insured/Insured Person may write to:
The Grievance Officer
L&T General Insurance Company Limited
601-602, 6th Floor, Trade Centre, Bandra Kurla Complex, Bandra East, Mumbai 400051
Helpline Number- <<toll free no>> or write to The Grievance Officer at <<abc@ltinsurance.com>>
In case the Insured/Insured Person is not satisfied with the decision of the above office, or have not received any response within 10 days, the Insured/Insured Person may contact the following official for resolution:
Head-Customer Services
601-602, 6th Floor, Trade Centre, Bandra Kurla Complex, Bandra East, Mumbai 400051
Helpline Number- <<toll free no>> or write to Head-Customer Services at <<abc@ltinsurance.com>>
In case the Insured/Insured Person is not satisfied with the decision/resolution the Insured/Insured Person may the Insured/Insured person may be entitled to approach the Insurance Ombudsman.
The complaint should be made in writing duly signed by the complainant or by his/her legal heirs with full details of the complaint and the contact information of the complainant.
The details of the Insurance Ombudsmen and their jurisdiction are as listed below-

Ombudsman Offices	
Areas of Jurisdiction	**Addresses of the Ombudsman Offices**
State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.	**AHMEDABAD** 2nd Floor, Ambica House, Nr. C U Shah College, 5, Navyug Colony, Ashram Road, AHMEDABAD-380014 Tel: 27546150, Fax: 079-27546142 Email: insombalhd@rdiffmail.com
States of Madhya Pradesh and Chattisgarh.	**BHOPAL** 1st Floor, 117, Zone II (Above D M Motors Pvt. Ltd.), Maharana Pratap Nagar, BHOPAL-462 011 Tel: 0755 - 2769200, Fax: 0755-2578103 Email:insombmp@satyam.net.in
State of Orissa.	**BHUBANESWAR** 62, Forst Park, BHUBANESWAR-751 009. Tel: 2535220, Fax: 0674-2531607 Email:susantamishra@yahoo.com, ioobbsr@vsnl.net
States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.	**CHANDIGARH** S.C.O No.101,102 & 103, 2nd Floor, Batra Building, Sector 17 D, CHANDIGARH-160 017 Tel: 0172- 2706196 EPBX:0172-2706468 Fax: 0172-2708274
State of Tamil Nadu and Union Territories - Pondicherry Town and	**CHENNAI** Fatima Akhtar Court , 4th Floor, 453 (Old 312) Anna

Karaikal (which are part of Union Territory of Pondicherry).	Salai, Teynampet, CHENNAI-600 018 Tel: 24333678, 24333668, 24335284 Fax: 044-24333664 Email:insombud@md4.vsnl.net.in
States of Delhi and Rajasthan.	**DELHI** 2/2 A, Universal Insurance Bldg, Asaf Ali Road, NEW DELHI-110 002 Tel: 23239611, Fax: 011-23230858 Email: insombudsmandel@netcracker.com
States of Andhra Pradesh, Karnataka and Union Territory of Yanam - a part of the Union Territory of Pondicherry.	**HYDERABAD** 6-2-46, Yeturu Towers, Lane Opp. Saleem Function Palace, A C Guards, Lakdi-Ka-Pool, HYDERABAD-500 004 Tel: 55574325, Fax:040-23376599 Email:insombud@hd2.vsnl.net.in
State of Kerela and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.	**KOCHI** 2nd Floor, CC 27/2603 Pulinat Bldg, Opp. Cochin Shipyard, M G Road, ERNAKULAM-682 015 Tel: 2373334, 2350959, Fax:0484-2373336 Email:insuranceombudsmankochi@hclinfinet.com
States of West Bengal, Bihar, Sikkim, Jharkhand and Union Territories of Andaman and Nicobar Islands.	**KOLKATTA** North British Building 29, N S Road, 3rd Floor, KOLKATTA-700 001 Tel: 22212666, 22212669, Fax:033-22212668
States of Uttar Pradesh and Uttaranchal.	**LUCKNOW** Jeevan Bhavan, Phase 2, 6th floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226001 Tel: 0522-2201188, 2231330, 2231331 Fax:0522-2231310 E-mail: ioblko@sancharnet.in
States of Maharashtra and Goa.	3rd Floor, Jeevan Seva Annexe (above MTNL), S V Road, Santacruz (W), Mumbai-400 054 Tel: 26106889, EPBX:022-26106889 Fax:022-26106052, 26106980 Email:ombudsman.i@hclinfinet.com
States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**GUWAHATI** Aquarius Bhaskar Nagar, R G Baruah Road, GUWAHATI 781 021 Tel: 2413525 EPBX:0361-2415430 Fax: 0361-2414051
Address and contact number of Governing Body of Insurance Council	Secretary General Governing Body of Insurance Council 5th Floor, Royal Insurance Building, 14 Jamshedji Tata Road, Churchgate, Mumbai 400020 022-22817515 Email: inscoun@vsnl.net

22. IRDA REGULATIONS: This Policy is subject to Regulations of IRDA (Protection Of Policyholder's Interest) Regulations, 2002 as amended from time to time.