GROUP HEALTH CARE - PROSPECTUS

Introduction

Group Health Care policy provides customised Health insurance coverage for employees/group members and their dependents based on a company's requirements. The rising costs in healthcare have made it imperative for companies, irrespective of their size, to safeguard the interests of group members in case of hospitalisation. Available at flexible and affordable rates, the policy helps companies to cushion the financial strain faced by their employees/group members due to unforeseen medical expenses.

Key Features & Benefits

- In-patient Treatment
- Pre-hospitalisation Medical Expenses
- Post-hospitalisation Medical Expenses
- Day Care Treatment
- Domiciliary Hospitalisation
- Emergency Ambulance
- Donor Expenses

There are several other optional covers like Alternative Treatment, Daily Cash Benefit, Home Nursing, Convalescence, etc. which can be included in the policy.

I. Base Covers

The Benefits available under this Policy are described below. Benefits will be payable subject to the terms, conditions and exclusions of this Policy and the availability of Basic Sum Insured and subject to sub-limits (if Optional Cover 40. Disease-wise sublimit opted for) and specified in respect of that Benefit and any limits applicable for the Insured Person as specified in the Policy Schedule/ Certificate of Insurance.

1. In-patient Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalisation during the Policy Period following an Illness or Injury for a minimum and continuous period of 24 hours that occurs during the Policy Period provided that:

(a) The Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(b) The Medical Expenses incurred are Reasonable and Customary for one or more of the following:

i. Room Rent and other boarding charges;
ii. ICU Charges;
iii. Operation theatre expenses;
iv. Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
v. Qualified Nurses' charges;
vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
vii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized and conducted within the same Hospital where the Insured Person is admitted;
viii. Anaesthesia, blood, oxygen and blood transfusion charges;
ix. Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
x. Inpatient physiotherapy charges

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2. Pre-hospitalisation Medical Expenses

We will reimburse the Insured Person's Pre-hospitalisation Medical Expenses incurred during a period up to the number of days as specified in the Policy Schedule/Certificate of Insurance prior to hospitalisation/day care treatment for Illness or Injury which occurs during the Policy period provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy
(b) The date of admission for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Illness/Injury subject to Any One Illness as defined

3. Post-hospitalisation Medical Expenses

We will reimburse the Insured Person's Post-hospitalisation Medical Expenses incurred during a period up to the number of days as specified in the Policy Schedule/Certificate of Insurance following an Illness or Injury which occurs during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy
(b) The date of discharge for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to the same Illness/Injury subject to Any One Illness as defined

4. Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

(a) The Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(b) The Medical Expenses incurred are Reasonable and Customary;
(c) We will only cover the Medical Expenses for those Day Care Treatments which are listed in Annexure II of this Policy. The complete list of Day Care Treatments covered is also available on Our website [www.zurichkotak.com];
(d) We will not cover any OPD Treatment under this Benefit.

5. Domiciliary Hospitalisation

We will indemnify the Medical Expenses incurred on the Insured Person's Domiciliary Hospitalisation during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

(a) We will cover medical expenses of an Insured person for treatment of a disease, illness or injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable.
(b) The domiciliary hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner
(c) The Medical Expenses incurred are Reasonable and Customary Charges;
(d) The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses under this Extension from the first day of Domiciliary Hospitalisation;
(e) The payment under this benefit is within the Basic Sum Insured, subject to the limits specified, if any.
(f) We will not indemnify any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses under this Extension;
(g) We shall not indemnify any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions:
    i. Asthma;
    ii. Bronchitis;
    iii. Chronic Nephritis and Chronic Nephritic Syndrome;
    iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
    v. Diabetes Mellitus and Insipidus;
    vi. Epilepsy;

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vii. Hypertension;
viii. Influenza, cough and cold;
ix. psychiatric or psychosomatic disorders as mentioned below;
    a. 2021 ICD-10-CM Diagnosis Code F32: Major depressive disorder, single episode
    b. 2021 ICD-10-CM Diagnosis Code F41: Other anxiety disorders
    c. ICD-10-CM Diagnosis Code F34: Persistent mood [affective] disorders
    d. ICD-10-CM Diagnosis Code F31: Bipolar disorder
    e. ICD-10-CM Diagnosis Code F20: Schizophrenia
    f. ICD-10-CM Diagnosis Code F50: Eating disorders
    g. ICD-10-CM Diagnosis Code F84: Autistic disorder
    h. ICD-10-CM Diagnosis Code F79: Unspecified intellectual disabilities
    i. ICD-10-CM Diagnosis Code F90: Attention-deficit hyperactivity disorders
    j. ICD-10-CM Diagnosis Code F42: Obsessive-compulsive disorder

x. Pyrexia of unknown origin for less than 10 days;
xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
xii. Arthritis, Gout and Rheumatism.

6. Emergency Ambulance

We will indemnify the Reasonable and Customary Charges incurred up to the limit specified in the Policy Schedule/ Certificate of Insurance towards transportation of the Insured Person by a healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury following an Emergency provided that:

(a) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;
(b) We will also provide cover under this Benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available / adequate treatment facilities at the existing Hospital.
(c) The limit under Ambulance cover is applicable for each claim admitted under the policy.

The payment under this benefit is within the Basic Sum Insured, subject to the limits specified, if any.

7. Donor Expenses

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the Sum Insured (subject to availability of Basic Sum Insured), provided that:

(a) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules;
(b) The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advise;
(c) We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;
(d) In case of Individual sum insured basis, this payout will be available on Individual basis and In case of floater sum insured basis, the payout will be available on floater basis.

The payment under this benefit is within the Basic Sum Insured, subject to the limits specified, if any.

We will not cover expenses towards the donor in respect of:

i. Any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses;
ii. Costs directly or indirectly associated to the acquisition of the organ;
iii. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

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8. Alternative Treatment (AYUSH)

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment (AYUSH) provided that:

(a) The Alternative Treatment is administered by a Medical Practitioner;
(b) The Insured Person is admitted to AYUSH Hospital or AYUSH Day Care Centre (for AYUSH treatment as an inpatient /for Day Care Treatment)

The payment under this benefit is within the Basic Sum Insured.

II. Optional Covers

1. Critical Illness Recuperation Benefit

We will pay a daily allowance for a specified number of days as mentioned in the Policy Schedule/Certificate of Insurance towards Recuperation Expenses, post discharge from the Hospital, If the Insured Person contracts any of the Critical Illnesses defined as per Annexure IV during the Policy period and undertakes treatment for the same in a Hospital during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of a Critical Illness defined as per Annexure IV;
(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual Sum Insured/ Floater Sum Insured).

The payment under this benefit is over and above the Basic Sum Insured subject to the limits specified, if any.

We shall not be liable to make payment for more than the maximum number of days per policy year as specified in the Policy Schedule/Certificate of Insurance for this Cover.

2. Hospital Daily Cash Benefit

We will pay the Daily Cash Amount specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) Deductible as specified in the Policy Schedule/ Certificate of Insurance is applicable to this Benefit
(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual Sum Insured/ Floater Sum Insured)

We shall not be liable to make payment for more than the maximum number of days per policy year specified in the Policy Schedule/Certificate of Insurance for this Cover.

The payment under this benefit is over and above the Basic Sum Insured subject to the limits specified, if any.

In case the Policy covers, ICU Daily Cash Benefit also, the deductible will be applied cumulatively on the entire duration of the stay in the hospital

3. ICU Daily Cash Benefit

We will pay the Daily Cash Amount specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation in an ICU during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) Deductible as specified in the Policy Schedule/ Certificate of Insurance is applicable to this Benefit

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(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual Sum Insured/ Floater Sum Insured).

We shall not be liable to make payment for more than the maximum number of days per policy year specified in the Policy Schedule/ Certificate of Insurance for this Cover.

The payment under this benefit is over and above the Basic Sum Insured subject to the limits specified, if any.

In case the Policy covers, Hospital Daily Cash Benefit also, the deductible will be applied cumulatively on the entire duration of stay in the hospital

4. Home Nursing

We will pay for the expenses incurred for medical care services of a qualified nurse at the residence of the Insured Person following discharge from hospital after treatment for Illness/ Injury provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) Such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to Illness/ Injury for which the Insured Person has undertaken treatment during the hospitalisation

The cover is applicable irrespective of the number of occurrences during the Policy period subject to the overall Basic Sum Insured and for a maximum of 30 days.

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any

5. Convalescence Benefit

We will pay the amount specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is Admitted in Hospital for a minimum period of 10 consecutive days provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) We shall not be liable to make payment under this cover in respect of an Insured Person more than once during the Policy Year.
(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual Sum Insured / Floater Sum Insured).

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any.

In case the Policy covers, Critical Illness Recuperation Benefit also, the payout in case of Critical Illness related Hospitalisation will be paid only under Critical Illness Recuperation Benefit

6. **Family Transportation Benefit**

We will reimburse the actual expenses incurred in transporting one Immediate Family Member from the Insured Person's residence to the Hospital where the Insured Person is admitted, provided that

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) Such Hospital is located at least 150kms away from the Insured Person's residence.

The payment under this benefit is over and above the Basic Sum Insured subject to limits specified, if any.

Note: In this Benefit, Immediate Family Member means the Insured Persons including Self and Group members as defined in the Policy Schedule/ Certificate of Insurance

7. **Accompanying Person's Expenses**

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We will pay the Daily Allowance specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation towards expenses incurred on one accompanying person at the Hospital/Nursing during Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual Sum Insured / Floater Sum Insured).

We shall not be liable to make payment for more than the maximum number of days per policy year specified in the Policy Schedule/ Certificate of Insurance for this Extension.

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any.

8. Cost of Prescribed External Medical Aid

We will reimburse the reasonable costs incurred by the Insured Person during the Policy Period for procuring External Aids and Appliances as prescribed by the Medical Practitioner provided that:

(a) We have accepted a claim under In-patient Treatment/ Day Care Treatment in respect of the same Hospitalisation;
(b) For the purposes of this Cover, External Aids and Appliances means any medically necessary prosthetic or artificial devices or any medical equipment including but not limited to spectacles, contact lenses, hearing aids, abdominal belts (used post-hernia and related surgeries), belts for prolapsed inter-vertebral disc (PIVD), crutches, wheel-chair and trusses (used post-hernia and related surgeries), and

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any.

Permanent Exclusion 5(q) of the Policy Wordings stands deleted to the extent of this Cover only.

9. Travel expenses for Treatment

We will reimburse the travel expenses of the Insured Person when an Insured Person, during the Policy Period, is travelling 150kms or more from his/ her residential address to a nearby place as prescribed by treating Medical Practitioner for undergoing an In-patient treatment which is not possible in the Insured person's current place of residence provided that:

(a) Transportation is under medical supervision in respect of the Insured Person and the Insured Person is medically cleared, by the treating Medical Practitioner, for travel via commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.
(b) If the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available / adequate treatment facilities at the existing Hospital.
(c) No claims for reimbursement of Medical Expenses incurred for services arranged by Insured Person will be allowed unless agreed by Us or Our authorized representative.

The payment under this benefit is over and above the Basic Sum Insured subject to limits specified, if any.

10. Cover for Non-Medical Expenses

We will reimburse the expenses incurred towards generally excluded items such as non-medical items like toiletries, cosmetics, personal comfort or convenience items, certain elements of room charges, administrative or non-medical charges, and external durable devices provided that:

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(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment in respect of the same Hospitalisation;

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any.

The list of items to be covered will be as per items mentioned in Annexure III

Permanent Exclusion 5(gg) of the Policy Wordings stands deleted to the extent of this Cover only

11. OPD Expenses

We will reimburse the reasonable and customary charges towards out-patient medical expenses in respect of Insured person:

(a) Diagnostic procedures like laboratory tests, MRI's, CAT Scan, Pathology tests
(b) Medical Practitioners consultations including Dental, Vision and ENT treatment
(c) Pharmacy expenses
(d) Non-surgical and Minor surgical procedures and treatments like stitching, dressing under local anesthesia, etc
(e) Others treatments like physiotherapy, acupuncture, chiropody, homeopathy, etc.
(f) Administration of Lucentis Injection

For the purpose of this Cover,

i. Outpatient **means** an Insured person who is not hospitalized but who visits a hospital, clinic or associated facility for diagnosis or treatment.

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any.

If You have opted for the OPD Dental Treatment and OPD Vision Treatment Cover separately, then the claim under the said covers will not be payable under the OPD Expenses Cover.

Permanent Exclusion 5(a), 5(p) 5(cc) and 5 (hh) of the Policy Wordings stands deleted to the extent of this Cover only.

12. OPD Dental Treatment

We will reimburse the medical expenses incurred towards dental treatment including any emergency treatment by a Dentist following an accident where the Insured Person suffers injuries or damage to his natural teeth and/or gums.

This benefit also provides cover for:

(a) The fees for a dental practitioner and associated costs for carrying out routine dental procedures like clinical oral examinations, tooth scaling, normal fillings, minor procedures and non-surgical extractions
(b) Root canal treatment and surgical extraction of tooth

This Benefit will exclude

i. Any instructions for plaque control, oral hygiene and diet
ii. Any treatment which is cosmetic in nature.

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any.

Permanent Exclusion 5(p), 5(r) 5(cc) and 5(hh) of the Policy Wordings stands deleted to the extent of this Cover only.

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13. OPD Vision Treatment

We will reimburse the following Medical expenses incurred in respect of the Insured person related to Vision tests/ consultations/ treatments/ prescriptions including but not limited to:

(a) One eye examination by an optometrist or ophthalmologist per Policy year
(b) The provision of lenses/ eyeglass to correct vision
(c) Medical treatment of the eye
(d) Administration of lucentis injection

The Benefit will exclude:

i. Sunglasses/ lenses which are not prescribed by an optometrist or ophthalmologist
ii. Any treatment which is cosmetic in nature.

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any.

Permanent Exclusion 5(p) 5(cc) and 5(hh) of the Policy Wordings stands deleted to the extent of this Cover only.

14. Second E-Opinion Cover

We will facilitate the Insured person for availing a Second E-Opinion on his / her medical condition occurring during the Policy Period as per the frequency provided in the Policy Schedule/ Certificate of Insurance, provided that:

(a) We shall only provide access to an E-opinion and this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;
(b) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
(c) The Insured person is free to choose whether or not to obtain the expert opinion and if obtained whether or not to act on it

15. Mortal Remains/ Funeral Expenses

We will reimburse the costs incurred up to the limit specified in the Policy Schedule/ Certificate of Insurance for expenses incurred for transportation of the mortal remains of the Insured Person from Hospital to his/her current place of residence in case of the unfortunate death of the Insured Person due to a disease/ illness/ injury/ accident during the Policy Period.

Further, we will also reimburse the costs incurred up to the limit specified in the Policy Schedule/Certificate of Insurance for expenses incurred for funeral expenses of the Insured Person in case of the unfortunate death of the Insured Person due to a disease/ illness/ injury/ critical illness accident during the Policy Period.

Provided that as a Condition Precedent, We are given a detailed account of the expenses incurred along with the supporting bills and documents, substantiating such expenses.

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any.

16. Maternity Benefit

We will indemnify the Medical Expenses incurred up to the Maternity Benefit Sum Insured specified in the Policy Schedule/ Certificate of Insurance for the delivery of the Insured Person's child (including caesarean section) during Hospitalisation or the Medically Necessary and lawful medical termination of pregnancy during the Policy Period provided that:

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(a) We will pay Medical Expenses in respect of the delivery of the Insured Person and/or any Surgical Procedures required to be carried out on the Insured Person as a direct result of the delivery
(b) A 9 month waiting period shall apply
(c) Medical Expenses incurred in connection with the medical termination of pregnancy within the first 12 weeks from conception are not covered unless certified to be necessary by the attending Medical Practitioner in order to maintain the life or relieve immediate pain or distress to the Insured Person
(d) Pre- & Post-hospitalisation expenses are not covered under this benefit.
(e) Ectopic pregnancy shall not be covered under this Extension, but any Claims will be considered under In-patient Treatment

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any.

Permanent Exclusion 5(o) of the Policy Wordings stands deleted to the extent of this Benefit only.

17. New Born Baby Cover
We will indemnify the Medical Expenses incurred on the Hospitalisation of the Insured Person's New Born Baby during the Policy Period within the Basic Sum Insured/ Maternity Sum Insured, subject to limits specified, if any (in case Maternity cover is opted for) mentioned in the Policy Schedule/ Certificate of Insurance provided that:
(a) The mother is covered as an Insured Person under the Policy and is hospitalised as an In-patient for delivery
(b) Medical Expenses incurred on the New Born Baby during and post birth up to 90 days from the date of delivery and is within the Basic Sum Insured or the Maternity Sum Insured, subject to limits specified, if any
(c) Any pre and post hospitalisation expenses for the new born shall not be covered under this benefit.

We will cover the New Born Baby beyond 90 days on payment of requisite Premium for the New Born Baby into the Policy by way of an endorsement or at the next Renewal, whichever is earlier.

18. Pre and Post Natal Care
We will reimburse the Pre-natal and post-natal Medical expenses as mentioned below:
(a) Pre- and post-natal Hospitalisation Expenses on any treatment availed from the date of conception till the date of discharge from the Hospital after delivery as an In-patient in a hospital and within the Maternity Sum Insured, subject to limits specified, if any.
(a) Pre- and post-natal (OPD) Medical Expenses (including expenses incurred on antenatal check-ups, doctor’s consultations for monitoring of the pregnancy and any complications arising therefrom) incurred on an out-patient basis upto the limits mentioned in the Policy Schedule/ Certificate of Insurance
(b) The Pre and Post Natal Care Cover is available only if the Maternity Cover is opted for in the Policy

19. Surgical Contraception (Sterilisation and Vasectomy)
We will pay the Reasonable and Customary charges for the Medical Expenses of the Insured person towards implanted/ injected contraceptives upon advice of a Medical practitioner, Medically Necessary expenses connected with surgical therapies including but not limited to Tubal ligation, vasectomies, etc. provided that:
(a) The Benefit will not pay for any OPD treatment

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any

20. External Congenital Disease Cover

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We will pay the Reasonable and Customary charges for the Medical Expenses of the Insured person in respect of External Congenital Diseases which are present at birth and which may or may not be inherited provided:
(a) The Benefit will not pay for any OPD treatment
The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any

Permanent Exclusion 5(x) of the Policy Wordings stands deleted to the extent of this Benefit only.

21. Hospitalisation Cover only for Accidents
We will pay the Medical Expenses incurred on the Insured Person's Hospitalisation during the Policy Period following an Accident/ Injury for a minimum and continuous period of 24 hours that occurs during the Policy Period provided that:
(a) The Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(b) The Medical Expenses incurred are Reasonable and Customary;
The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any and the Basic Sum Insured being fully utilised.

22. Hospitalisation Cover only for Critical Illness
We will pay the Medical Expenses incurred on the Insured Person's Hospitalisation during the Policy Period following a Critical Illness for a minimum and continuous period of 24 hours that occurs during the Policy Period provided that:
(a) The Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner pertaining to the Critical Illness defined;
(b) The Medical Expenses incurred are Reasonable and Customary;
(c) The Critical Illness falls under the defined list of Critical Illnesses mentioned under "Critical Illness Annexure IV"

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any and the Basic Sum Insured being fully utilised.

23. Medical Advancement Surgery Cover
We will pay the Reasonable and Customary charges upto the limit specified in the Policy Schedule/Certificate of Insurance in respect of the Insured person's In-patient Hospitalisation or Day Care Treatment during the Policy Period for Medical Advancement surgery provided that:
(a) It is a Medically Necessary Treatment and follows the written advice of a Medical Practitioner
(b) Coverage under this Benefit includes
  (i) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
  (ii) Balloon Sinuplasty
  (iii) Deep Brain stimulation
  (iv) Oral chemotherapy
  (v) Immunotherapy- Monoclonal Antibody to be given as injection
  (vi) Intra vitreal injections
  (vii) Robotic surgeries
  (viii) Stereotactic radio surgeries
  (ix) Bronchial Thermoplasty
  (x) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
  (xi) IONM - (Intra Operative Neuro Monitoring)
  (xii) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

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(xiii) Bariatric Surgery,
(xiv) Milk teeth banking (does not include the cost of harvesting and storage),
(xv) Cyber knife/ Gamma Knife treatment,
(xvi) Peritoneal dialysis,
(xvii) Cochlear Implant Treatment (Including the Surgery but excluding the cost of implant),
(xviii) Laser Tonsillectomy, etc.

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any

Permanent Exclusion 5(c) and 5(q) of the Policy Wordings stands deleted to the extent of this Benefit only.

Treatment/ surgery which is on an experimental basis or which is under clinical trials, unproven or investigational treatment will be excluded from this cover

24. Infertility treatment
We will pay the Reasonable and Customary charges upto the limits mentioned in the Policy Schedule/Certificate of Insurance for In-patient treatment or Day Care treatment of the Insured person in respect of any infertility treatment provided that:
(a) The Benefit will not pay for any OPD treatment

The payment under this benefit is within the Basic Sum Insured or the Maternity Sum Insured, subject to limits specified, if any

Permanent Exclusion 5(n) of the Policy Wordings stands deleted to the extent of this Benefit only.

25. Sports Activity Cover
We will pay the Reasonable and Customary charges upto the limits mentioned in the Policy Schedule/Certificate of Insurance for In-patient treatment of an Insured Person due to an Accident/ Injury sustained while engaged in a professional sport carried out in accordance with the guidelines, codes of good practice and recommendations for safe practices as laid down by a governing body or authority.

The payment under this benefit is within the Basic Sum Insured, subject to limits specified, if any.

Permanent Exclusion 5(f) of the Policy Wordings stands deleted to the extent of this Benefit only.

26. Vaccination Expenses
We will, on a reimbursement basis, cover the Reasonable and Customary Charges in relation to vaccination expenses of an Insured Person as prescribed by the Medical Practitioner up to the limits as specified in the Policy Schedule/Certificate of Insurance.

The payment under this benefit is over and above the Basic Sum Insured, subject to limits specified, if any.

Permanent Exclusion 5(v) of the Policy Wordings stands deleted to the extent of this Benefit only.

27. Wellness Program
By way of this Benefit the insured can avail any or all of the below mentioned services upto the limits/ frequency specified in the Policy Schedule/Certificate of Insurance through the Network Provider or Vendor tie-up:

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(a) Health Risk Assessment (HRA)
Health Risk Assessment questionnaire is used as a tool for evaluation of Health and quality of life. It helps you to understand your lifestyle and its impact on your health status. The HRA will be an online assessment provided by Us through Vendor tie-ups to the Insured Person.

(b) Health Check-up and Report evaluation
We will arrange for a diagnostic/ preventative Health Check-Up at any of our Network Provider based on the list of tests mentioned in the Policy Schedule/ Certificate of Insurance and provide report evaluation/ counselling for the test reports

(c) Online customer profile
Based on the HRA taken and the other Check-ups, if any, undertaken by the Insured Person, We will maintain an online customer profile through Vendor tie-ups which can be accessed by the customer to review his Health status.

(d) Medical Centre Management
We will provide with or arrange for the maintenance of a Medical room equipped with a doctor at the designated work site chosen by You through the Network Provider.

(e) Diet & Nutrition Plans
We will arrange for dieticians/ nutritionist through our Vendor tie-ups to provide for counselling to the Insured Person

(f) Online Doctor Chat/ E-consultations
We will provide with or arrange for an online platform through our Network Provider for providing with Doctor Chat and e-consultations to the Insured Person

(g) Doctor Directory
We will provide with or arrange for an online platform to the Insured Person through our Vendor tie-ups for providing access to Doctor Directory containing information on General Practitioners, specialists and super specialists

(h) Doctor Appointment
We will provide with or arrange for an online platform to the Insured Person through Vendor tie-ups for fixing up Doctor Appointments for the Insured Persons

(i) Health Camps - on campus
We will arrange for Health Camps for fitness assessments and overall health profiling at the designated work sites chosen by You through our Network Providers/ Vendor tie-ups

(j) Expert Sessions - on campus
We will arrange for Expert Chat sessions/ workshops with doctors, dieticians, nutritionists, psychologists at the designated work sites chosen by You to the Insured Person through Network Providers/ Vendor tie-ups

(k) Second E-Opinions:
We will provide second opinion in the electronic form to the Insured Person through our Vendor tie-up

(l) Discounted offerings - on health and wellness services

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We will facilitate the Insured Person for various offerings on health and wellness services like Diagnostic Centres, Pharmacy, Consultations, Gymnasiums, Yoga, etc.) through the Network Providers/ Vendor tie-ups

(m) Disease Management Programs: Eg. Diabetes, Healthy Heart, Stress Management etc.
We will help the Insured Person track his health through our Vendor tie-ups who will guide in maintaining/ improving your health condition.

(n) Lifestyle/Wellness Management Programs: Eg Maternity, Quit Smoking
We will help the Insured person track his overall lifestyle and fitness well -being through our Vendor tie-ups who will provide guidance in undergoing there programmes

(o) Personalized Health Records
We will provide with or arrange for an online platform to the Insured Person through our Vendor tie-ups for maintaining the Health records for the Insured Persons

(p) Health & Wellness Reminder Services
We will provide with or arrange for an online platform/ mobile application to the Insured Person for providing Health and Wellness Reminders like Vaccination alerts, Pill reminders, etc.

(q) Health Concierge Desk/ Health Assistance Services (Opinions - Doctor on call/home, Ambulance services, Health tools)
You can contact Us to avail the following services:
1. Emergency assistance information such as nearest ambulance, blood bank, hospital, etc.
2. Referral for medical service provider, home nursing, etc.

(r) Home Health
We will provide with or arrange through Vendor tie-ups, Home Health services like physiotherapy, nursing care, trained attendants, medical equipment, etc. for the Insured Person

(s) Emergency Medical Evacuation/ Air Ambulance services
We will arrange through an Assistance provider for transportation of the Insured person beyond 150 kms from the place of residence/ injury/ accident or emergency situation

Terms and Conditions for Wellness Program:

- Any information provided by you shall be kept confidential
- For services which are provided through empanelled medical experts/ centres/ service providers, we are only acting as a facilitator, hence we would not be liable for any incremental cost of the services
- All medical services are being provided by empanelled medical experts/ centres/ service providers who are empanelled after full due diligence. Nonetheless, Insured Person may consult their personal doctor before availing the medical services. The decisions to utilise the services will be solely be at the Insured Person's discretion.
- We/Company/Us or its group entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person/ You may claim to have suffered or sustained or incurred by way of or on account of Wellness services utilised.

28. Floater Cover

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We will cover the members of the Policyholder as per Relationships defined for the Group members on a Family Floater Sum Insured basis. Where the Policy is obtained on floater basis covering the family members, the Sum Insured will be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period.

29. Corporate Buffer
We will provide for a Corporate Buffer as per limits specified in the Policy Schedule/Certificate of Insurance during the Policy period provided that:
(a) Insured Persons can avail benefit from this buffer whenever they exhaust their respective Sum Insured limit as specified in the Policy Schedule/ Certificate of Insurance
(b) Coverage under this Benefit can be opted for listed conditions as chosen by You based on the group requirements and mentioned in the Policy Schedule/ Certificate of Insurance

30. Pre-existing Disease Waiting Period Waiver
Any claim arising out of, relating to or howsoever attributable to pre-existing diseases or any complication arising from the same will be covered from inception of the Policy or as per specifically opted waiting period as stated in the Policy Schedule/ Certificate of Insurance in which case the coverage will be applicable post the continuous coverage with Us

Exclusion No. 1 will not be applicable.

31. 30 days Waiting Period Waiver
This benefit provides for waiver of Exclusion No. 2 of the Policy and the coverage under the Policy will commence from day one of the Policy period without any waiting period.

32. Specified disease/ procedure Waiting Period Waiver
This benefit provides for waiver of Exclusion No. 3 of the Policy and treatment in respect of diseases, illness, and injury as mentioned in Exclusion No. 3 of this Policy shall stand covered from day one of the Policy period without any waiting period.

33. 9 Months Maternity Waiting Period Waiver
This benefit provides for waiver of Exclusion No. 4 of the Policy in respect of Maternity Benefit claims, and coverage under the Policy for Maternity claims will commence from day one of the Policy period.

34. Room Rent Capping
We will pay for the room rent charges as per the limits set out in the Policy Schedule/ Certificate of Insurance for Normal and ICU room category and also based on the location of the hospital.

If the Insured Person incurs Room Rent that is higher than the eligible Room Rent as per the limits specified under this Benefit then We will be liable to pay only a rateable proportion of the Associated Medical Expenses incurred in the proportion of the difference between the eligible Room Rent and the Room Rent actually incurred, provided that Reasonable and Customary costs incurred on medicines/pharmacy, medical consumables, medical implants and diagnostic costs will be reimbursed based on the actual amounts incurred.

Proportionate deductions will not be applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category. Further, proportionate deductions will not be applied in respect of ICU Charges.

35. Deductible

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We will indemnify the Medical Expenses incurred in Excess of the Deductible for the listed Benefits in respect of the Insured person as per limit specified in the Policy Schedule/ Certificate of Insurance. The Deductible limit will apply to an Insured person for each Policy year on each payable claim in the Policy year as specified in the Policy Schedule/ Certificate of Insurance.

36. Co-payment
We will offer a co-payment option upto the limit as specified in the Policy Schedule/ Certificate of Insurance. If the Co-payment is in force, We will pay only the defined limit of the admissible claim amount and the balance will be borne by the Insured Person.

37. Disease-wise sublimit
We will apply sub-limits as specified in the Policy Schedule/ Certificate of Insurance to the treatment/ surgery as listed in the Annexure V. Our liability is such case will be only upto the sub-limit amount specified in the Policy Schedule/ Certificate of Insurance

38. Domiciliary Hospitalisation Exclusion Cover
We will exclude Domiciliary Hospitalisation from the Basic Covers and the below mentioned Exclusion will be applicable to You.

Exclusion: Any expenses arising out of Domiciliary Hospitalization will be excluded as per the attached cover; unless covered under extension 'Domiciliary hospitalization cover'

39. Donor Expenses Exclusion Cover
We will exclude Donor Expenses Cover from the Basic Covers and the below mentioned Exclusion will be applicable to You.

Exclusion: Expenses related to donor screening, treatment, including surgery to remove organs from a donor in the case of transplant surgery will be excluded as per the attached cover unless covered under extension **'**Donor Expenses'**.**

III. Exclusions

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 36 months of continuous coverage after the date of inception of the first policy with insurer.
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 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. 30 Days Waiting Period (Code – Excl03)

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

3. Specified disease/ procedure waiting period (Code – Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures

(a) Cataract;
(b) Benign Prostatic Hypertrophy;
(c) Myomectomy, Hysterectomy unless because of malignancy;
(d) All types of Hernia, Hydrocele;
(e) Fissures and/or Fistula in anus, haemorrhoids/piles;
(f) Arthritis, gout, rheumatism and spinal disorders;
(g) Joint replacements unless due to Accident;
(h) Sinusitis and related disorders;
(i) Stones in the urinary and biliary systems;
(j) Dilatation and curettage, Endometriosis;
(k) All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
(l) Dialysis required for chronic renal failure;
(m) Tonsillitis, adenoids and sinuses;
(n) Gastric and duodenal erosions and ulcers;
(o) Deviated nasal septum;
(p) Varicose Veins/ Varicose Ulcers.

4. 9 Months Maternity Waiting Period

Any Medical Expenses incurred in respect of Maternity Benefit will not be covered during the first 9 months from the Policy Period Start Date. This exclusion does not apply to Renewals of the Policy with Us or to any Insured Person whose Policy has been accepted under the Portability Benefit under this Policy.

5. Permanent Exclusions

a. Investigation & Evaluation (Code- Excl04)

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

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 (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

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

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

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

k. Code- Excl14
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.

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.

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 (Code- Excl18)**
   i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy
   ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

p. Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;

q. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;

r. Expenses incurred on all dental treatment unless necessitated due to an Accident;

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s. Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services;

t. Any acupressure, acupuncture, magnetic and such other therapies;

u. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;

v. Vaccination or inoculation of any kind, unless it is post animal bite;

w. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise);

x. Treatment relating to Congenital external Anomalies;

y. any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition

z. Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;

aa. Any treatment taken outside India;

bb. Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;

cc. Non- allopathic treatment; unless covered under Alternative treatments (AYUSH)

dd. Any consequential or indirect loss arising out of or related to Hospitalization;

ee. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority;

ff. Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;

gg. All non-medical expenses listed in Annexure III (List I) of the Policy.

hh. Any OPD treatment will not be covered

ii. Medical supplies including elastic stockings, diabetic test strips, and similar products.

jj. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

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kk. Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy will not be covered unless it forms a part of in-patient treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the policy Schedule/ Certificate of Insurance.

ll. Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

IV. Claim administration

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule/ Certificate of Insurance) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy:

(a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;

(b) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person;

(c) We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;

(d) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

1. CLAIMS PROCEDURE

On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to Our liability under the Policy the following procedure shall be complied with:

(a) For Cashless Facility

Cashless Facility will be available at a Network Provider of the Company. The complete list of Providers is available on Our website (The list is updated as and when there is any change in the Network Provider) or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

– **Pre-authorization for Planned Hospitalization:**

At least 48 hours prior to a planned Hospitalization, We or Our TPA shall be contacted to request pre authorization for availing the Cashless Facility for that planned Hospitalisation. Each such request must be accompanied by all the following details:

i. The Health Card We have issued to the Insured Person;
ii. The Policy Number;
iii. Name of the Policyholder;
iv. Name and address of Insured Person in respect of whom the request is being made;
v. Nature of the Illness/Injury and the treatment/surgery required;
vi. Name and address of the attending Medical Practitioner;
vii. Hospital where treatment/surgery is proposed to be taken;

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viii. Proposed date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We /Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

Turn Around Time (TAT) for issue of Pre-Authorization within 1 hours from receipt of complete documents for initial and within 3 hours from receipt of complete documents for final approval at the time of discharge.

In Case of Claim Contact Us at:

24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@zurichkotak.com
In the event of claims, please send the relevant documents to:
Family Health Plan (TPA) Ltd,
Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad, 500 034.

– **Pre-authorization for Emergency Care:**

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

i. The Health Card We have issued to the Insured Person;
ii. The Policy Number;
iii. Name of the Policyholder;
iv. Name and address of Insured Person in respect of whom the request is being made;
v. Nature of the Illness/Injury and the treatment/surgery required;
vi. Name and address of the attending Medical Practitioner;
vii. Hospital where treatment/surgery is being taken;
viii. Date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/ Our TPA will request additional information or documentation in respect of that request with the provider.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre-authorisation as there is insufficient Base Annual Sum Insured there is insufficient information to determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

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We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

(b) For Reimbursement Claims

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

i. The Policy Number
ii. Name of the Policyholder;
iii. Name and address of the Insured Person in respect of whom the request is being made;
iv. Nature of Illness or Injury and the treatment/surgery taken;
v. Name and address of the attending Medical Practitioner;
vi. Hospital where treatment/surgery was taken;
vii. Date of Admission and date of discharge;
viii. Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim along with claim form (and necessary documents).

2. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided with these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

(a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
(b) Original Pre – authorization request
(c) Copy of Pre – authorization approval letter
(d) Copy of the photo identity document of the Insured Person;
(e) Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner;
(f) Original bills from chemists supported by proper prescription;
(g) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
(h) Indoor case papers (if available);
(i) Medical Practitioner's referral letter advising Hospitalization in non-Accident cases and referral slip for all investigations carried out;
(j) Hospital discharge summary;
(k) FIR (if done) or MLC (if conducted) for Accident cases ;
(l) Post mortem report (if applicable and conducted);
(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

3. CLAIMS FOR PRE-HOSPITALISATION MEDICAL EXPENSES AND POST-HOSPITALISATION MEDICAL EXPENSES

(a) All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:
   i. Duly Completed Claim Form

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ii. Investigation Payment Receipt
iii. Original Investigation Report
iv. Original Pharmacy Bills
v. Original Pharmacy Prescription
vi. Copy of Discharge Summary
vii. Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:
i. Duly Completed Claim Form
ii. Investigation Payment Receipt
iii. Original Investigation Report
iv. Original Pharmacy Bills
v. Original Pharmacy Prescription
vi. Copy of Discharge Summary
vii. Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

(c) If the Claim is not notified to Us within these specified timeframes, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

General Terms and Clauses

1. Disclosure of Information

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

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Complete Discharge

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

4. 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

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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.

5. 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.

6. Cancellation

a. The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall refund proportionate premium for unexpired policy period subject to no claim (s) were made during the policy period.

Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

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b. 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.

7. 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 30 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.

8. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

9. 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 thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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

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

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

10. 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.

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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 atleast 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.

11. 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.

12. Premium Payment in Instalments:

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

i. Grace Period of 15 days (where premium is paid on monthly instalments) and 30 days (where premium paid in quarterly / half yearly/ annual instalments) would be given to pay the instalment premium due for the policy.

ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also

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

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

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

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

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

13. 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.

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14. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy 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.

16. Redressal of Grievance

In case of any grievance the insured person may contact the company through
Website: www.zurichkotak.com
Toll free: 18002664545
E-mail: care@zurichkotak.com
Courier:
Zurich Kotak General Insurance Company (India) Limited, 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievanceofficer@zurichkotak.com
For updated details of grievance officer, kindly refer the link:
https://www.zurichkotak.com/customer-support/grievance-redressal-process

For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@zurichkotak.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.

The details of the Insurance Ombudsman is available at:
https://www.zurichkotak.com/customer-support/grievance-redressal-process
The updated details of Insurance Ombudsman offices are also available on the website of Council for Insurance Ombudsmen: www.cioins.co.in/ombudsman
The details of the Insurance Ombudsman is available at Annexure I

Grievance may also be lodged through the Bima Bharosa Portal – https://bimabharosa.irdai.gov.in

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17. CLAIM SETTLEMENT (Provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim along with claim form (and necessary documents).

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.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

1. Eligibility

Minimum Entry Age	1 day
Maximum Entry Age	No Limit

Self, lawfully wedded spouse (more than one wife)/ Partner (including same sex partners), son (biological/ adopted), daughter (biological/ adopted), mother (biological/ foster), father (biological/ foster), brother (biological/ step) sister (biological/ step, mother in-law, father in-law, son in-law, daughter in-law, brother in-law, sister in-law.
For the purpose of this Policy, Partner shall be taken as declared at the time of Start of the Policy Period and no change in the same would be accepted during a Policy Period. However, an Insured Person may request for change at the time of Renewal of the cover.

2. Material Change
Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

3. No constructive Notice
Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

4. Terms and condition of the Policy
The terms and conditions contained herein and in the Policy Schedule/ Certificate of Insurance of the Policy shall be deemed to form part of the Policy and shall be read together as one document.

5. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

6. Policy Disputes
Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

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7. Role of Group Administrator/ Policyholder

(a) The Policy holder should provide the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.
(b) In case of employer-employee policies, the employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.
(c) In case of such policies, claims of the individual employees may be processed through the employer
(d) In case of non-employer-employee policies, We shall generally issue the Certificate of Insurance. However, We may provide the facility to the Group Administrator to issue the Certificate of Insurance to the members.
(e) In case of such policies, the Group Administrator may facilitate the claims process for the members however the payment will be made only to the beneficiary which is the Insured Person

8. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

9. Communications & Notices

Any communication, notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:
In Your case, at Your last known address per Our records in respect of this Policy.
In Our case, at Our address specified in the Policy Schedule/ Certificate of Insurance.
No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

10. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule/ Certificate of Insurance, during normal business hours or contact Our call centre.

11. Electronic Transactions

You agree 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, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 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.

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12. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate in the case of any Insured Person's demise during the policy period/year:

Termination of cover takes place on account of death of the insured person and pro-rata refund of premium of deceased insured person is processed for the unexpired policy period, provided no claim has been made. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

13. Sanction Exclusion Clause:

Notwithstanding any other terms under this agreement, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

Details of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
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 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh and Chattisgarh.
Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
Chandigarh: Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.

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Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Ernakulam: Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
Kolkata: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Lucknow: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar and Jharkhand.
Pune: Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).