POLICY WORDINGS
Bharti AXA Smart Super Top Up Policy

Preamble & Operative Clause

Bharti AXA General Insurance Company Limited will provide insurance cover to the person(s) named in the Schedule based on the material facts recorded in the proposal and declaration made and agreed premium has been paid and realized in full.

We will pay the insured person(s) in respect of an insured event occurring during the policy period and subject to the Conditions, Sum Insured, Scope of Coverage, Geographical limits, Endorsement, Deductible and Exclusions in the manner and to the extent set forth in this policy.

Definitions

Any words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy or Schedule. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

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

- **"Any one illness"** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital where treatment was taken.

- **"AYUSH"** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

- **"Aggregate policy deductible"** refers to a specified rupee amount the policyholder needs to pay against medical expenses on cumulative basis under the policy during a policy year before the liability of the Insurer arises.

  In other words, the policyholder will be treated as his/her self-insurer till the medical expenses incurred for one or several events of hospitalization on cumulative basis reaches the threshold deductible limit in specified rupee amount during the policy year. Subsequently, the liability of the insurer arises for any medical expenses incurred that exceeds the specified rupee amount

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

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

- **"Company/We/Our/Ours"** means Bharti AXA General Insurance Company Limited.

- **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

- **"Congenital Anomaly"** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
  - **a) Internal Congenital Anomaly**-Congenital anomaly which is not in the visible and accessible parts of the body.
  - **b) External Congenital Anomaly**-Congenital anomaly which is in the visible and accessible parts of the body

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

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

- **"Day care treatment**" means medical treatment, and/or surgical procedure which is:
  - **a)** undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

  - **b)** which would have otherwise required hospitalization of more than 24 hours.

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

- **"Day care centre"** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
  - **a)** has qualified nursing staff under its employment;
  - **b)** has qualified medical practitioner/s in charge;
  - **c)** has fully equipped operation theatre of its own where surgical procedures are carried out;
  - **d)** maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

- **"Deductible"** means a cost sharing requirement under a health insurance policy that provides that the company will not be liable for a specified rupee amount in case of indemnity sections and for a specified number of days/hours in case of hospital cash section which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

- **"Dependent Child"** means a natural or legally adopted child, aged between 91 days to 23 Years and financially dependent on the Policy holder.

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

- **"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.

- **"Domiciliary hospitalization"** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
  - **a)** the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
  - **b)** the patient takes treatment at home on account of non-availability of room in a hospital.

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

- **"Family Floater**" means the Sum Insured shown in the Schedule which represents the Company's maximum liability for any and all claims made by any one Insured and/or all Insured Person(s) together during the Policy Period.

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

- **"Hospital"** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

    a) has qualified nursing staff under its employment round the clock;
    b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    c) has qualified medical practitioner(s) in charge round the clock;
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

- **"Hospitalization"** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for Day care treatments, where such admission could be for a period of less than 24 consecutive hours.

- **"ICU (Intensive Care Unit) Charges**" means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

- **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
    b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
        I. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        II. it needs ongoing or long-term control or relief of symptoms
        III. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
        IV. it continues indefinitely
        V. it recurs or is likely to recur

- **"Injury"** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

- **"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/You/Your "** means the primary Insured who has the highest age amongst other person named in the Schedule of the Policy in case of family floater Policy. In case of an Individual Policy the only member mentioned in the schedule of the Policy shall be referred as "Insured".

- **"Insured Person"** means the person named in the Schedule to the Policy and for whose benefit the insurance is proposed and appropriate premium paid.

- **"Intensive care unit (ICU)**" means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

- **"Maternity expenses"** means;

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

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

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

- **"Medically necessary treatment"** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
  a) is required for the medical management of the illness or injury suffered by the insured;
  b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
  c) must have been prescribed by a medical practitioner;
  d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

- **"Network Provider"** means hospitals or health care providers enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an insured by a cashless facility.

- **"Newborn baby"** means baby born during the Policy Period and is aged upto 90 days.

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

- **"Notification of claim"** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

- **"OPD treatment"** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

- **"Policy Period"** means the period between the inception date and the expiry date specified in the Schedule. Policy period can be 1/2/3 year(s) in context of this policy.

- **"Policy"** means this document of Policy describing the terms and conditions of this contract of insurance (basis the statements in the Proposal Form and the Information Summary Sheet), any annexure thereto, including the company's covering letter to the Insured / Insured person if any, the Schedule attached to and forming part of this Policy and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

- **"Policy Schedule"** means the document attached to and forming part of this Policy mentioning the details of the Insured Person(s), the Sum Insured, the period, coverage and the limits to which benefits under the Policy are subject to.

- **"Policy Year"** means the duration of each 12 calendar months from the inception date under the policy. Eg., Period of first 12 months shall be termed as **First Policy Year**, period exceeding 12 months upto 24 months shall be termed as **Second Policy Year** and period exceeding 24 months upto 36 months shall be termed as **Third Policy Year**.

- **"Portability"** means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer.

- **"Post-hospitalization Medical Expenses"** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

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

- **"Pre-Existing Disease"** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice/treatment was received within 48/24 months (as defined in the policy) prior to the first policy issued by the insurer and renewed continuously thereafter.

- **"Pre-hospitalization Medical Expenses"** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
  a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
  b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

- **"Qualified nurse"** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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

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

- **"Room Rent**" means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

- **"Senior citizen"** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

- **"Subrogation"** means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

- **"Sum Insured"** means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

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

- **"Third Party Administrators or TPA''** means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations.

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

Scope of Cover

- **A. Mandatory Section**

I. In-Patient Care Expenses- Necessary & Reasonable expenses incurred during in-patient care for a Medical/Surgical treatment of a Disease/Illness/Injury at any hospital in India on advice of a qualified Medical Practitioner. In-patient Care Expenses include

1) Room Rent/Boarding Expenses
2) Nursing Expenses
3) ICU Charges
4) Medical Practitioner's fees
5) Anesthetist, Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Fees
6) Drugs, Medicines, X-ray & Diagnostic tests.
7) Physiotherapy
8) Cost of Prosthetic devices used intra operatively during the Surgical Procedure.

Any expenses related to Hospitalization for Evaluation/Investigation/ List of Excluded items/ Non Payable items shall not be payable.

II. Domiciliary Hospitalization Expenses- Medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

However, this does not cover

I. Treatment of less than 3 days. In the event of treatment period exceeding 3 continuous days, coverage shall be provided from the first day for expenses incurred for the entire course of treatment.
II. Post-Hospitalization expenses;
III. The following medical conditions:

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,
b. Arthritis, Gout and Rheumatism,
c. Chronic Nephritis and Nephritic Syndrome,

d. Diarrhoea and all type of Dysenteries including Gastroenteritis,
e. Diabetes Mellitus and Insupidus,
f. Epilepsy,
g. Hypertension,
h. Psychiatric or Psychosomatic Disorders of all kinds,
i. Pyrexia of unknown origin.

Domiciliary hospitalization also covers expenses on Qualified nurse(s) engaged on the recommendation of the attending Medical Practitioner.

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

- **B. Optional Sections**

I. Day Care Treatment Expenses- This section covers hospitalization expenses towards medical treatment, and/or procedure incurred by the Insured / Insured Person which is undertaken under General or Local Anesthesia in a Hospital/day care centre (where 24 hours of hospitalization is not required due to technologically advanced treatment) which shall be payable, in respect of listed treatments as given in the Appendix I. The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

II. Pre- Post Hospitalization Expenses- Necessary & Reasonable expenses incurred prior to or following an In-patient Care/ Day Care Treatment /Domiciliary Hospitalization if opted to by the insured shall be covered subject to Pre & Post Hospitalization period specified in the Schedule and Exclusions/Conditions under the policy.

Pre Hospitalization	**Post Hospitalization**
1. Doctor's Consultation Charge	1. Doctor's Consultation for Follow-up
2. Cost of Medicine & Drugs	2. Cost of Medicine & Drugs
3. Diagnostic Tests	3. Diagnostic Tests
	4. Physiotherapy treatment in Hospital Premises

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

III. **Organ Donor Expenses-** The expenses incurred in organ donor's treatment for the harvesting of the organ donated and Donor's Post Hospitalization expenses upto 180 Days from date of organ donation, provided that:

I. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs and tissues rules 2014 (amendment) and the organ donated is for the use of the Insured Person, and

II. There shall be an admissible claim under In-patient Care or Day Care Treatment /Domiciliary Hospitalization if opted to by the Insured..

The post hospitalization expenses do not relate to any complication(s) arising due to the harvesting of the organ donated. This Section does not cover costs directly or indirectly associated with the acquisition of the donor's organ.

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

IV. **Surface Ambulance Charges-** Reimbursement against expenses upto sublimit specified in the schedule and incurred on a surface transport ambulance offered by a registered healthcare or ambulance service provider used to transfer the Insured Person(s) to the nearest Hospital requiring Emergency Care or if advised by the medical practitioner.

There shall be an admissible claim under In-patient Care or Day Care Treatment.

The coverage under this Section is limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

V. **AYUSH -** This section provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred for In-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems provided that the treatment has been undertaken in

a) Central and State Government Hospitals
b) NABH accredited Ayurvedic hospitals
c) Teaching hospitals attached to Ayurvedic colleges recognized by Central Government/Central Council of Indian Medicine
d) Ayurvedic hospitals having registration with a Government Authority under appropriate Act in a State/UT, minimum fifteen beds, minimum five qualified and registered Ayurvedic doctors, adequate number of qualified paramedical staff, dedicated Ayurveda therapy sections and daily maintenance of medical records.

Note:

a) The reimbursement under Ayush will be applicable for inpatient hospitalization claims only;
b) The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;

The coverage under this Section is available upto the Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

VI. **Dental Treatment-** Reimbursement of medical expenses incurred towards dental treatment following an accident where the Insured Person(s) suffers injuries or damage to his/her natural teeth and/or gums. This section further provides cover for medical expenses incurred for follow up treatment for the same accidental dental injury up to a maximum of 15 days by the same Dentist. This coverage is subject to sublimit as specified in the Schedule.

Dental Treatment can be availed on Out-patient or In-Patient Care/ Day care Treatment Basis.

The coverage under this Section is limited to the sub-limit under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy. Policy deductible shall not apply in case of dental treatment covered under the policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

VII. Home Nursing Coverage

The Company, on a reimbursement basis, shall pay the Reasonable and Customary Charges incurred during the Policy Year towards a Qualified Nurse arranged by the Hospital or by the Company's network of service providers to visit the Insured Person's home to give expert nursing services limited to the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy, provided that:

1. The Insured Person must have significant difficulty coping with the required activities of daily living and specialist Medical Practitioner who treated the Insured Person must have recommended these services in writing.
2. The claim becomes payable provided that a claim has been admitted under this policy under the In-Patient Care Expenses and is related to the same condition.
3. The Company shall cover visits by a Qualified Nurse for the period as specified in the policy schedule as it is required for a medically necessary treatment which would normally have been provided in a Hospital subject to the limits as specified in the Policy Schedule.
4. The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons).
    a. Eating (being able to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available).
    b. Bathing (being able to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene).
    c. Dressing (being able to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other Surgical Appliances).
    d. Toileting (being able to get on and off the toilet and manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene).
    e. Transferring (being able to get in and out of bed or a chair without assistance).
    f. Mobility (being able to move indoors from room to room on level surfaces at the normal place of residence).
5. Home nursing coverage is not related to any Domiciliary Hospitalisation.
6. The company is liable to pay for a qualified nursing services, limited for the period for which services have been availed not exceeding 6 weeks during the policy year.
7. All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

VIII. Cumulative Bonus

a. Regular Cumulative Bonus

If no claim has been made in a Policy Year by any Insured / Insured Person, then for each such Policy year, the Company will offer a Cumulative bonus.

Cumulative bonus will be provided on the Initial Policy **In-Patient Care Expenses** Sum Insured, provided that the Policy is renewed continuously.

The sub-limits applicable to various sections will remain the same and shall not increase proportionately with the increase in Cumulative Bonus.

In case of a claim, the Cumulative bonus earned shall be automatically reduced in the same proportion in the following renewal of the Policy. This will not affect the initial **In-Patient Care Expenses** Sum Insured of the Policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

Regular Cumulative Bonus	
Age at the inception of 1st Policy year <45 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 100% of initial Policy **In-Patient Care Expenses** S.I
Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 50% of initial Policy **In-Patient Care Expenses** S.I

b. Guaranteed Cumulative Bonus:

In case the Insured has opted for Guaranteed Cumulative Bonus at inception of the policy, the Cumulative Bonus shall get accrued in case of a claim free year and will not get reduced on occurrence of a claim. The rate of accrual shall remain the same as that in Regular Cumultive Bonus. Guaranteed Cumulative Bonus, if opted at inception, shall replace the Regular Cumulative Bonus.

Guaranteed Cumulative Bonus	
Age at the inception of 1st Policy year <45 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 100% of initial Policy **In-Patient Care Expenses** S.I

Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	10% of initial Policy **In-Patient Care Expenses** S.I per annum not exceeding Cumulative Bonus of 50% of initial Policy **In-Patient Care Expenses** S.I

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

IX. Wellness and Value Added Services

a. Wellness Rewards- Insured can accumulate rewards by opting for an array of wellness programs listed below, that will help assess his/her health status and aid in improving the overall well-being. Each specific program can be opted only once by a particular Insured Person in a policy year.

There will be no limitation to the number of programs one can enroll however maximum rewards that all the insured person(s) in a single policy period can earn, will be limited to 5% of the policy premium in the first year and 10% of the policy premium in the subsequent years and multi-year policies subject to continuous utilization of these programs. The Wellness Rewards will get accrued in the following manner:

Program Type	**Rewards Scale#**	
	Activization Year 1	**Activization Year 2 & above***
Health Awareness – Health risk assessment	Upto 1% of the Policy Premium**	Upto 2% of the Policy Premium
Health Action – Voluntary Health Checkup which includes all the tests listed below and undergone by the Insured/Insured persons in the last 6 months from the date of renewal with us and their readings • CBC • ESR • Urine Routine • General Physical Examination- Pulse, BP, Height, Weight, Eyesight, Chest & abdominal conditions • Blood Sugar- Fasting Blood Sugar & Post Prandial Blood Sugar • Triglycerides	Upto 2.50% of the Policy Premium	Upto 5% of the Policy Premium

• Serum Cholesterol • Chest X Ray • ECG		
Health Affinity – Active Membership for any programs which keeps you moving like (on Annual membership basis) Gym membership, Yoga, Swimming, Zumba, etc. Also participation in Professional sporting events like Marathon, Walk for a cause, etc.	Upto 1.5% of the Policy Premium	Upto 3% of the Policy Premium
Total Accrual	Upto 5% of the Policy Premium	Upto 10% of the Policy Premium

The reward scale percentages are applicable basis the proposer covered under the policy. While these can be availed by family members also but the accrual shall happen based on activities availed/performed by the proposer covered under the policy.

***** Activization year means the policy year in which the insured performs all or any of the activities as mentioned in the above program types. The accrual shall happen on continuous coverage basis and if the insured fails to continue these activities in subsequent years or fails to redeem these discounts in the subsequent year/subsequent renewals, the accrual shall fall to zero and the insured will have to start the process again to achieve the maximum discount benefit.

** Policy Premium means the premium paid by the proposer to the Company for the period post application of

all discounts & loadings excluding any applicable taxes.

- The Total Accrual rewards earned as reward scale percentage of the premium paid during the activization year shall be converted to and accumulated as reward points.
- In case of Multi-year policies, the insured is required to perform all or any of the activities at least once during the tenure of the insurance.
- The value of each earned rewards point is worth Re.1 and can be redeemed in the following manner

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1. Adjustment of 1st year premium, when the insured purchases selected health insurance products from Bharti AXA General Insurance Co Ltd. post accrual of the wellness rewards points under this policy. However, the total rewards points that can be utilized shall not exceed 10% of the policy premium for such health policy. The rewards points can be redeemed on selected health insurance products offered by Bharti AXA General Insurance Co. Ltd.

2. This accrued discount can also be adjusted while paying the renewal premium under the same policy.
3. The equivalent value of the accrued total discount can be redeemed against any OPD Benefit (Doctor consultation, Dietician/Nutritionist consultation, purchase of Pharmacy (allopathy/ayurvedic/homeopathy medicines), 2nd Medical Opinion, Diagnostics, etc. services offered by Bharti AXA General Insurance network of service providers.

- Rewards Points earned by an insured cannot be transferred to anyone or rewards points earned under multiple such programs cannot be clubbed together for redemption in any single policy.
- All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

b. Wellness Management Services: The insured will have a choice to avail various wellness benefits/services under this benefit head provided by the Company through the network of specialists/service providers.

1. Health Coach to monitor your day to day well being
2. Chronic Condition Screening – Customized Health Checks including gene screening to understand the potential health risks the insured(s) may encounter in future or to avail regular screenings for chronic conditions to stay abreast about their on-going health and corrective/precautionary measures can be taken.
3. Condition Specific Care
    a. Orthopedics Program (Rehabilitation and mobilization, Nursing attendant, Physiotherapist and medical equipments, etc.)..
    b. Oncology Program (Palliative care support, Stroma care, Colostomy, Tube feeding, Supportive care, etc.).
    c. Pulmonary Program (Services/programs related to Improving breathing ability. Improving overall strength and exercise tolerance, programs to increase participation in daily physical and social activities)..
    a. Diabetes Management Program (Services such as Personal Health Coach, Personal Nutritionist, Hypo/Hyper Alerts Management, etc may be availed on the basis of need or as recommended by the treating medical practitioner).
    b. Internal Medicine Program (Services such as Doctor visits at home, Triage nursing, Medicine delivery, etc. may be availed on the basis of need or as recommended by the treating medical practitioner).

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

X. Switch Benefit- We will offer the Insured an option to switch into selected Nil Deductible health insurance products offered by Bharti AXA General Insurance Company Limited for same Sum Insured without re-evaluation of health status or any pre policy check provided that:

A. All Insured Persons has been insured under the policy for first time prior to the age of 45 years and has been renewed continuously and without any break in insurance,

B. This option to switch into selected Nil Deductible health insurance Policy shall be exercised by the Insured Person at time of renewals post completion of 4th policy year ; provided that it has been renewed continuously and without any interruption

C. Insured Person will be offered continuity of coverage in terms of waiver of waiting periods to the extent of benefits covered under this Policy. The Switch Benefit can be exercised only once by the Insured Person .All accrued benefits under this policy shall stand extinguished in the event of discontinuation of this Policy at any point of time or shifting to any other health insurance Policy with Bharti AXA General Insurance Company Limited.

D. The Insured can exercise this option at the time of every fourth consecutive claim free year.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule for the switched policy shall apply.

XI. Deductible Incentive- If no claim has been made in a Policy Year by any Insured / Insured Person, then for each such Policy year, the Company will reduce the deductible as per the table mentioned below.

Deductible Incentive	
Age at the inception of 1st Policy year upto 45 yrs.	10% reduction in the initial policy deductible each year not exceeding 50% of the policy deductible
Age at the inception of 1st Policy year >45 yrs. and <65 yrs.	5% reduction in the initial policy deductible each year not exceeding 25% of the policy deductible

Deductible incentive will be provided on the deductible at the inception of the 1st Policy year, provided that the Policy is renewed continuously.

The sub-limits applicable to various sections will remain the same and shall not reduce proportionately with the change in deductible.

In case of a claim, the accrued deductible incentive shall automatically reset in the same proportion as the earned deductible incentive in the following renewal of the Policy. However the deductible shall never exceed the deductible at the inception of the 1st Policy year.
Continuity of earned deductible incentive shall not be ported /carried forward in the following condition:-

- If the Insured exercises option to change the Policy Coverages/ Sum insured/ Deductible during currency or at the time of renewal in the same product or any other health insurance product offered by Bharti AXA General Insurance Co. Ltd. except when there is a natural addition of member in the same policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XII. **Non Payable items -** The company agrees to pay for all the reasonable expenses incurred by the Insured towards the cost of Non Payable items not exceeding the available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy. The list of Non Payable items is mentioned in the Appendix II.

The below exclusion stands modified to the extent covered under this policy

"Non-payable items as per appendix II"

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XIII. **Sum Insured Enhancement –**The **In-Patient Care Expenses** Sum Insured can be enhanced one grid up subject to no claim have been lodged/ paid under the policy. In case of increase in the Sum Insured, waiting period shall not apply afresh in relation to the amount by which the Sum Insured has been enhanced.

The Insured can exercise this option at the time of every fourth consecutive claim free policy years. No fresh medicals shall be required for such enhancement of the Sum Insured.

The renewal premium shall be subject to change in revised Sum Insured conditional upon.

All other clauses, terms and conditions and exclusions applicable to and specified in the policy schedule shall apply.

XIV. Hospital Daily Cash - Daily cash amount will be payable per day up to the specified limits as mentioned in the Schedule to this Policy if the Insured Person is Hospitalized for treatment of any Disease / Illness / Injury for which a valid claim is admissible. In-Patient care expenses is admissible under the Policy for each continuous and completed period of 24 hours and if the Hospitalization exceeds for more than 24 hours. First continuous and completed period of 24 hours will act as deductible.

This benefit shall not be applicable to Domiciliary Hospitalization/Day-Care Treatment if opted to by the Insured. This is paid up to a maximum of 30 days including all the members & all claims for the entire Policy Year.

This benefit is subject to the specified limits as mentioned in Schedule over and above the In-Patient Care Expenses Sum Insured as mentioned in the Schedule.

We will pay the benefit for the particular hospitalization event for which a valid Inpatient Care expenses claim is admissible under the policy.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XV. Emergency Hospitalization (Worldwide Basis)–

The Company shall pay or reimburse to the Insured/ Insured Person expenses incurred for availing emergency medical assistance required on account of any disease/ illness/ injury sustained or contracted whilst on a Trip upto the limit of Sum Insured as specified in the Schedule of Policy.

This is an annual multi trip cover and the insured shall have the option to opt for this cover only at the time of policy inception.

The Sum Insured offered under this section shall be equal to 5 Lakh Indian rupees.

- This section intends to cover:-Out-patient treatment, provided, the same is critical and cannot be deferred till the insured/ insured person's return to the Republic of India.
- The proposer covered under the policy shall be employed or having business in India.

- The coverage under this section is applicable for business & leisure trips where the duration of any single trip should not exceed 5 days.
- In-patient treatment in a local hospital at the place the Insured Person is staying at the time of occurrence of an insurable event.
- Medical aid prescribed by a Medical Practitioner as Medically Necessary part of a treatment for broken limbs or injuries (e.g. plaster casts, bandages and walking aids).
- Radiotherapy, heat therapy or photo therapy and other such treatment prescribed by a Medical Practitioner.
- X-ray, diagnostic tests and all reasonable costs towards diagnostic methods and treatment of all disease/illness/injury provided these pertain to the disease/illness/injury due to which hospitalization was deemed Medically Necessary.
- Cost of transportation, including necessary medical care, by recognized medical service providers for medical attention to the nearest hospital or to the nearest Medical Practitioner or to a special clinic if prescribed by a Medical Practitioner.
- Life saving unforeseen emergency measures provided to the Insured Person by the Medical Practitioner for the disease/illness/injury arising out of a Pre-existing condition. The treatment for these emergency measures would be paid till the Insured Person becomes medically stable, as ascertained by the Panel Doctor of the Emergency Assistance Service Provider. All further medical costs to maintain medically stable state would have to be borne by the Insured/Insured Person.

  All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

Specific Definition:

"Emergency Assistance Service Provider" means any organization or institution appointed by the Company for providing services to the Insured/Insured Person for an insurable event.

Specific Exclusions:

1. Any pre-existing condition, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured/Insured person's life.

2. Where the insured person is travelling against the advise of a physician or receiving or on a waiting list for specified medical treatment; or is travelling for the purpose of obtaining treatment or has received a terminal prognosis for a medical condition; or

3. Treatment of orthopedic, degenerative, oncological diseases, unless the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's life.
4. Treatment which could be reasonably delayed until the Insured Person's return to the Republic of India. The question of what can or what cannot be reasonably delayed will be decided jointly by the treating Medical Practitioner, Emergency Assistance Service Provider and the Company and shall be in accordance with accepted standards of medical care.
5. Charges in excess of reasonable and customary charges incurred for emergency treatment on account of an insured event.
6. Treatment relating to the removal of physical flaws or anomalies (cosmetic treatment or plastic surgery in any form or manner unless medically required as part of treatment for cancer, accidents and burns).
7. Expenses incurred in connection with rest or recuperation at a spa, health resort, Sanatorium, convalescence home, rehabilitation measures, private duty nursing, respite care, domiciliary care, long-term nursing care, custodial care and treatment related alcoholism and drug dependency.
8. Maternity, child birth and any consequences, including changes in other chronic conditions as a result of pregnancy. However, this exclusion will not apply in following cases:
   a) Ectopic Pregnancy proved by diagnostic means and certified to be life threatening condition / situation by the attending Medical Practitioner
   b) If the medical assistance provided abroad involves unforeseen emergency measures to save the Insured Person's or the child's life in the event of acute complications, provided that the Insured Person has not completed the age of 38 years and the 30th week of the pregnancy is not yet completed.
9. Rehabilitation and/or physiotherapy or the costs of prostheses/ prosthetics (artificial limbs) etc.

XVI. Convalescence Benefit

In case the Insured / Insured Person is hospitalized for a continuous period of 10 days or more for treatment of any Disease/ Illness /Injury for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured / Insured Person of a fixed amount as mentioned in the Schedule of benefit attached to this Policy.

This benefit offers additional Sum Insured over and above the **In-Patient Care Expenses** Sum Insured as mentioned in the Policy Schedule. This benefit under any policy shall be payable only once during the policy year.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XVII. Health Check-up:

The Company will cover the cost of preventive health checkup every year provided that there are no claims made or paid related to any insured person covered under the previous policy year. Insured / Insured Person further understand and agree that this benefit is only available at Renewal for Policies that are renewed without any break.

Preventive health checkup under this section shall any of the following:-

- CBC
- ESR
- Urine Routine
- General Physical Examination- Pulse, BP, Height, Weight, Eyesight, Chest & abdominal conditions
- Blood Sugar- Fasting Blood Sugar & Post Prandial Blood Sugar
- Triglycerides
- Serum Cholesterol
- Chest X Ray
- ECG

The liability of the Company under this Section shall be restricted to 1% of the **In-Patient Care Expenses** Sum Insured on aggregate basis to all Insured Person covered under the previous policy year.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

XVIII. Personal Accident:

Benefits & Definitions Applicable to this section

If at any time during the currency of this Policy, the Insured/ Insured Person shall sustain any bodily injury resulting solely and directly from accident caused by external, violent and visible means, then the Company shall pay to the Insured /insured person, his or her nominee, beneficiary or legal heir, as the case may be, the Sum Insured specified in the Schedule.

Personal Accident Sum Insured shall be the lesser amount of the following:

- 12 times of the gross annual income of the proposer covered under the policy.
- In-Patient Care Expenses Sum Insured
- Sum Insured for dependent spouse & parents/in laws shall be restricted to 50% of the In-Patient Care Expenses sum Insured upto maximum INR. 5,00,000.

- Sum Insured for dependent children shall be restricted to 25% of the In-Patient Care Expenses sum insured upto maximum INR. 2,50,000.

i. Accidental Death:

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of death of the Insured/Insured Person, the Sum Insured stated in the Policy Schedule shall become payable. Once this benefit is paid, the coverage under this policy would cease for the respective member.

ii. Permanent Total Disability:

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of:

A. sight of both eyes, or of the actual loss by physical separation of two entire hands or two entire feet, or of one entire hand and one entire foot, or of such loss of sight of one eye and such loss of one entire hand or one entire foot, the amount stated in the Policy Schedule shall become payable;
B. use of two hands or two feet, or of one hand and one foot, or of such loss of sight of one eye and such loss of use of one hand or one foot, the amount stated in the Policy Schedule shall become payable.
C. Loss of all fingers and both thumbs OR loss of both arm - at shoulder; between shoulder and elbow ; at and below elbow OR Loss of both leg - at hip; between knee and hip ; below knee, , then a lump sum stated in the Policy Schedule shall become payable.

NOTE: For the purpose of Clauses above, 'physical separation' of a hand means separation at or above the wrist and of the foot means at or above the ankle.
Permanent Total Disability can be claimed only once during the lifetime of the Insured. Once this benefit is paid, the personal accident coverage would cease for the respective member.

iii. Permanent Partial Disability:

If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and irrecoverable loss of:

A. the sight of one eye, or of the actual loss by physical separation of one entire hand or of one entire foot, fifty percent (50%) of Sum Insured the amount stated in the Policy Schedule shall become payable;
B. use of a hand or a foot without physical separation, fifty percent (50%) the amount stated in the Policy Schedule shall become payable.

NOTE: For the purpose of Clauses above, 'physical separation' of a hand means separation at or above the wrist and of the foot means at or above the ankle.

C. If such injury shall within twelve calendar months of its occurrence be the sole and direct cause of the total and/or partial and irrecoverable loss of use or of the actual loss by physical separation of the following, then the percentage of the Sum Insured as indicated below shall be payable.

Table of Benefits	Percentage of Personal Accident Sum Insured
1. Death (worldwide)	100%
2. PTD – (worldwide) Total and irrecoverable loss of :	
i) Sight of both eyes or of the actual loss by physical separation of two entire hands or two entire feet or one entire hand and one entire foot or of such loss of sight of one eye and such loss of one entire hand or one entire foot.	100%
ii) Use of two hands or of two feet or of one hand and one foot or of such loss of sight of one eye and such loss of use of one hand or one foot.	100%
iii)Loss of all fingers and both thumbs OR loss of both arm - at shoulder; between shoulder and elbow ; at and below elbow OR Loss of both leg - at hip; between knee and hip ; below knee	100%
3. Permanent total and absolute disablement disabling the Insured Person from engaging in any employment or occupation of any description whatsoever.	100%
4. PPD - Total and irrecoverable loss of various parts as given below:	
The sight of one eye or the actual loss by physical separation of one entire hand or one entire foot.	50%
Use of a hand or a foot without physical separation	50%
Loss of speech	50%
Loss of toes – all	20%
Loss of toes great - both phalanges	5%
Loss of toes great - one phalanx	2%
Loss of toes other than great, if more than one toe lost: each	2%
Loss of hearing - both ears	75%
Loss of hearing - one ear	30%
Loss of four fingers and thumb of one hand	50%
Loss of four fingers of one hand	40%
Loss of thumb - both phalanges	25%

Loss of thumb – one phalanx	10%
Loss of index finger – three phalanges	15%
Loss of index finger – two phalanges	10%
Loss of index finger - one phalanx	5%
Loss of middle finger or ring finger or little finger – three phalanges	10%
Loss of middle finger or ring finger or little finger – two phalanges	7%
Loss of middle finger or ring finger or little finger - one phalanx	3%
Loss of metacarpals – first or second (additional) or third, fourth or fifth (additional)	3%
Any other permanent partial disablement	Percentage as assessed by a panel doctor of the Company

The Permanent Partial Disability benefit may be paid multiple times for mutually exclusive disablements until the limit of sum insured is exhausted during the lifetime of the customer. In other words, the coverage would continue even after the payment of benefit if the sum insured limit is not exhausted. However, if any claim arises under the Accidental Death and Permanent Total disability post triggering of the Permanent Partial Disability benefit, the respective applicable sum insured would become payable subject to deduction of the benefit amount already paid under section Permanent Partial Disability.

The maximum liability of the company under this section is restricted to the lifetime SI .In the event of a claim been paid under the policy, SI will not be replenished to the initial sum insured under Personal accident at the time of renewal.

If due to any single accident, any Insured person sustains injury and there are admissible claims under multiple sections of Personal Accident, the liability of the Company shall be restricted to the highest Sum Insured specified under any one section of Personal accident.

(i) Specific Exclusions applicable to this Section

The Company shall not be liable under this Policy for;

a. Death or disablement resulting directly or indirectly caused by, contributed to or aggravated or prolonged by child birth or from pregnancy or in consequence thereof.

b. Any payment in case of more than one claim under the policy during any one period of insurance by which the maximum liability of the Company in that period would exceed the Sum Insured as indicated in the Policy Schedule.
c. Any pre-existing disability / accidental injury.
d. Accidental death or permanent disability due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.
e. Accidental death or permanent disability caused by curative measures, radiation, infection, poisoning except where these arise from an accident.
f. Any claim in respect of accidental death or permanent disablement of the Insured/Insured Person.
    - from intentional self-injury, suicide or attempted suicide
    - due to willful or deliberate exposure to danger except in an attempt to save human life
    - whilst under the influence of liquor or drugs or other intoxicants
    - whilst engaging in aviation, flying or taking part in aerial activities (including cabin crew) whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world
    - arising or resulting from the Insured committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanour or civil commotion
    - whilst engaging in racing, hunting, mountaineering, ice hockey, winter sports.
g. Any consequential loss or damage cost or expense of whatsoever nature.
h. Death or permanent disablement due to accidental injury arising out of or directly or indirectly connected with or traceable to war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainments of all Kings, Princes and people of whatsoever nation, condition or quality.
i. Death or permanent disablement due to accidental injury, directly or indirectly, caused by or contributed to by or arising from -
    A. ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel and for the purposes hereof, combustion shall include any self-sustaining process of nuclear fission;
    B. nuclear weapons material.
j. Any accident to an Insured/Insured Person which arises in the course of his/her occupation if his/her occupation falls within the following categories or involves the following activities: Air crew, ship crew, professional sportsman, diving, oil-rig platform and/or off-shore work, fire fighting, police, naval, military, air force service or operations and any hazardous occupation.

k. Whilst engaging in Adventure Sports. The list of adventurous sports are Water Rafting, Wildlife/Jeep Safaris, Trekking, Camping, Boat safaris, Parasailing, Paragliding, Elephant/Camel/Horse/Yak Safaris, Cycling, House Boat stays, Motor Bike tours, Kayaking, Rock Climbing, Artificial Wall Climbing, Bungee Jumping, Paintball, Suba Diving, Hot Air Ballooning, Canoeing, Mountain Biking, Rappelling, Snorkeling, Zip wires & high Rope course, Abseiling, Surfing, Water Skiing, Skiing, Caving, Self-Drive tours, Mountaineering/Hiking, All Terrain Vehicle, Hang Gliding, Snowboarding, Ultra-Light flying, Heli-skiing, Sky Diving.

All other clauses, terms and conditions, and exclusions applicable to and specified in the policy schedule shall apply.

XIX. Critical Illness Benefit- If, 60 days after the inception of this Policy, the Insured / Insured Person is at any time during the Policy period (after the above waiting period of 60 days), being diagnosed as contracting any Critical Illness as specified below, the specified limits as mentioned in Schedule (over and above the In-Patient Care Expenses Sum Insured mentioned in the Schedule) for this benefit shall be payable to the Insured/Insured Person as Lump Sum benefit.

However, in case of diagnosis of multiple illnesses qualified as Critical Illness under the Policy, the payment of compensation shall be limited to the limit specified in the schedule and shall be payable only once in the lifetime of Insured/Insured person. Critical Illness benefit will lapse after reporting of and payment of one claim for the claiming Insured/Insured person.

After availing the Critical Illness Benefit, if the Insured / Insured Person takes treatment for the Critical Illness in a Hospital in India, the hospitalization expenses incurred for the same would be payable/reimbursed, subject to the deductible & terms and conditions of the Policy, out of the Sum Insured available for Hospitalization Expenses under this Policy.

Critical Illness limit opted cannot be more than Sum Insured opted for In-Patient Care Expenses. The illnesses qualified as Critical Illnesses and covered in this section are as follows:

1. Cancer
2. End Stage Renal Failure
3. Multiple Sclerosis
4. Major Organ Transplant
5. Heart Valve Replacement

6. Coronary Artery Bypass Graft
7. Stroke
8. Paralysis
9. Myocardial Infarction
10. Coma
11. Parkinson's Disease
12. Benign Brain Tumour
13. Alzheimer's Disease
14. End Stage Liver Disease
15. Surgery of aorta
16. Deafness
17. Loss of speech
18. Major Burns
19. Motor Neurone Disease with Permanent Symptoms;
20. Primary Pulmonary Hypertension;
21. Pulmonary Artery Graft Surgery;
22. Muscular Dystrophy;
23. Systemic Lupus Erythematosis with Lupus Nephritis;
24. Pneumonectomy;
25. Medullary Cystic Disease

Specific Critical Illness Definition (Applicable to Critical Illness Benefit Section & Restricted Critical Illness Endorsement)

1. Cancer of Specified Severity:

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. Kidney Failure Requiring Regular Dialysis:
I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

3. Multiple Sclerosis with persisting symptoms:
I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

4. Major Organ / Bone Marrow Transplant:
I. The actual undergoing of a transplant of –

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

II. The following are excluded:

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

5. Open Heart Replacement or Repair of Heart Valves:
The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

6. Open Chest – CABG (Coronary Artery By-pass Graft) surgery:

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

II. The following are excluded:

1) Angioplasty and/or any other intra-arterial procedures

7. Stroke Resulting In Permanent Symptoms:

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

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

8. Permanent Paralysis of Limbs:

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

9. Myocardial Infarction (First Heart Attack of specified severity):

I. The first occurrence of heart attack or 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 Myocardial Infarction should be evidenced by all of the following criteria:

i. A History of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers

II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overtischemic heart disease OR following an intra-arterial cardiac procedure.

10. Coma of specified severity:

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

(ii) life support measures are necessary to sustain life; and

(iii) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

11. Parkinson's Disease:

A definite diagnosis of Parkinson's disease by a consultant neurologist. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability. For the above definition the following are not covered:

- Other Parkinsonian syndromes.
- Parkinson‟s disease secondary to drug abuse

12. Benign Brain Tumour:

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

13. Alzheimer's Disease:

The Unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age 60 that has to be confirmed by a specialist Medical Practitioner (Neurologist) and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT scan, MRI, PET of the brain). The disease must also result in a permanent inability to perform independently three or more Activities of Daily Living or must result in need of supervision and the permanent presence of care staff due to the disease. These conditions must be medically documented for at least 90 days.

Alzheimer's disease is a condition which affects the brain Symptoms include memory loss, confusion, communication problems and general impairment of mental function. The condition gradually worsens, which can lead to changes in personality and makes routine tasks difficult. Eventually, 24 hour care may be needed.

14. End Stage Liver Failure:

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

15. Surgery to Aorta

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

16. Deafness:

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

17. Loss of Speech:

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist. All psychiatric related causes are excluded.

18. Third Degree Burns:

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.19. Motor Neurone Disease with Permanent Symptoms;

19. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

20. Primary (IDIOPATHIC) Pulmonary Hypertension:

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

21. Pulmonary Artery Graft Surgery;

The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

22. Muscular Dystrophy;

A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to us, with confirmation of at least 3 of the following 4 conditions:

a. Family history of muscular dystrophy;

b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;

c. Characteristic electromygrom; or

d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months:

23. Systemic Lupus Erythematosus (SLE):
A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:

1. Permanent neurological deficit with persisting clinical symptoms*; or

2. The permanent impairment of kidney function tests as follows; Glomerular Filtration Rate (GFR) below 30 ml/min.

   * Permanent neurological deficit with persisting clinical symptoms.

3. Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

4. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma

24. Pneumonectomy:
The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

• Removal of a lobe of the lungs (lobectomy)
• Lung resection or incision

25. Medullary Cystic Disease:
A progressive hereditary disease of the kidneys characterised by the presence of cysts in the medulla, tubular atrophy and intestitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic renal failure. The diagnosis must be supported by renal biopsy.

All other clauses, terms and conditions and exclusions applicable to and specified in the policy schedule shall apply.

XX. Air Ambulance

The Company shall pay for transportation in an airplane or helicopter, which is certified to use as an ambulance for Emergency Care which require immediate and rapid transportation from the site of first occurrence of the Illness / Accident to the nearest Hospital within a reasonable timeframe. This cover is available only where the medical treatment required and as advised by medical practitioner is not available in any Hospital of the city of first occurrence. The claim would be reimbursed up to the actual expenses subject to available Sum Insured under **In-Patient Care Expenses** of this Policy as mentioned in the Schedule to this Policy.

The Company shall not pay for air ambulance for the transfer of Insured / Insured Person within the same city of first occurrence. Return transportation is excluded.

Claim under this section is payable on per hospitalization event basis and admissibility of claim under this section shall be determined basis an admissible hospitalization claim under the policy that requires admission in the hospital as In-Patient.

The coverage is available on worldwide basis including geographical limits within India.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to and specified in the policy schedule shall apply.

General 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:

- Any Disease/Illness contracted during the first thirty days from the date of policy inception. Such waiting period stands waived off for accidental claims subject to policy terms and conditions. However this waiting period shall be waived off, if the same Insured/Insured Person(s) is covered under a retail indemnity health insurance policy with Bharti AXA General Insurance Co. Ltd for a period exceeding 30 days.

Specified Ailment Waiting Period - Hospitalization Expenses incurred on treatment of following Diseases or Illness or procedures/surgeries within a waiting period of 2 years from the inception of initial / first Policy:

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems
8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22. Gout and Rheumatism
23. Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

This exclusion, however, doesn't apply in case of

- Subsequent renewals with the Company without a break post the waiting period specified in the Schedule of the policy
- Portability to the extent of waiting period and Sum Insured waived off in the Schedule of the Policy.

In the event that the above listed Illness/diseases arise on account of a pre-existing condition, they shall be covered under this policy only upon completion of Pre-existing disease waiting period.

- Any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any Pre-existing Disease or any complication arising from the same during the Pre –existing diseases waiting period.

- Congenital external diseases, defects or anomalies, genetic disorders.
- Non payable items as per appendix II
- Stem cell Therapy or surgery, or growth hormone therapy.

- Pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to a claim for In-patient Treatment only.
- Sterility, treatment whether to effect or to treat infertility, any fertility, subfertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services.
- Expenses related to organ donation other than what is covered under Organ Donor Expenses Section. 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.
- Dental treatment and surgery that do not require hospitalization, unless it is accidental in nature and admissible under Dental Treatment Section.
- General debility or exhaustion ("rundown condition").
- Items of personal comfort and convenience including but not limited to cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental/Misc. charges / services and supplies not explained.
- Vitamins and tonics unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

- Any treatment or part of a treatment that is not of a reasonable charge, not Medically Necessary; drugs or treatments which are not supported by a prescription.

- Artificial limbs, crutches or any other external appliance and/or device used for diagnosis or treatment (except when used intra-operatively).

- The cost of the following equipment is not payable under the policy. However the company shall pay the rental charges during the stay in hospital.

    a) BIPAP Machine
    b) CPAP/CAPD Equipment
    c) Infusion Pump
    d) Oxygen Cylinder
    e) Ambulance Equipment
    f) Arthroscopy and Endoscopy Instruments

- Admission primarily for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

- Preventive care, vaccination including inoculation and immunizations (except in case of post-bite treatment).

- Convalescence, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.

- Experimental, investigational or unproven treatment devices and pharmacological regimens. Admission primarily for diagnostic purposes not related to Illness for which Hospitalization has been done.

- Conditions for which treatment could have been done on an OPD basis in India without any Hospitalization.

- Treatment of obesity and any weight control program/supplies/services.

- Treatment for correction of eye sight due to refractive error.

- Cosmetic, aesthetic and re-shaping treatments and surgeries
  a) Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.
  b) Circumcisions (unless necessitated by Illness or injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.

- Substance abuse and de-addiction programs- Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies.

- War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, mutiny, military or usurped acts, seizure, capture, arrest, restraints and detainment of all kinds.

- Any Illness or Injury arising from Insured Person committing or attempting to commit any breach of law with criminal intent or intentional self-injury or attempted suicide while sane or insane.

- Any treatment/loss required arising from Insured Person's participation in any hazardous activity including but not limited to scuba diving, engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parachuting, hang gliding, rock or mountain climbing, winter sports, mountaineering (where ropes or guides are customarily used), caving or potholing, hunting or equestrian, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), polo, snow and ice sports, professional sports or any other potentially dangerous sport.

General Conditions

- **Entry Age –** The minimum entry age for the Primary insured person & Spouse shall be 18 Years. Maximum Entry age shall be 65 Years.
  Dependent Children can be covered from the 91st day after birth till 23 Years.

- **Category of Room –** The Company shall pay Room Rent Charges on actuals incurred expenses. There is no restriction on the category of room availed for treatment of disease/illness/ injury.

- **Pre-Policy Checkup**

- – Insured Person(s) proposed to be covered under the Insurance policy may be required to undergo Pre-Policy Checkup at our network based on Age, Sum insured & any declared health condition as stated in the Company's underwriting guidelines. Based on the findings of the medical reports, we may accept/reject the proposal or send a counter offer letter with restrictive terms/permanent exclusions/Loadings.

  Proposer shall within 7 days from the date of receipt of the communication; give us consent on the counter offer. In the event of no confirmation from the proposer within the timelines, we will consider non-acceptability of counter offer and process the refund.

  The Company shall bear minimum 50% of the expenses related to Pre-Policy Checkup upon acceptance of the proposal, successful issuance of the policy and subsequent non-cancellation during the free look period.

  In the event of rejection of the proposal or Proposer not keen to accept the counter offer made by us, we will process the refund of premium after deduction of entire Pre-Policy Checkup Charges.

- **Deductible** - Admissibility of claim arises only when the aggregate of expenses covered under hospitalization (Single or Multiple) exceeds the defined aggregate policy deductible opted. Amount payable is only in excess of the defined aggregate policy deductible specified in the Schedule.

  Deductible shall apply afresh for each Policy Year in case of Multiyear policies.

- **Geographical Limits & Currency** - This Policy only covers medical treatment taken within India. The following sections if opted shall be covered on worldwide basis:
  a. Hospital Daily Cash
  b. Convalescence Benefit
  c. Emergency Hospitalization (Worldwide basis)
  d. Personal Accident
  e. Critical Illness Benefit
  f. Air Ambulance

  All payments under this Policy will only be made in Indian Rupees within India.

- **Free Look Period** - Policyholder has a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If the Policyholder has any objections to any of the terms and

conditions, he / she have the option of cancelling the Policy stating the reasons for cancellation and in such a case, the Company will refund premium subject to

a) A deduction of the expenses incurred on any medical check-up, stamp duty charges, if the risk has not commenced.
b) A deduction of the expenses incurred on any medical check-up, stamp duty charges and proportionate risk premium for period on cover, if the risk has commenced.
c) A deduction of pro-rata risk premium in proportion to the risk covered during such period, where only a part of risk has commenced.

The Policy can be cancelled only if Insured Person(s) has not made any claims under the Policy. Free look provision is not applicable and/or available at the time of renewal of the Policy.

- **Disclosure of Information Norm –** The policy shall be cancelled ab-initio and no benefit shall be payable in the event of untrue or incorrect statements, mis-representation, mis-description or non-disclosure of any material particulars in the proposal form/ Interactive Voice Response (IVR), personal statement, declaration and relevant documents, or any material information having been withheld by the Policy holder/Insured Person(s) or any one acting on their behalf to obtain a benefit under this policy.

- **Cancellation/Termination –**

  a) **Cancellation by Insured** – The Policyholder may choose to cancel the policy by giving 15 days, notice in writing to the Company. The Company shall cancel the policy from the date of receipt if the notice after retaining premium for the period this policy has been in force at Company's short period rates. Provided however that refund on cancellation of Policy by the Insured shall be made only if no claim has occurred up to the date of cancellation of this Policy.

Period on Risk	Rate of Premium to be retained by Company for 1 year Policy	Rate of Premium to be retained by Company for 2 years Policy	Rate of Premium to be retained by Company for 3 years Policy
Up to 1 month	25%	15%	10%
Exceeding 1 month Up to 3 months	50%	25%	15%
Exceeding 3 months Up to 6 months	75%	50%	25%
Exceeding 6 months Up to 12 months	100%	75%	50%
Exceeding 12 months Up to 18 months	N.A	85%	75%
Exceeding 18 months Up to 24 months	N.A	100%	85%
Exceeding 24 months Up to 30 months	N.A	N.A	90%

Beyond 30 months	N.A	N.A	100%

b) **Cancellation by Company** – The Company may cancel the policy ab-initio and forfeit the premium without any refund in the event the condition for disclosure of information norm is not complied with or if the Policyholder/Insured person(s) have resorted to any fraudulent/dishonest means to claim under the policy.

Subject to no claims reported under the policy, in an event of unfortunate death of an insured person or in case of non-cooperation of the Policyholder/Insured Person in implementing the terms and conditions of this policy or upon notification of any material change from the Policyholder/Insured Person(s), the Company shall refund the prorated premium for the unexpired period for which premium has been received in full.

The Company shall exercise the right to cancel by giving 15 days, notice in writing to the address specified in the Schedule.

In the event of non-realization of premium, Company shall cancel the Policy from date of policy inception, irrespective of the fact, whether a separate communication has been sent to the Policyholder or not.

- **Material Change-** The Policyholder/Insured Person(s) shall immediately notify in writing to the Company of any material change which has a bearing to the risk. The Company may decide to adjust the scope of the cover and/or the premium or cancel the policy as per Cancellation/Termination condition, if necessary, accordingly.

- **Renewal Terms –** The policy is renewable for life except on except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the Policyholder/Insured Person(s) or any one acting on behalf of them.

  The premium for renewal will be applicable as per the agreed premium based on age and underwriting policy and will not load the premium for any adverse claims experience of particular insured. The Company shall also not deny the renewal on the ground that the insured person(s) had made a claim or claims in the preceding policy years.

  The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDAI) and inform the same to the Insured at least 3 months prior to the date of revision and/ or modification or renewal. In the likelihood of this policy being withdrawn in future, the Company will inform the same to the Policyholder at least 3 months prior to expiry of the policy. Policyholder will have the

option to migrate to other plan under similar health insurance policy at the time of renewal, provided the policy is maintained without a break.

The Policyholder can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured person(s), Pre-Policy Check-up, claim history and subject to acceptance by the Company. All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured.

All applications for renewal of the policy must be received by us before the end of the policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy. However, there is no coverage for injury sustained or disease contacted during this period

- **Renewal Notice –** The Company shall ordinarily give notice for renewal of the Policy and accept renewal premium in all cases except in case of non-cooperation of the Insured/Insured Person in implementing the terms and conditions of this Policy. Every renewal premium shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the insured that may result to enhance the risk of the Company under the guarantee hereby given. No renewal receipt shall be valid unless it is on the printed/electronic form of the Company and signed by an authorized official of the Company.

Portability.

From another company to Bharti AXA Policy

- If the proposed Insured Person was insured continuously and without a break under another Indian retail health insurance Policy with any other Indian General Insurance company or stand-alone Health Insurance Company, it is understood and agreed that:

  (1) If Insured person wish to exercise the Portability Benefit, The Company should have received the application for portability and the completed Portability Form with complete documentation at least 45 days before the expiry of the existing insurance Policy.

  (2) This benefit is available only at the time of renewal of the existing health insurance Policy.

  (3) Portability benefit is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions / waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(5) The Portability Benefit shall be applied by the Company within 15 days of receiving the completed Application and Portability Form from the proposer subject to the following:
(a) Proposer shall provide the Company all additional documentation and/or information requested;
(b) The proposer shall pay the Company the applicable premium in full;
(c) The Company may, subject to medical underwriting, restrict the terms upon which the Company may offer cover, the decision as to which shall be in the Company sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.
(d) There is no obligation on the Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if the proposer have given all documentation to the Company; This is subject to Company's Board approved Underwriting policy filed with Authority.
(e) The Company shall be received necessary details of medical history and claim history from the previous insurance company for the Insured Person's previous health insurance Policy through the IRDA's web portal.

- No additional loading or charges shall be applied by the Company exclusively for porting the Policy.

From the Company's existing health insurance policies to this Pol

- If the proposed Insured Person was insured continuously and without a break under another health insurance Policy with the Company, it is understood and agreed that:

(1) If the Insured wish to exercise the Portability Benefit, the Company should have received the Insured's application and completed Portability Form before the expiry of the existing insurance Policy;

(2) This benefit is available only at the time of renewal of existing health insurance Policy.

(3) Portability benefit is available only up to the existing cover. If the proposed Sum Insured is higher than the Sum Insured under the expiring Policy, waiting periods would be applied on the amount of proposed increase in Sum Insured only, in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(4) Waiting period credits would be extended to Pre-existing Diseases and time bound exclusions/waiting periods in accordance with the existing guidelines of the Insurance Regulatory and Development Authority.

(5) The Portability Benefit shall be applied by the Company within 15 days of receiving Insured's completed Application and Portability Form subject to the following :

(a) Insured / Insured Person shall give the Company all additional documentation and/or information request's;

(b) Insured / Insured Person pay the Company the applicable premium in full;

(c) The Company may, subject to medical underwriting, restrict the terms upon which the company may offer cover, the decision as to which shall be in Company's sole and absolute discretion; This is subject to Company's Board approved Underwriting policy filed with Authority.

(d) There is no obligation on Company to insure all Insured Persons or to insure all Insured Persons on the proposed terms, even if Insured/ Insured person have given all documentation. This is subject to Company's Board approved Underwriting policy filed with Authority.
(e) No additional loading or charges shall be applied by Company exclusively for porting the Policy.

The Company reserves the right to modify or amend the terms and the applicability of the Portability Benefit in accordance with the provisions of the regulations and guidance issued by the Insurance Regulatory and Development Authority as amended from time to time.

- **Notice -** Any notice, direction or instruction under the Policy shall be in writing and if it is to:
  a) Insured Person, it would be sent at the address specified in Schedule / endorsement.
  b) Company, shall be delivered to the address specified in the Schedule.
  c) No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of the Company unless explicitly stated in writing by the Company.

- **Multiple Policy & Contribution –**

  In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar polices.

  If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder/Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies.
  1. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
  2. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

3. The Insured Person having multiple policies shall also have the right to prefer claims from other policy / policies for the amounts disallowed (Including but not limited to exhaustion of Sum Insured) under the earlier chosen policy / policies, even if the sum insured is not exhausted. Then the Insurer(s) shall settle the claim subject to the terms and conditions of the other policy / policies so chosen.

I. Claim Notification - Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured Person/Insured Person's representative to intimate the claim to the Company. The intimation can be given in following ways:

- Toll Free call Centre of the TPA (24x7) - **1800-103-2292**
- Toll Free call Centre of the Insurance Company(24x7) - **1800-103-2292**
- Login to the website of the Insurance Company and intimate the claim – http://www.bharti-axagi.co.in/contact-us
- Send an email to the TPA/Company- customer.service@bhartiaxa,.com
- Post/courier to TPA/Company - Claims, Bharti AXA General Insurance Company Limited spectrum Tower, 3rd flr, Chincholi Bunder Rd, Rajan Pada, Mindspace, Malad West, Mumbai, Maharashtra 400064
- Directly Contacting our Company office but in writing. - Bharti AXA General Insurance Company Limited, 19th Floor, Parinee Crescenzo, G-Block, Bandra Kurla Complex, Opposite MCA Club, Bandra (E), Mumbai - 400051

In all the above, the intimations are directed to a central team for prompt and immediate action.

- **Claim Procedure -** Procedures for Cashless and Reimbursement Service have been laid down under the policy.

a) Cashless Claims Service – Insured Person(s) can avail the Cashless services in any of our network providers. In Order to avail Cashless Claims Service, the following procedure must be followed:-

The duly filled claim form and Health Card with all supporting documents shall be furnished to the TPA/Company through the TPA desk at the provider's premises where the Insured person(s) shall undertake treatment. Notification of claim should be done at least 48 hours prior to the Insured Person(s) hospitalization for planned treatment and within 24 hours of the start of the Insured Person(s) hospitalization for Emergency Treatment.

The TPA will check the policy coverage as per the eligibility and send an authorization letter to the provider. In case there is any deficiency in the documents sent to TPA for cashless authorization, the same shall be communicated to the network provider by TPA within 6 hours of receipt of the documents.

Cashless Service may not be available to claim requests where conclusive information/complete document are not available to establish the admissibility of claim under the policy. The Policyholder/Insured Person(s) shall pay such expenses to the hospital and may register a Reimbursement claim under the policy. A panel of doctors representing the Company shall review the merits of such cases. However there is no obligation to pay if such claims do not qualify in lieu of the scope of cover, exclusions and policy terms and conditions.

If the cashless is approved, the original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorization does not guarantee that all costs and expenses will be covered. The Company reserves the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. If the claim is admissible under the policy, the Company will make the payment to the extent of the liability directly to the network provider subject to policy Scope of cover, Exclusions, Terms & Conditions, and Endorsement.

Those cases where initial covered Medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other Insurer (if covered under any other Health Insurance Policy).
The list of network providers is available in the TPA/Company's website.

b) Reimbursement Claims Service – The Policyholder/Insured person(s) or any one acting on behalf shall register a claim through our toll- free number specified in the Policy/Health Card to the Company/ TPA with the particulars mentioned below:-

i. Policy Number/Health Card No.
ii. Name of the Policyholder & Details of the Insured Person(s) availing treatment
iii. Details of the disease/illness/injury
iv. Name and address of the hospital
v. Any other supporting information

Within 15 Days from the date of discharge from the hospital, the policyholder/Insured Person(s) shall further furnish the documents mentioned in the **Claim Documentation Section** to the TPA at his own expense. The

Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the policy.

If there is any deficiency in the documents/ information submitted by you, the Company will send the deficiency letter within 7 days of receipt of the claim documents.

- **Claim Documentation**
  - i. Duly filled Claim form
  - ii. Photocopy of Government ID Proof, PAN Card and Health Card.
  - iii. Original Hospital Bills with bill no. along with break-up of each item and Discharge/Daycare - summary/certificate/card from the Hospital.
  - iv. Original Hospital payment Receipt of the hospital bill with receipt number. (Reimbursement Claim)
  - v. Original Cash Memos from Hospital Pharmacy/Chemist, supported by proper prescriptions.
  - vi. Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner /Surgeon demanding such Pathological tests.
  - vii. First Consultation letter and subsequent Prescriptions.
  - viii. Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.
  - ix. Attending Doctor's/Consultant's/Specialist's/Anesthetist's original bill and receipt, and certificate regarding diagnosis.
  - x. Medical Case History/Summary.
  - xi. Original bills & receipts for claiming Ambulance Charges.
  - xii. Original invoice/bills for Implants (viz. Stent / PHS Mesh / IOL etc.) with original payment receipts.
  - xiii. Hospital Registration Number and PAN details from the hospital.
  - xiv. Doctor's registration Number and Qualification from the doctor.
  - xv. Treating Doctor's certificate giving details of Injury (How, when & where injury sustained).
  - xvi. First Information Report from Police Department/ Copy of Medico Legal Certificate for Medico Legal Cases.
  - xvii. Original Death Summary from hospital, copy of Death certificate from treating doctor or hospital authority, copy of legal heir certificate (if nomination is not available) and port-mortem report (if conducted) to be furnished in an event of death of the Insured person.

Pre-Post hospitalization Claims to be submitted along with a self-attested copy of Point iii) and originals of Point no. i), ii), v), vi), ix) mentioned in the Claim Documentation Section.

In the case of a covered Hospitalization, the costs of which were not initially estimated to exceed the Deductible but were subsequently found likely to exceed the Deductible, the intimation should be submitted along with a copy of intimation made to the other insurer immediately on knowing that the Deductible is likely to be exceeded.

In the event of the original documents being provided to any other Insurance Company, The Company shall accept verified photocopies of such documents attested by such other Insurance Company along with the Settlement letter.

If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organization/provider, then on request from the Insured Person, We will provide attested copies of the bills and other documents submitted by the Insured Person.

- **Claim Payment**

On receipt of the complete set of claim documents, the Company will make the payment for the admissible amount, along with a settlement letter within 30 days to the extent of the liability subject to policy Scope of cover, Exclusions, Terms & Conditions, and Endorsement.

Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid.

- **Dishonest or 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 Policy holder/Insured Person or anyone acting on his/her behalf to obtain any benefits under the Policy, the policy shall be cancelled ab-initio and all benefits under this Policy shall be forfeited. There will be no refund of premium. If there is any claim already paid under the policy, Company shall have the right to reclaim the amount already paid from the Policyholder/Insured Person(s).

- **Right to Investigate -** The Insured Person(s) shall at any time as may be required authorize and permit the TPA and/or Company 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. 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 extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.

- **Policy Disputes -** Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

- **Arbitration -** If any dispute or difference shall arise as to the quantum to be paid under this policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole Arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single Arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 Arbitrators, comprising of 2 Arbitrators and 1 to be appointed by each of the parties to the dispute/difference and the third Arbitrator to be appointed by such 2 Arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

It is agreed and understood that no dispute or difference shall be referred to arbitration; the Company has disputed or not accepted liability under the policy.

It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that the award by such Arbitrator/Arbitrators of the amount of the loss shall be first obtained.

GRIEVANCES REDRESSAL PROCEDURE:

The Company is committed to extend the best possible services to its customers. However, If Policyholder/Insured Person have a grievance that he/she wish us to redress, he/she may contact the Company with the details of their grievance via:

•Website: www.bharti-axagi.co.in

•Email: customer.service@bhartiaxa.com

•Phone: 022-61188888080

•Courier: Any of the Company's Branch office or corporate office

Policyholder/Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Escalation Level 1

In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at :

Write to: Bharti AXA General Insurance, Spectrum Towers, 3rd floor, Malad Link Road, Malad (west), Mumbai- 400064

Call: 022-48815939

Email: NGRO@bhartiaxa.com

3rd floor, Spectrum Tower, Rajan Pada

Mindspace, Malad (W), Mumbai - 400 064

Escalation Level 2

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:

Email : CGRO@bhartiaxa.com

Escalation Level 3

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, or, If Policyholder/ Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.

•Website: www.bharti-axagi.co.in

•Email: customer.service@bhartiaxa.com

•Phone: 022-61188888080

•Courier: Any of the Company's Branch office or corporate office

Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Grievance Redressal Cell of the Consumer Affairs Department of IRDAI

The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.

•Website: igms.irda.gov.in

•Email: complaints@irda.gov.in

•Toll Free Number 155255 (or) 1800 4254 732

Fill and send the Complaint Registration Form along with any letter or enclosures, if felt necessary, by post or courier to:

General Manager
Consumer Affairs Department- Grievance Redressal Cell,
Insurance Regulatory and Development Authority of India(IRDAI),
Sy.No.115/1,Financial District, Nanakramguda,
Gachibowli, Hyderabad-500032

The Compliant Registration Form is available for download at http://www.policyholder.gov.in/uploads/CEDocuments/complaintform.pdf

List of Ombudsmen

Office Details
AHMEDABAD - Shri/Smt..... Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
BENGALURU - Smt. Neerja Shah Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
BHUBANESHWAR - Shri/Smt..... Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.

Office Details
Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
DELHI - Shri/Smt..... Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
GUWAHATI - Shri Kiriti .B. Saha Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,

Office Details
Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in
HYDERABAD - Shri I. Suresh Babu Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
KOLKATA - Shri/Smt..... Office of the Insurance Ombudsman,

Office Details
Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
LUCKNOW -Shri/Smt..... Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
NOIDA - Shri/Smt..... Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
PATNA - Shri/Smt.....

Office Details
Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
PUNE - Shri/Smt..... 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@ecoi.co.in