

HOSPITAL CASH DAILY ALLOWANCE Policy Wordings

SECTION A) PREAMBLE

Our agreement to insure You is based on Your Proposal to Us, which is the basis of this agreement, and Your payment of the premium. This Policy records the entire agreement between Us and sets out what We insure, how We insure it, and what We expect of You and what You can expect of Us.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

Words or terms mentioned below have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine include references to the plural or to the female wherever the context permits:

1. Accident, Accidental :

An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- Central or State Government AYUSH Hospital; or
- Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy or
- AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - Having at least 5 in-patient beds;
 - Having qualified AYUSH Medical Practitioner in charge round the clock;
 - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
 - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3. AYUSH Day Care Centre:

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

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

4. Any one illness :

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

5. Condition Precedent :

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

6. Congenital Anomaly :

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

- Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body
- External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body

7. Day care centre :

A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -up with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

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

8. Day Care Treatment :

Day care treatment means medical treatment, and/or surgical procedure which is:

- undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
- which would have otherwise required a hospitalization of more than 24 hours.

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

9. Dental Treatment :

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

10. Disclosure to information norm :

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.

11. Domiciliary Hospitalisation :

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

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

12. Emergency Care :

Emergency care means management of 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's health.

13. Grace Period :

Grace period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

14. Hospital :

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

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

15. Hospitalization :

Hospitalization means admission in a Hospital for a minimum period of 24 consecutive In patient Care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

16. Illness :

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 for 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

17. Inpatient Care :

Inpatient care means treatment for which the Insured has to stay in a hospital for more than 24 hours for a covered event.

18. Injury :

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

19. Intensive Care Unit :

Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring 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.

20. ICU Charges :

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.

21. Medical Advice :

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

22. Medical expenses :

Medical Expenses means those expenses that an Insured 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 had not been Insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

23. Medical Practitioner/Doctor/ Physician :

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 or Ayurvedic and or such other authorities 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 and acceptable to Us.

24. Medically Necessary Treatment :

Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

- i. is required for the medical management of the illness or injury suffered by the Insured;

- ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a medical practitioner,
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

25. Migration :

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

26. Network Provider :

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

27. Non-Network Provider :

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

28. Notification of Claim :

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

29. OPD treatment :

OPD treatment means 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.

30. Portability :

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

31. Pre-Existing Disease :

Pre-existing disease means any condition, ailment or injury or disease

- a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement Or
- b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.

32. Qualified Nurse :

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.

33. Reasonable and Customary charges :

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.

34. Renewal :

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

35. Room rent :

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

36. Surgery or Surgical Procedure :

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.

37. Unproven/Experimental treatment:

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

SECTION B) DEFINITIONS- SPECIFIC DEFINITIONS

1. AYUSH Treatment refers to medical expenses incurred on hospitalisation under Ayurveda, Yoga and Naturopathy Unani, Siddha and Homeopathy systems

2. Bajaj General Network Hospitals / Network Hospitals :

Bajaj General Network Hospitals / Network Hospitals means the Hospitals which have been empanelled by Us as per the latest version of the schedule of Hospitals maintained by Us, which is available to You on request.

3. Daily Allowance :

Means the amount and period specified in the schedule.

4. Family :

For the purpose of Individual Sum Insured policy- includes the insured; his/her lawfully wedded spouse, and dependent children, Grandchildren, Parents, Sister, Brother, Father In law, Mother In law, Aunt, Uncle

5. Limit of Indemnity :

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Limit of Indemnity represents Our maximum liability to make payment for each and every claim per person and collectively for all persons mentioned in the Schedule during the policy period and in the aggregate for the person(s) named in the schedule during the policy period, and means the amount stated in the Schedule against each Cover and subject to the limits specified in section C.

6. Named Insured/ Insured :

Insured means the persons, or his Family members, named in the Schedule provided that an Insured or his Family Members has attained the age of 3 months and is not older than 65 years of age at the commencement of the Policy Period.

7. Nominee :

Nominee means a person designated by You to receive the proceeds of this Policy upon Your death.

8. Schedule means the schedule and any annexure to it.

9. You, Your, Yourself/ Your Family named in the schedule means the person or persons that We insure as set out in the Schedule.

SECTION C) COVERAGE

➤ **Scope of cover**

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

➤ **Tenure of Policy:**

1 year, 2 years or 3 years

➤ **OPERATIVE PART**

In the event of Accidental Bodily Injury or Illness first occurring or manifesting itself during the Policy Period and causing the Insured's or the Named Insured's Hospitalisation within the Policy Period, the Company will pay:

- a. The Daily Allowance for each continuous and completed period of 24 hours of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Illness, or
- b. Two times the Daily Allowance for each continuous and completed period of 24 hours required to be spent by the Insured or Named Insured in the Intensive Care Unit of a Hospital during any period of Hospitalisation necessitated solely by reason of the said Accidental Bodily Injury or Illness for a maximum period of 7 days for each hospitalisation.

SECTION D) EXCLUSIONS UNDER THE POLICY -STANDARD EXCLUSIONS

Exclusions

No indemnity is available hereunder and no payment will be made by the Company for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

I. Waiting Period

1. Pre-existing Diseases waiting period (Excl01) :

- a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Hospital Cash Daily Allowance Policy with us.
- b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- c. If the Insured is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
- d. Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. Specified disease/procedure waiting period (Excl02) :

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

1. Treatment of cataracts	2. Haemorrhoids
3. Benign Prostatic Hypertrophy	4. Fissure in ano
5. Hysterectomy	6. Stones in the Urinary and Biliary systems
7. Menorrhagia	8. Surgery on ears
9. Fibromyoma	10. Tonsils or Sinuses
11. D&C	12. Skin and all internal tumours/cysts/nodules/polyps of any kind including breast lumps

13. Endometriosis	14. Gastric or Duodenal ulcer
15. Hernia of all types	16. Backache
17. Hydrocele	18. Prolapsed Intervertebral disc
19. Fistulae	

3. 30-day waiting period (Excl03) :

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

II. General Exclusions :

1. Investigation & Evaluation (Excl04) :

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

2. Rest Cure, rehabilitation and respite care- (Excl05) :

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

3. Obesity/Weight Control (Excl06) :

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

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

4. Change-of-gender treatments (Excl07) :

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

5. Cosmetic or plastic Surgery (Excl08) :

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

6. Breach of law (Excl10) :

Expenses for treatment directly arising from or consequent upon any Insure Person committing or attempting to commit a breach of law with criminal intent

7. Excluded Providers (Excl11) :

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

8. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Excl12)

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

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

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

12. Unproven Treatments (Excl16) :

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

13. 13. Sterility and Infertility (Excl17) Expenses related to sterility and infertility. This includes: a) Any type of contraception, sterilization b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI c) Gestational Surrogacy d) Reversal of sterilization

14. Maternity (Excl 18) :

- a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
- b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SECTION D) EXCLUSIONS UNDER THE POLICY - GENERAL EXCLUSIONS

- i. Any dental treatment that comprises of cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization.
- ii. Medical expenses where Inpatient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock
- iii. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority. Any Medical expenses incurred due to Act of Terrorism will be covered under the Policy.
- iv. The cost of spectacles, contact lenses, hearing aids, crutches, dentures, artificial teeth and all other external appliances and/or devices whether for diagnosis or treatment except for Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents etc.
- v. External medical equipment of any kind used at home as post Hospitalization care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.
- vi. Congenital external diseases or defects or anomalies, growth hormone therapy, stem cell implantation or surgery except for Hematopoietic stem cells for bone marrow transplant for haematological conditions.
- vii. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)
- viii. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating Medical practitioner.
- ix. All non-medical items as per Annexure II
- x. Any treatment received outside India is not covered under this Policy.
- xi. Circumcision unless required for the treatment of Illness or Accidental bodily injury.
- xii. Treatment for any other system other than modern medicine (allopathy) and AYUSH therapies

SECTION E) CONDITIONS - STANDARD GENERAL TERMS AND CLAUSES

1. Disclosure of information :

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

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

2. Condition Precedent to Admission of Liability :

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

3. Moratorium Period :

After completion of sixty continuous months of coverage (including portability and migration) no look back would be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

4. Premium Payment in Instalments (Wherever applicable) :

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

- i. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.
- ii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
- iii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
- iv. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period
- v. No interest will be charged if the instalment premium is not paid on due date.
- vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- viii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

5. Claim Settlement. (provision for Penal interest) :

- i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such

- cases, the Company shall settle or reject the claim within 15 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

6. Multiple Policies :

- i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
- iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/ she wants to claim the balance amount.
- iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

7. Renewal of Policy :

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

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

8. Possibility of Revision of Terms of the Policy Including the Premium Rates :

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

9. Withdrawal of Policy :

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

10. Fraud :

- i. If any claim made by the Insured beneficiary, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured beneficiary or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
- ii. Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
- iii. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured beneficiary or by his agent or the hospital/ doctor/any other party acting on behalf of the Insured beneficiary, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
 - the suggestion, as a fact of that which is not true and which the Insured beneficiary does not believe to be true;
 - the active concealment of a fact by the Insured beneficiary having knowledge or belief of the fact;
 - any other act fitted to deceive; and
 - any such actor omission as the law specially declares to be fraudulent
- iv. The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured beneficiary / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement or suppression of material fact are within the knowledge of the insurer

11. Portability:

The Insured beneficiary will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed.

Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link <https://irdai.gov.in/document-detail?documentId=393128>

(Please note referred link is of the IRDAI website and subject to change from time to time.)

12. Migration:

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

For Detailed Guidelines on migration, kindly refer the link<https://irdai.gov.in/document-detail?documentId=393128>

(Please note referred link is of the IRDAI website and subject to change from time to time.)

13. Nomination:

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

14. Free Look Period :

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of Thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

15. Complete Discharge :

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

16. Cancellation:

(A) Cancellation by the Policyholder

The Policyholder can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired policy period as detailed below:

1. Cancellation of policy where full premium received at policy inception -

- Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.
- Multi-year Policy:
 - For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
 - For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

2. Cancellation of policy where Premium Received on Instalment Basis

The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

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

(C) Cancellation by the Company

The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Policyholder/insured person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

17. Grievance Redressal Procedure :

The company has always been known as a forward-looking customer centric organization. It takes immense pride in its approach of "Caringly Yours". To provide you with top-notch service on all fronts, the company has provided with multiple platforms via which you can always reach out to us at below mentioned touch points

1. Our toll-free number 1-800-209- 5858 or 020-30305858, say Say "Hi" on WhatsApp on +91 7507245858
2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website- www.bajajgeneralinsurance.com/branch-locator.html
3. Register your grievances / complaints on our website- www.bajajgeneralinsurance.com/about-us/customer-service.html
4. E-mail-
 - a. Level 1: Write to careforyou@bajajgeneral.com and for senior citizens to seniorcitizen@bajajgeneral.co.in
 - b. Level 2: In case you are not satisfied with the response given to you at Level 1 you may write to our Grievance Redressal Officer at ggro@bajajgeneral.co.in
 - c. Level 3: If in case, your grievance is still not resolved, and you wish to talk to our care specialist, please give a missed call on +91 80809 45060 OR SMS To 575758 and our care specialist will call you back
5. If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at - www.cioins.co.in/ombudsman.html

The contact details of the ombudsman offices are mentioned **Annexure I**.

SECTION E) CONDITIONS – SPECIFIC TERMS AND CLAUSES

18. Insurance of family :

If this Policy is taken for the benefit of the Insured's family (and not by an employer for his employees), then it is a condition precedent to

the Company's liability that the following categories of persons are included and maintained as Named Insureds:

- a. The lawful spouse of the Insured, who is not older than 65 years of age at the commencement of the Policy Period.
- b. The lawful children of the Insured and his spouse aged between 3 months and 21 years at the commencement of the Policy Period who are living with the Insured and/or his spouse and who have no income of their own.

19. Basis of claims payment :

- a. The payout under this policy is on benefit basis.
- b. In respect of any period of Hospitalisation for which the Company is liable to make payment under Operative Part 2, the Company shall have no liability to make payment under Section C 1.
- c. A continuous and completed period of less than 24 hours of Hospitalisation consequent upon an insured event shall be deemed to be a continuous and completed period of 24 hours if such period extends to at least 12 hours and also includes 0300 hours.
- d. We shall make payment in Indian Rupees only.
- e. If claim event falls within two policy periods the claims shall be administered taking into consideration the available sum insured in the two policy periods, including the deductibles (if any) for each policy period. The claim amount to be payable shall be reduced up to the extent of the premium to be received for renewal by due date of renewal of this policy, if the same is not received earlier.

11. Arbitration :

Arbitration Clause shall not be applicable.

12. Territorial Limits :

This Policy covers an insured event arising, occurring and/or manifesting itself only in India, and the Company's liability to make any payment shall be to make payment within India and in Indian Rupees only.

13. Duties and Obligations of the Insured and/or named Insured :

After the Occurrence of an Insured Event It is a condition precedent to the Company's liability under this Policy that in the event of any Accidental Bodily Injury or Illness that may give rise to a claim:

- a. the Insured and/or the Named Insured shall immediately and in any event within 14 days provide the Company with written notification of a claim, and
- b. the Insured and/or the Named Insured shall take every other reasonable step and/or measure to minimise the consequence of the Bodily Injury or Illness, and
- c. the Insured and/or the Named Insured shall expeditiously provide the Company with or arrange for the Company to be provided with any and all information and documentation in respect of the claim and/or the Company's liability hereunder that may be requested, and submit himself for examination by the Company's medical advisors as often as may be considered necessary by the Company.

14. Insured :

Only those persons named as the insured in the Schedule shall be covered under this Policy. Cover under this Policy shall be withdrawn from any insured member upon such insured member giving 14 days written notice to be received by Us.

15. Communications :

Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule.

16. Notifications & Declarations :

- a. Any and all notices for the attention of the Company shall be submitted in writing and shall be delivered to the address specified in the Schedule.
- b. All notices for the attention of the Insured or the Named Insured shall be posted and addressed to the Insured's address as stated in the Schedule.
- c. The Insured and Named Insured agree that the Insured shall also act on behalf of all Named Insureds as to:
 - The giving and receiving of any notice under or in respect of this Policy (including notice of cancellation),
 - The payment of premiums and the receipt of any return premium, and
 - The acceptance of any endorsements to this Policy.

17. Discounts :

- a. Family Discount: 5% family discount shall be offered if 2 or more than 2 of any of the Dependent family members are covered under a single policy. The family discount will be offered for both new policies as well as for renewal policies.

- b. Long Term Policy Discount:

- 4 % discount is applicable if policy is opted for 2 years
 - 8 % discount is applicable if policy is opted for 3 years This is not applicable if premium is paid in instalments

18. Governing Law :

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

19. Entire Contract :

The Policy constitutes the complete contract of insurance. No change or alteration in this Policy shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by an endorsement on the Policy.

SECTION E) CONDITIONS - OTHER TERMS AND CLAUSES

20. Reimbursement Claims Procedure :

- a. You or someone claiming on Your behalf must inform Us in writing immediately with 48 hours of hospitalization in case emergency hospitalization & 48 hours prior to hospitalization in case of planned hospitalization.
- b. You must immediately consult a Doctor and follow the advice and treatment recommends.
- c. You must take reasonable steps or measures to minimise the quantum of any claim that may be made under this Policy.

- d. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary at Our cost.
- e. You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation (written details of the quantum of any claim along with all original supporting documentation as per the claims documents list specified below).
- f. In the event of the death of the insured person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 30 days*
- g. In event of a claim, the original documents to be submitted & after the completion of the claims assessment process the original documents may be returned if requested by the insured in writing, however we will retain the Xerox copies of the claim documents.
- h. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted along with the letter confirming the status of the claim & settlement details if any

***Note:**

Waiver of conditions (a), (e) and (f) may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit.

- List of claim documents
 - i. Claim Form duly signed by the insured.
 - ii. Copy of Discharge Summary / Discharge Certificate.
 - iii. Copy of Final Hospital Bill
 - iv. Aadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)

Annexure I:
Contact details of the Ombudsman offices

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 – 25501201 /02 /05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL - Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 – 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 – 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI -	Tamil Nadu, Puducherry Town and Karaikal (which are part of

Office Details	Jurisdiction of Office Union Territory, District)
Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Puducherry)
DELHI - Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwhati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI – Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW – Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdha, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahrach, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkar Nagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar..
MUMBAI -	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).

Office Details	Jurisdiction of Office Union Territory, District)
<p>Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/ 27/ 29/ 31/ 32/ 33 Email: bimalokpal.mumbai@cioins.co.in</p>	
<p>NOIDA - Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in</p>	<p>State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.</p>
<p>PATNA - Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in</p>	<p>Bihar, Jharkhand.</p>
<p>PUNE - Insurance Ombudsman 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- 24471175 Email: bimalokpal.pune@cioins.co.in</p>	<p>Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).</p>

Note: Address and contact number of Governing Body of Insurance Council:

Council for Insurance Ombudsmen, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.

E-mail: inscoun@cioins.co.in, Tel: 022 -69038800/69038812, Website: <https://www.cioins.co.in>

Please visit our website for list of network hospitals and network Diagnostic Centres,

Website: www.bajajgeneralinsurance.com/general-insurance.html. Please refer to Support (Customer Service Support Page) on the website.

or

Please get in touch with 24*7 helpline number: 1800-103-2529 (toll free) / 020-30305858