PART B: Health Insurance Policies	
I	**Prior to Sale**
1	1. Insurers are required to make available products/add-ons/riders to provide wider choice to the policyholders/prospects catering to a. **all ages**; b. all types of existing **medical conditions**; c. **pre-existing diseases and chronic conditions;** d. all systems of medicine and treatments including Allopathy, AYUSH and other systems of medicine; e. every situation of treatment including domiciliary hospitalization, outpatient treatment (OPD), Day Care and Homecare treatment; f. all regions, all occupational categories, persons with disabilities and any other categories; g. **all types of Hospitals and Health Care Providers** to suit the affordability of the policyholders/prospects. Policyholder shall not be denied coverage in case of emergency situations. Note: The above does not imply that the Insurer shall have one product to cater to all of the above. 2. Insurers shall allow for customization of products by customer by providing the flexibility to choose products / add-ons / riders as per his / her medical conditions / specific needs.
2.	**Products are to be made available in compliance with various laws:** Insurers shall offer products in accordance with relevant provisions of the following Laws: a) The Mental Healthcare Act, 2017; b) The Rights of Persons with Disabilities Act, 2016; c) The Surrogacy (Regulation) Act, 2021; d) The Transgender Persons (Protection of Rights) Act, 2019, and e) The HIV and AIDS (Prevention and Control) Act, 2017.

3.	**Purchase of insurance policy** i. Insurance products are offered only by insurers registered with IRDAI. A prospect can buy such products from an insurer directly or through any of the distribution channels. ii. Such purchase can be made either by visiting the office of Insurer / distribution channel or online by visiting the website the insurer /distribution channel. iii. "Distribution channel" for purchasing the insurance products, includes individual agents, corporate agents, insurance brokers, web aggregators, insurance marketing firms, Common Service Centre, etc. Authorized distribution channels to sell insurance products may be verified from the respective websites of the insurance companies whose products are offered for sale.
4.	**Advertisements** i. Insurance companies and the distribution channels may advertise the insurance products offered for sale. Such advertisements could be in the form of television advertisements, radio announcements, social media circulations, newspaper advertisements, pamphlets or leaf lets etc. Generally, the information available in such advertisements are indicative and may not provide complete details of the product. ii. Insurance advertisements carry the registered name of the insurers and unique identification number (UIN) of the insurance products, wherever insurance product is advertised. iii. Before purchasing any insurance product, the prospect should read the prospectus of the product shared by the insurer/distribution channels. The prospect may also verify the details of the product from the website of the insurer.
5.	**Prospectus** **i.** In order to explain the features, benefits, exclusions, and various other details offered in insurance products to customers, insurers are required to have prospectus for each of the product offered by them for sale and are uploaded in their website. **ii.** To understand specific details of any insurance product/s, a prospect may read the prospectus available on the insurers website or may ask the representative of the insurer or distribution channel to provide the same.
II	**At proposal stage**

1	**Proposal Form:** i. For purchasing an insurance policy, insurer will require a proposal form to be submitted by the prospect. ii. Proposal form will be made available in Hindi or English. However, if sought by the prospect, it will also be provided in regional language. iii. A prospect, while buying an insurance policy, is required to provide the information / details sought in the proposal form, including the following: a. mobile no, email id, present and permanent address; b. bank account details; c. name of the nominee and his/her mobile no, email id, present, permanent address, relationship of the nominee, details of authorized person for minor nominees and details of bank accounts of the nominee; iv. If asked in the proposal form, prospects are required to provide health and other medical details. v. Ayushman Bharat Health Account (ABHA) number is a hassle-free method of accessing and sharing health records digitally. With specific consent of the policyholder, insurers may facilitate creation of ABHA number as per the procedures laid down. Further, express consent of the policyholder shall be obtained for sharing of medical records and any other related information in every instance. vi. In case, the prospect is not familiar with the language printed in the proposal form, insurer or the distribution channel shall explain the details sought in the proposal form. In such case, a declaration shall be obtained from the prospect that the details have been explained to him/her. vii. A policyholder or prospect, who is a person with disability, may duly authorize a representative to give declaration on his/her behalf. viii. Prospects should exercise due care and provide required information in the proposal form which forms the basis of issuance of an insurance policy. True and complete information in the proposal form enables insurers to assess the risks appropriately and to decide on the proposal form. This also facilitates hassle-free claim servicing by the insurer. Hence, the information should be given responsibly. ix. In case there is a change in any of the information already provided in the proposal form like mobile number, email IDs, residential address, bank account details, nominee details during the term of the policy, policyholder should update such information with the insurer, to enable the insurer to provide efficient policy servicing. x. Proposer before signing the proposal form or enrolment form in case

	of group insurance should ensure that all the details as required therein have been provided.
2	**Nomination** i. While filling the proposal form, prospect is required to provide the details of the nominee. ii. Nomination is mandatory to facilitate payment of claim amount in the event of death of policyholder. iii. Policyholder may nominate one or more person and specify the percentage of claim amount payable in the event of death of the policyholder. iv. Where any nominee is a minor, it shall be lawful for the policyholder to appoint any person in the manner laid down by the insurer, to receive the money secured by the policy in the event of his/her death during the minority of the nominee. v. Nomination can be changed at any time during the term of the policy.
3	**Payment of premium / premium deposit:** i. Premium is required to be paid only after the insurer communicates the decision of acceptance of the proposal. ii. Risk Cover shall commence only after receipt of premium. iii. No premium deposit / proposal deposit is required to be paid to the insurer along with the proposal form except in case of policies issued basis declaration of good health where risk cover commences immediately on receipt of premium. There should not be scope for either short or excess collection of premiums. iv. Insurers shall ensure that explicit consent is obtained from the prospect/policyholder for deduction of amount towards premium payment from bank account.

4	**Processing of proposal forms (Underwriting of the proposal)** i. On receipt of the proposal form, the insurer shall process the proposal with speed and efficiency. In case of requirement of further details/clarifications on details given in the proposal form, the same should be called for in one-go and not on piecemeal basis within 7 days from the date of receipt of the proposal form. ii. In such case, the prospect should provide such information at the earliest so that the decision on the proposal form can be taken with speed and efficiency. iii. The insurer shall take decision on the proposal form within 7 days. On acceptance of the proposal form, the insurer shall: a) promptly communicate its decision to the prospect along with the premium payable. b) provide coverage from the date of receipt of premium. iv. In case of non-acceptance of proposal, insurer shall inform the prospect its decision within 7 days along the reasons for non-acceptance. v. After the acceptance of a proposal, the prospect will be referred to as the "policyholder or insured". The person whose risks are covered is called 'insured'. The person in whose name insurance policy is issued is called "policyholder.
5	**Issuance of the insurance policy** Insurer, on acceptance of the proposal and upon receipt of the premium, issues the insurance policy in electronic form. Choice of the prospect/policyholder/customer for availing physical policy document shall be mandatorily sought in the proposal form. All policies issued in electronic form by the insurer directly to the policyholder shall also be issued in physical form, if requested by the policyholder. Policies issued in electronic form shall be digitally signed.
6	**Insurers shall, within 15 days of the acceptance of a proposal, furnish the following to the prospect without any additional charge:** i. Policy document, ii. Copy of the proposal form submitted by the prospect, iii. Customer Information Sheet, iv. Medical Reports, if applicable.
III	**At the time of receipt of policy document**

1	**Customer Information Sheet (CIS)** 1. CIS is a statement provided by the insurer along with the policy document that provides in simple words, important information and basic features of the policy issued at one place. 2. CIS is to be provided with every policy in the format as given in Schedule D for Health insurance. It is a document provided by the Insurer along with the policy document that explains in simple words, the basic features of a policy at one place. The CIS shall: a. be provided to every policyholder in case of both Individual Insurance policy holder as well as a Member of Group Insurance Policy. b. have details like i. type of insurance, ii. sum Insured, iii. coverage provided, iv. summary of exclusions which policy does not cover, v. sub-limits (a pre-defined limit above which insurer will not pay), vi. deductibles (specified amount upto which an insurer will not pay any claim/which will be deducted from total claim, if the claim amount is more than the specified amount), co-payment, vii. waiting period(s) (time period during which specified diseases / treatments are not covered), and viii. certain important things such as Free Look Period, Policy Renewal, Migration, Portability and Moratorium Period. c. contain information regarding the Claims Procedure, Policy Servicing and Grievance Redressal Mechanism including contact details of Insurance Ombudsman of appropriate jurisdiction. 3. Acknowledgment in physical or digital will have to be obtained from the Policyholder. On request, CIS will be made available in regional language. 4. While CIS provides in simple words basic and important features of a policy, the policyholder may refer the policy document for complete details about the policy issued.

	5. Where the policyholder finds any inconsistency in the coverage or scope of the policy, the same may be taken up with the insurer either directly or through the distribution channel engaged for procuring the policy for suitable rectification.
2	**Free Look Period:** i. A period of 30 days, from the date of receipt of the policy document is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more. ii. Irrespective of the reasons mentioned, insurer must accept the request of the policyholder to exercise the option of free look period. The policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any incurred by the insurer on medical examination of the proposer and stamp duty charges.
3.	**Digilocker** The policyholder has an option to store the soft copy of the policy document in Digilocker.
IV	**During the currency of the policy**
1	**Payment of premium** i. Insurance policy will remain in-force and continue to offer the coverage as indicated in the policy, as long as the policyholder pays the premium as specified in the policy. ii. To avail the benefits of an insurance policy, the policyholder must pay premium on or before due date throughout the premium payment term subject to the grace period as applicable. iii. Premium shall be paid only to the account of the insurer. It can be paid either directly to the insurer or through its authorized distribution channel. iv. Insurer/authorized distribution channel shall issue valid premium acknowledgement immediately.

2	**Grace Period for payment of premium:** i. "Grace period" is the additional time given for payment of premium after the due date, without any penalty or late fee. It is available in other than single premium policies. However, coverage will be available during the period of grace based on policy terms and conditions. ii. Grace period from the due date of premium is: a. Fifteen days where premium is paid in monthly instalments; and b. Thirty days where premium is paid in quarterly / half-yearly / annual instalments. iii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also. iv. 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. The same is applicable for both Indemnity and Benefit products.
3	**Service request** i. During the term of the policy, Policyholders are allowed to change the details already provided to the insurer such as address, contact details, nominee details, etc. When such requests are received from the policyholder, Insurers shall acknowledge the same immediately and update the changes requested for within 7 days. ii. Where the requests have not been attended to, a grievance can be registered as detailed in para VI (1).
4	**Cancellation of indemnity-based health insurance policy by the policyholder:** The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall: a) refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period. b) refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced. In case of any delay in refund, the insurer shall refund such amounts along with interest at the bank rate plus 2 percent on the refundable amount, from the date of receipt of the request for free look cancellation till the date of refund. Such interest shall be paid suo-moto by the insurer.

5	**Renewal of Health Insurance Policy:** i. A health insurance policy is renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate to another product. ii. An Insurer shall not deny the renewal on the ground that the policyholder had made a claim (s) in the preceding policy years. iii. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured**.**
6	**Migration in case of Indemnity policies:** In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.
7	**No Claim Bonus:** The Insurer may reward the policyholders who do not make claim in the form of No Claim Bonus (NCB). Such NCB shall be paid as per the choice/ express consent of the policyholder in the following forms at the time of every renewal: a. Cumulative Bonus: Addition in the Sum Insured without an associated increase in premium; and/or b. Discount in renewal Premium.
8	**Policy/Claim cannot be contested** No policy and claim of health insurance shall be contestable on any grounds of non-disclosure and/or misrepresentation except for established fraud, after the completion of the Moratorium Period, i.e. 60 months of continuous coverage Note: The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.
V	**At the time of claim**

1	**On happening of the contingency (ies) / claim** **i.** Policyholder or the claimant, as applicable, is required to intimate the insurer, about the happening of a claim under the insurance policy, at the earliest possible time either in person or through: a) Online mode; b) distribution channel; c) Third Party Administrator (TPA); d) Hospital /Health care Provider where such facility is provided; e) authorized call centre of the insurer; f) any other mode as may be specified in the policy document. **ii.** No claim shall be rejected or closed for want of documents or for delayed intimation of claim.
2	**Processing of claim** i. Claim intimation received by the insurers shall be processed and settled within timelines specified. For time line for settlement of the claims of health, please refer para 3. ii. In case the claim is not settled within the specified timelines, then the claimant is entitled for interest at bank rate plus 2 percent from the date of receipt of intimation to till the date of payment. Such interest shall be suo-moto paid by the insurers.
3	**Claim settlement under health Insurance policies**
3 (i)	**Cashless facility for health insurance** **1. Approval for Cashless facility:** i. Insurer shall decide on the request for cashless authorization immediately but not more than **one hour** of receipt of request. ii. Insurers may arrange for dedicated Help Desks in physical mode at the hospital to deal and assist with the cashless requests. iii. Insurers shall also provide pre-authorization to the policyholder through Digital mode. **2. Final authorization for Discharge from the hospital** i. Insurer shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital. In no case, the policyholder shall be made to wait to be discharged from the Hospital. ii. If there is any delay beyond three hours, the additional amount if any charged by the hospital shall be borne by the insurer from

	shareholder's fund.
3(ii)	In the event of the death of the policyholder during the treatment, the insurer shall: i. immediately process the request for claim settlement. ii. get the mortal remains (dead body) released from the hospital immediately.
3(iii)	**Settlement of health insurance Claims** 1. TPAs are registered with the Authority, and may be engaged by insurers to provide services related to health insurance policies on behalf of insurers, in particular, at the time of claim. 2. Insurer shall ensure that the claims registered are attended to at speed and the claims are settled at the earliest possible time. 3. Pursuant to intimation of the claim, Insurers and Third-Party Administrators (TPAs), shall collect the required documents from the Hospitals. Policyholder shall not be required to submit the documents. 4. No claim shall be repudiated without the approval of Product Management Committee (PMC) or a three-member sub-group of PMC called the Claims Review Committee (CRC). 5. In case, the claim is repudiated or rejected or disallowed partially, details shall be communicated to the claimant along with full details giving reference to the specific terms and conditions of the policy document. 6. Settlement of claims (other than cashless) shall be settled within fifteen days from submission of claim.

4	**Group Insurance Policies** 1. There are two types of group insurance policies viz. Employer-Employees and Non-Employer-Employees policies. 2. In case a group insurance policy is issued to an employer-employee group: i. the employer shall be treated as the group master policyholder and the employees shall be treated as the members of the group. ii. the employer shall share the group insurance policy to all the members of the group in confirmation of insurance protection of each individual member. iii. claims shall be paid directly to the employee or the beneficiary as the case may be. iv. In order to provide cashless claim settlement for health insurance from the date of commencement of cover, the Insurer shall obtain the details of members of the group from the master policyholder, at the earliest. No claim shall be denied for non-availability of details of members of the group. 3. In case a group insurance policy is issued to a non-employer-employee group: i. the individual group member shall be the insured member and the holder of the policy shall be the master policyholder. ii. the insurer shall issue a certificate of insurance giving details of group policies viz., schedule of benefits, period of cover, premium to be paid, terms of the policy, exclusion etc. to the members of the group. 4. Claims shall be paid directly to the employee or the beneficiary as the case may be.
5	**Claims in respect of multiple Policies held by policyholders:** **1.** Indemnity Policies: a) If a policyholder has more than one health insurance policy from different insurers he/she can file for claim settlement as per his/her choice under any policy. b) The Insurer of that chosen policy shall be treated as the primary Insurer. c) In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder, his/her choice of the other insurer(s) and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

	2. Benefit based Policies: On occurrence of the insured event the policyholder, can claim from all Insurers under all policies.
VI	**Complaints Mechanism:** In case the policyholder or the claimant is required to raise any complaint against the insurer, distribution channel, authorized entity to collect premium, third-party administrators, he/she may use the Grievance redressal procedure given below:
1	Lodging of complaint i. Where the policyholder / beneficiary is not satisfied with the services of the insurer or the distribution channel, he / she can lodge complaints directly with the insurer or with the distribution channel including TPA or with both using any one of the following modes: o By visiting their nearest branch; o Through letters or email; o On insurer's website; or o by calling at their designated call centre of the insurer. The policyholder or the claimant also has the option to register the complaint on-line at IRDAI's Bima Bharosa by visiting https://bimabharosa.irdai.gov.in/. Insurers shall integrate its grievance portal with the Bima Bharosa portal to facilitate the registering/ tracking of grievance on-line by the policyholders. The insurer's system must be equipped with a real-time mirroring functionality that ensures their grievance database is consistently synchronized with the Bima Bharosa.
2	**Turnaround time for resolution of complaints / grievance** i. On receipt of a complaint, the complainant will have to be given an acknowledgement immediately. Insurers should provide resolution to the complaint within 14 days along with the reasons for not accepting the complaint with specific reference to the relevant terms and conditions of the policy. ii. The complainant can track the status of a complaint by logging-in to the Bima Bharosa or to the insurer's grievance portal or on the call centre of the insurer. iii. The insurer shall have in place robust technology-based infrastructure for handling Grievance Redressal which also has functionality to identify unrelated / unidentifiable complaints sourced by fraudsters.

3	**Filing of complaint before Insurance Ombudsman** i. In case the complainant is not satisfied with the resolution of grievance provided by the insurer, they can escalate the unresolved / partially resolved complaints to Insurance Ombudsman of concerned jurisdiction, in case the claim amount is up to Rs. 50 lakhs. ii. The policyholder has option to take up the matter before insurance ombudsman of competent jurisdiction without any charge / fee through any of the following options: a. In person; b. Online by visiting https://cioins.co.in/Complaint/Online; c. In writing through post or through email by giving complete details. iii. Details such as name and address of the Insurance Ombudsman of competent jurisdiction shall be available in the policy document. It shall also be provided in the resolution letter given by the insurer. It is also available at https://cioins.co.in/Complaint/Online.
4	**Implementation of Ombudsman Award** i. The Insurer is required to comply with the award of the Insurance Ombudsman within 30 days of receipt of award. ii. In case the Insurer does not honour the Insurance Ombudsman award within 30 days, a penalty of Rs. 5000/- per day shall be payable to the complainant for each day of delay. iii. Such penalty is in addition to the penal interest liable to be paid by the Insurer under the Insurance Ombudsman Rules, 2017. iv. This provision will not be applicable in case insurer chooses to appeal against the award of the Insurance Ombudsman within 30days. In such case, due intimation shall be sent to the Policyholder.
VII	**Miscellaneous provisions**
1	**Caution against spurious/fraudulent calls** i. Policyholders or the prospects should be aware of spurious phone calls and fictitious / fraudulent offers through messages or any other means of communications. ii. IRDAI or its officials do not involve in any activities of insurance business like selling insurance policies, announcing bonus or investment of premiums, refund of amounts. Policyholders or the prospects receiving such phone calls are requested to lodge a police complaint. iii. Insurers and Insurance Intermediaries sending commercial communications to their existing or prospective customers shall fulfil the extant regulatory requirements prescribed by the Telecom Regulatory Authority of India.

2	**Unclaimed amount** 1. Policyholder or the claimants are required to provide his/her correct mobile number, address, bank details in the proposal form and update such information as and when it is changed. In the absence of such details, settlement of claims by the insurers will be delayed, as the policyholder or the claimants can't be reachable and/or bank account details may not be available for claim settlement. This results in unclaimed amounts lying with the insurer. 2. "Unclaimed Amount" is an amount payable to consumers, including income accrued thereon, remaining unpaid beyond twelve months from the due date of such payment, on account of their non-contactability. 3. A claimant / policyholder can search if there is any unclaimed amount payable to him / her by any insurer at Bima Bharosa website of IRDAI at **https://bimabharosa.irdai.gov.in/Home/UnclaimedAmount** which provides at one place access to website links of various insurers where unclaimed amounts held by them are displayed. It can also be verified from the website of the concerned insurer. 4. Unclaimed amount belonging to policyholder / claimant can be identified by matching any two of the following fields: o Policy Number o PAN of the Policyholder o Name of the Policyholder o Date of birth of the policyholder 5. The unclaimed amounts can be claimed from the concerned insurer by following the due process as specified by the insurer. 6. In case the unclaimed amount is not claimed within 10 years, the same is transferred to Senior Citizens' welfare fund (SCWF). 7. The claimant / policyholder can claim the unclaimed amounts up to 25 years from the date of transfer of the same to the SCWF through the concerned insurer. If no claim is made up to a period of 25 years after transfer to the SCWF, such amounts shall be escheat to the Central Government.

3	**Portability in case of Health Indemnity Policies** i. Portability means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained from one insurer to another insurer. ii. By porting, the policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy. iii. The Acquiring and the Existing Insurers shall jointly, ensure that the entire underwriting details and claim history of the Policyholders are seamlessly transferred. iv. The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal. v. The Acquiring insurer shall decide and communicate on the proposal at the earliest possible time but not more than 5 days of receipt of information from Existing insurer. vi. A policyholder desirous of porting his/her policy to another insurer shall apply 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 due date for renewal. Insurers are free to consider proposal for portability even if the policyholder has approached within 15 days from the renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy. vii. No charges shall be levied on the policyholder for porting-in or porting-out.
4	To know more details as regards health insurance business, please refer IRDAI's Master circular no. IRDAI/HLT/CIR/PRO/84/5/ 2024 dated 29.05.2024 at https://irdai.gov.in/document-detail?documentId=4942918 and IRDAI (Insurance Products) Regulations, 2024 at https://irdai.gov.in/consolidated-gazette-notified-regulations.

Section 2

Broad requirements to be complied with by the Insurers

Chapter I

CITIZENS' CHARTER

1. Citizens' Charter

1.1. To empower customers with information about availability of products, standards of service, time limits that the consumers can reasonably expect, and avenues of grievance redressal, every Insurer shall put in place Citizens' Charter specifying the service standards both in qualitative and quantitative terms. A schedule of timelines in servicing of policies of Life, General and Health insurer is placed at Schedule A.

1.2. To bring awareness, the citizen's charter shall be widely publicized.

2. Fair treatment to customers: All prospects or policyholders shall be treated equitably, honestly and fairly at all stages of their relationship. Treating customers fairly shall be an integral part of the corporate culture of all insurers and distribution channels. Special attention shall be given to the needs of vulnerable groups. All insurers and distribution channels shall endeavour to deliver, inter-alia, following outcomes in their dealings with customers:

2.1. prospects or policyholders can be confident that they are dealing with insurers and distribution channels where the 'fair treatment of customers' is central to the corporate culture and core values.

2.2. products solicited and services offered are designed to meet the needs of prospects or policyholders and are targeted accordingly; and are affordable.

2.3. prospects or policyholders are provided with clear and updated information and are kept appropriately informed before, during and after sale, including the costs (Premium, charges etc.), risks, and exclusions or limitations.

2.4. Where prospects or policyholders receive advice, the advice is suitable and takes account of their needs and circumstances.

2.5. prospects or policyholders are provided with product(s) which suit their requirement and meet their reasonable expectation.

2.6. prospects or policyholders do not face post-sale barriers imposed by insurers and distribution channels, if any, to change product, submit a claim or make a complaint.

Chapter II

ACTIVITIES PRIOR TO SALE OF INSURANCE POLICIES

3. Prospectus (refer Regulation 9 (c) of the Regulations)– A prospectus of insurance product shall be legible, avoid fine print and have font size of atleast 11. Minimum Information to be given to customers at the time of sale:

3.1. Unique Identification Number (UIN) for the insurance product.

3.2. scope of benefits.

3.3. extent of insurance cover.

3.4. warranties, exclusions/exceptions and conditions of the insurance cover along with explanations.

3.5. status of continuance of insurance coverage during the grace period.

3.6. a description of the contingency or contingencies to be covered by insurance.

3.7. class or classes of lives or property or any other subject eligible for insurance

3.8. In case of linked or index linked products, the funds/index offered, charges levied, including the upper limits, underlying risks with each of the funds offered.

3.9. Criteria on which discounts in premium can be allowed and percentage of such discount on meeting of one or more criteria.

3.10. allowable riders or add-on covers on the insurance products.

3.11. in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits).

3.12. Exclusions specific to the policy, which can be covered on payment of additional premium.

3.13. Terms & conditions applicable in case of lapse, revival, discontinuance, surrender.

4. Benefit Illustration for Life insurance products

4.1. Every Insurer carrying on life insurance business shall provide at the point of sale to the prospect or policyholder, a customized benefit illustration. It shall be in addition to the prospectus. A minimum font size of eleven (11) shall be used to print the same as per Schedule B.

4.2. Such benefit illustration shall form part of the policy document.

4.3. In case of online sale: Before the prospect is directed to fill up the proposal form, explicit confirmation for Benefit Illustration from the prospect shall be obtained about their understanding the benefits illustrated. A customized Benefit Illustration shall be provided to the proposer immediately, thereafter.

5. Suitability requirements for Life insurance products

5.1. Suitability assessment shall be done in case of savings related life insurance products and annuity products except those annuities purchased from proceeds of NPS and from employer offered superannuation fund.

i. 'Suitability information' is the information of a prospect on age, income, family status, life stage, financial and family goals, investment objectives, insurance portfolio already held, etc.

ii. 'Suitability Assessment' means evaluation of suitability of a product for the prospect, based on the suitability information collected from them and considering the nature of product, mode of premium payment and tenure of policy as well as premium payment period.

iii. Suitability information collected and the recommendations of the sales person involved in solicitation, shall be preserved by the Insurer making them part of the policy records.

5.2. Every life insurer shall have a Board approved policy on assessing the suitability of a product to the prospect /policyholder and recommending suitable products to them. The policy shall also dwell on the measures to curb mis-selling, force-selling and mis-leading sales. It shall also deal with record keeping and retention thereof.

5.3. Consent of the prospect and the concerned sales person involved in the solicitation of the business shall be obtained on the Suitability Information. In case of Suitability assessment in online sales, express consent of the prospect/policyholder shall be obtained for capturing suitability information. Consent can be in the form of One Time Password (OTP) from the registered mobile number /email of the prospect only.

6. Premium Acknowledgement

6.1. Every insurer shall ensure that:

i. the electronic premium payment option is made available to enable the premium payments directly to the insurer.

ii. distribution channels, if authorized to collect premiums, shall ensure that such premium payments are not collected into their own bank account or to any third party bank accounts except specifically permitted under the relevant Regulations / Guidelines.

iii. acknowledgements are issued immediately on collection of premium at the point of collection.

6.2. Where an insurer has authorised any distribution channel or any other person to collect and acknowledge the receipt of premium, the Insurer shall be accountable to the premium acknowledgements issued by such entity.

7. **Mis-selling :** Insurers or distribution channels, as applicable, shall be responsible for the solicitation process and conduct of business applicable to them. To avoid mis-selling of insurance policies, a mechanism shall be put in place to inter-alia include

7.1 Ensure that fair treatment to customers is integral part of corporate culture.

7.2 Personnel authorized to solicit insurance business must use only the approved prospectus issued by the insurer.

7.3 Sales persons of insurers or the distribution channels, as applicable, involved in the solicitation are duly qualified and appropriately trained periodically.

7.4 Lay down a mechanism of obtaining customer feedback.

7.5 Punitive action for breach of market conduct including blacklisting the sales person who indulge in unhealthy solicitation practices or market misconduct.

7.6 **Strengthen Financial Underwriting**: Insurers shall ensure that the financial underwriting requirements are clearly spelt out to assess the continued financial capacity of the prospect to pay the premium for the duration of the premium paying term along with the sources available to the prospect for such premium payments.

7.7 **Provide training -** Periodical training shall be provided to Intermediaries, distribution channels and their employees on their products (existing and new), TATs in policy servicing, changes in the regulations etc.

7.8 A return in this regard shall be filed in the format specified in Master Circular on Submission of Returns.

CHAPTER III
PROPOSAL FOR SALE OF INSURANCE POLICIES

8. Matters to be included in proposal form [refer Regulation 10(2)]

Every Proposal form shall contain provisions to capture:

i. relevant and necessary information to underwrite the risks, to enable policy servicing and claim servicing;

ii. nominations as per regulation 18 of IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024;

iii. Bank account details of prospect and the nominee;

iv. Mobile number of the prospect and email-id, if available;

v. relevant provisions of section 41 and section 45 of the Act.

9. Insurers shall consider the "Exit Form" submitted to the National Pension Scheme (NPS) by its subscriber at the time of exit from NPS as the proposal form in case of offering immediate annuity products to the NPS subscribers. Further details, if any required, such as nomination, if not available in the exit form may be collected from the NPS subscriber.

10. Insurers shall endeavour to obtain the proposal form in electronic form, with proper authentication from the concerned prospect.

11. In case of a physical proposal form, it may be made available in Hindi or English. However, if requested by the prospect, the same may be made available in any of the regional languages.

12. Processing of the proposal Form/Underwriting:

12.1. Insurers shall process the proposal form as per Board approved underwriting policy specific to the insurance product for which the proposal is submitted and ensure that the information sought in the proposal form:

a) is duly filled in and complete in all aspects, and

b) put in place a mechanism to verify the correctness of the mobile numbers and the emails provided in the proposal form and ensure that the details provided belong to the prospect / policyholders.

12.2. Any further requirements as required under the respective underwriting policy or consequential documents shall be called for within 7 days from the date of receipt of the proposal form at one time and not on piece-meal basis.

12.3. The decision on the proposal thereof, shall be communicated to the proposer within a reasonable period but not exceeding 7 days from the date of receipt of proposal(s) or any requirements called for by the insurer, whichever is later.

12.4. It is the duty of the insurer to furnish to the insured, with no additional

charges, either a soft copy or a hard copy of the proposal form submitted by the prospect, along with the policy document within 15 days of the acceptance of a proposal.

13. Declaration

13.1. Insurer shall ensure that the proposal form has a provision for obtaining declaration by the prospect/policyholder, in case the prospect is not familiar with the language used in the proposal form, that details of the form are explained to him/her.

13.2. A policyholder or prospect who is a person with disability and requires assistance in completing the proposal form, may duly authorize a representative to give declaration on his/her behalf.

14. E-Proposal Form

14.1. Every insurer soliciting insurance business through electronic mode shall create an e--proposal form similar to the physical proposal form.

14.2. The insurer shall obtain the consent directly from the prospect only from their registered mobile number or email ID to conclude online sale, by adopting latest technological security protocols. The insurer shall maintain evidence for the proposer's consent received on the duly filled proposal form.

CHAPTER IV
ISSUANCE OF INSURANCE POLICIES

15. Matters to be stated in Insurance policies [refer regulation 11(b)]

15.1. Insurers shall use at least font size eleven (11) in insurance policies.

15.2. Policy documents shall include such other details as specified in Schedule C.

General Principles governing issuance of life, General and Health insurance policies

16. Insurers shall endeavour to

16.1. classify the exclusions, wherever possible as under:

(a) Standard exclusions applicable to all policies;

(b) Exclusions specific to the policy which cannot be waived;

(c) Exclusions which can be opted for cover by paying additional premium.

16.2. categorize policy conditions into following:

(a) Conditions precedent to the contract;

(b) Conditions applicable during the contract;

(c) Conditions when a claim arises;

(d) Conditions for renewal of the contract;

(e) Conditions for cancellation of the contract; and

(f) Conditions for grievances redressal.

16.3. Insurers shall mandatorily include in the policy document all the applicable exclusions for a particular product. No further deductions shall be made from the claim amount in the name of any other exclusions.

17. Customer Information Sheet (CIS)

17.1. Every Insurer shall have in place a Customer Information Sheet (CIS) that explains policyholders in simple words, the basic features, terms and conditions of the policy in the format specified in **Schedule D separately for Life, General and health insurance products.**

17.2. Every insurer shall forward the Customer Information Sheet (CIS) to the policyholder, along with the policy document and shall ensure compliance with the following:

b. All details provided for in the CIS shall be duly filled in.
c. The CIS shall have minimum font size 11.
d. CIS shall be made available in regional languages if the policyholder so desires.

e. Insurers or distribution channels, as the case may be, shall forward the CIS to all policyholders and shall obtain acknowledgement either in physical or digital form.

f. The policy document forwarding letter shall contain a cross reference to the CIS.

17.3. Where any inconsistency has been pointed out by the prospect / policyholder, the insurer shall ensure that the same is addressed in a time bound manner.

Use of Digilocker facility

18. To enable the policyholder to use Digilocker, Insurers shall enable their IT systems to interact with the Digilocker and shall publish such enablement for the information of the policyholders.

CHAPTER V
SERVICING OF POLICYHOLDERS AND SETTLEMENT OF CLAIMS

Servicing of Policyholders

19. All insurers shall endeavour to establish appropriate technology based infrastructure to handle servicing of policyholders and list all possible services that the policyholder can avail. It may facilitate submission of service request from the policyholder through online, check the status of service request, seeking further information or clarification, submission of details or clarifications amongst others.

Settlement of claims

20. If a claim intimation is received at the distribution channels or TPA or Hospital as the case may be, it shall have necessary system in place to immediately forward the claim intimation details to the insurer.

21. Insurers shall endeavour to establish appropriate technology-based infrastructure to handle all the claims processing facilitating registration of claims intimation, providing acknowledgements, submission of documents etc.

22. No claim shall be rejected or closed for want of documents or for delayed intimation of claim.

23. Insurers shall have claims manual/ standard operating procedures (SOPs) that are reviewed periodically and must ensure that claims are settled as per the specified Turn Around Times (TATs).

CHAPTER VI

PORTABILITY OF HEALTH INSURANCE POLICIES

24. Portability of Health Insurance Policies

24.1. Insurers shall allow portability in respect of all individual, family floater and group health insurance policies at the time of renewal.

24.2. A policyholder desirous of porting his/her policy to another insurer shall apply 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 due date for renewal.

Provided that Insurers are free to consider proposal for portability even if the policyholder has approached within 15 days from the renewal date of the existing policy, but in all such cases acquiring insurer shall ensure that there is no break in policy.

24.3. The acquiring insurer shall furnish to the policyholder, the Portability Form authorizing it to obtain policy and claim related information from the existing insurer. The policyholder shall fill in the portability form along with proposal form and submit the same to the acquiring insurer.

24.4. On receipt of the Portability Form, the acquiring insurer shall seek the necessary details of policy and previous claim information, if any, from the existing insurer through the portal maintained by Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.

24.5. The existing insurer, shall furnish the requisite data for porting insurance policies within
72 hours of the receipt of the request. The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.

24.6. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc. from the policy of Existing Insurer to the new policy issued by the Acquiring Insurer.

24.7. On the port-in policies during the port-in year, acquiring insurer shall not pay any commission or incentive to its own employees or distribution channel or employees of the distribution channel. No charges shall be levied on the policyholder for porting-in or porting-out.

CHAPTER VII

COMPLIANCE WITH JUDCIAL / QUASI JUDICIAL AWARDS ETC.

Ombudsman Awards

25. All insurers and distribution channel shall ensure that:

25.1. As specified in rule 17 (6), all the ombudsman awards passed in favour of the policyholders / claimant are to be paid within 30 days from the date of receipt of the awards.

25.2. The insurer, in terms of rule 17 (7) of Insurance Ombudsman Rules, 2017, shall also pay penal interest at a rate, which is 2 percent above bank rate from the date the claim ought to have been settled.

25.3. In cases where the Insurer prefers an appeal against the award of the Ombudsman, such appeal against the award shall be filed within the stipulated time limit of 30 days only.

25.4. The Insurer is required to comply with the award of the Insurance Ombudsman within 30 days of receipt of award by the Insurer. In case the Insurer does not honour the ombudsman award, a penalty of Rs. 5000/- per day shall be payable to the complainant. Such penalty is in addition to the penal interest liable to be paid by the Insurer under the Insurance Ombudsman Rules, 2017. This provision will not be applicable in case insurer chooses to appeal against the award of the Insurance Ombudsman.

26. Other Judicial / Quasi-Judicial Awards

26.1. Orders of Judicial / Quasi-Judicial bodies are to be complied within the time frame stipulated in the order or award.

26.2. In cases where time frame is not specified in the order / award, the order/award should be complied within 45 days of the receipt of the order / award by the Insurer.

26.3. In cases where the Insurer prefers an appeal against the order of the Judicial / Quasi-Judicial body, such appeal should be preferred within the stipulated time limit as per the rules applicable. The Complainant should be informed in the matter immediately.

26.4. Quarterly statement on the status of court cases as per the format provided in Master Circular on Submission of Returns shall be submitted to the Authority.

CHAPTER VIII

OTHER SERVICES RELATED ASPECTS

27. Life Verification Certification

Insurers shall put in place necessary technology based systems like using biometric enabled digital service to have life verification certification for annuity payouts.

28. Website

Every insurer should have a website publishing information about services offered, FAQs on policy servicing aspects, facilities for enquiry, lodging of complaints, etc. in addition to the disclosure mandated by the Authority. Insurers shall provide a search tool on their website for verification of distribution channels they are engaged with. There should be a facility for a prospect/policyholder to fetch the distribution channels in a specified location to whom they can approach, for purchasing an insurance policy and service the lead generated.

29. Training:

Insurer shall provide periodical training to distribution channels and employees of the Insurers on their products (existing and new), TATs in policy servicing, changes in the regulations etc.

30. Technology solutions:

The insurer shall endeavor to put in place technology solutions so as to ensure an effective, efficient and a seamless onboarding of policyholders, objective suitability assessment (in case of life insurance policies), renewal of policy, servicing of policies, registering and changing nominations, grievance redressal and claim settlement process.

CHAPTER IX

Repeal of the Guidelines and Circulars

31. List of Circulars / Guidelines repealed

31.1. This Master Circular supersedes the following Guidelines/Circulars:

S. No.	Circular/Guideline Reference Number	Description
1.	028/IRDA/LIFE/PAN/Aug-2009	Requirement of PAN for Insurance Products
2.	3/CA/GRV/YPB/10-11 DATED 27.07.2010	Guidelines on Grievance Redressal by Insurance Companies
3.	IRDA/CAD/CIR/AGN/137/08 DATED 25.08.2010	Disclosure of Agency detail on policy document
4.	IRDA/IT/ORD/MIS/15/2/09/2010	Implementation of Integrated Grievances Management System (IGMS)
5.	CAD/Insu.Omb/10-11 dated 23.11.2010	Awards passed by Insurance Ombudsman
6.	CAD/01/10-11 DATED 21.01.2011	Verification of the Authenticity of calls
7.	IRDA/HLTH/MISC/CIR/216/09/2011	Circular on Delay in claim intimation/documents submission with respect to All life insurance contracts and All Non-life individual and group insurance contracts
8.	IRDAI/ HLT/ REG / CIR / 298 / 12 / 2020	Disclosure of benefit / premium illustration for Health insurance policies issued on floater basis
9.	IRDA/Life/MISC/Cir/153/08/2013	ECS mandate under Life Insurance Policies
10.	IRDA/LIFE/CIR/GDL/034/01/2014	Standard Format for Filing of Policy Documents with the Authority
11.	IRDA/Life/Misc/Cir/106/05/2015	Guidelines on issuance of Premium Acknowledgements
12.	IRDAI/Cir/Misc/194/11/2015 dated 03.11.2015	Non-compliance of Awards of Insurance Ombudsman or Order of MACT of consumer
13.	IRDA/LIFE/CIR/MISC/140/8/2015	Obtaining Annuity Options from the Policy holders

14.	IRDAI/CAD/CIR/MISC/01/2016 Dated 31.01.2016	Grievance Redressal Processes-Instruction
S. No.	Circular/Guideline Reference Number	Description
15.	IRDAI/CAD/CIR/MISC/03/2016 Dated 31.03.2016	Non-compliance of awards
16.	IRDAI/SDD/MISC/CIR/135/07/ 2016	Operationalisation of Central KYC Records Registry (CKYCR)
17.	IRDA/LIFE/CIR/MISC/134/07/2 016	Advance Discharge Voucher
18.	IRDA/NL/CIR/MISC/149/06/201 7	Delay in Claim Intimation/ Documents Submission
19.	IRDAI/Life/Misc/Cir/202/12/201 8	Intimation of receipt of premium through SMS by the Insurer to the Policyholders
20.	IRDAI/LIFE/CIR/173/09/2019 DATED 26.09.2019	Benefit Illustration and other market conduct aspects
21.	IRDAI/CAD/CIR/MISC/001/01/2 019 DATED 21.01.2019	Submission of quarterly statement on mis-selling complaints
22.	IRDAI/CAD/CIR/MISC/038/03/2 019 DATED 05.03.2019	Non-compliance of awards passed by Ombudsman
23.	Nil dated 04.09.2020	Cell for Redressal of grievance of Policyholders
24.	INSTRUCTION DATED 18.04.2022	Revised Instruction on PRAGATI
25. I	IRDAI/CAD/CIR/MISC/105/05/2 022 DATED 26.05.2022	Adhering the timelines of awards settlement as per Ombudsman Rules.
26.	IRDAI/ INT/ CIR/ DGLKR/ 0301 O2/2021	Issuance of digital insurance policies by insurance companies via Digilocker
27.	IRDAI/Life/Misc/CIR/116/05/20 20	Circular on Pre-Issuance Verification Call (PIVC)
28.	LC/SP/SI/VER 1.0	Illustrations - Life Insurance Business: Standards of Practices

29.	IRDA/NL/CIR/MISC/214/2016	Delay in Claim Intimation and documents submission with respect to individual life, non-life and group non-life insurance contracts
30.	IRDAI/Life/CIR/MISC/188/09/2022	Immediate Annuity Products

CITIZENS' CHARTER (HEALTH)

BASIC SERVICE STANDARDS

S. No	SERVICE	DESCRIPTION OF ITEM OF SERVICE	Regulatory Turnaround Time
1	New Business Proposal Processing	Processing of Insurance Proposal and seeking further requirements for consideration of the proposal	7 days
		Decision on proposal from the date of receipt of proposal or from the date of receipt of additional requirement whichever is later	
		Providing copy of the policy along with the proposal form	15 days
		Free look cancellation and refund of deposit from the date of receipt of the request	7 days
2	Post Policy Service Request	Post Policy Service Requests concerning mistakes / corrections in the Policy document	7 days
3	Policy Servicing (from the date of receipt of request for the service specified)	Change of Address (KYC Norms to be complied)	
		Registration /Change of Nomination, Assignment.	
		Alteration in Original Policy Conditions (where applicable)	
		Issuance of duplicate policy	7 days
		Inclusion of new member in case of group policies	
		Any other non-claim related changes	
		Cancellation of policy and refund of premium	

4	Claims	Acceptance of cashless claims by TPA /company to Hospital and communicate to them	1 hour
		TPA's offer of settlement to the Insurer / Hospital after submission of document	3 hours
		Settlement of claims (other than cashless)	15 days
5	Auto Action by the Insurer	Premium Due Intimation	One month before due date
6	Complaints	Acknowledgement to complainant	Immediately
		Action on Complaint & Intimation of Decision to the complainant	14 days
		If complaint is NOT resolved by the Insurer, **communicate the details to the Policyholder** of options including referring the complainant to **Insurance** Ombudsman / Consumer Court.	14 days from original date of receipt of complaint. *

*(The policyholder may approach the Insurance Ombudsman if his / her complaint is not resolved within 30 days or if the decision of the company is not acceptable to the policyholder.)

Schedule B

Form and manner of policy documents and Benefits Illustration (refer clause 4.1)

1. All insurers shall provide benefit illustration as per the requirements of each product or combination of products and is customized as per requirements of the prospect, if required.

2. Insurers shall also provide customized benefit illustration in the format on their websites so as to enable the customers to make out the difference while opting for coverage.

3. Every insurer shall, as applicable, provide benefit illustrations to prospects or policyholders at the point of sale for all products, except for the following products:

a. Regular Premium Pure term products

b. Regular Premium Pure health products

c. Group term products

d. Group credit life products

e. Group fund based products

4. The calculation of net yield for Linked products is illustrated for the information of insurers.

5. The illustrations shall be clear and fair to enable a customer to make an informed decision. They shall clearly distinguish between guaranteed and non-guaranteed benefits and state that the quantum of benefits in respect of non-guaranteed category may vary.

6. Insurers shall review the assumptions used in the benefit illustrations during the annual actuarial valuation and revise the benefit illustrations wherever required.

7. Except for those life insurance products where all the benefits are assured in absolute amounts at the outset of the contract, all other life insurance products shall provide the prospective policyholder a customized benefit illustration at the point of sale, illustrating the guaranteed and non-guaranteed benefits at gross investment returns as stipulated by the Authority. Considering the dynamic nature of movement of interest rates, such gross investment returns are currently stipulated as 4% p.a. and 8% p.a, for other than annuity products.

8. The benefit illustration shall be part of the sales literature and shall be furnished to the prospective policyholder along with the sales literature before concluding the sale.

SCHEDULE - C

Matters to be stated in Insurance policies

(refer clause 14.2)

1. Matters to be Stated in a Health Insurance Policy

1.1 A health insurance policy shall clearly state:

i. The name of the policyholder and the names of each beneficiary covered,

ii. Product Name, UIN of the product, code number,

iii. contact details of the person involved in sales process,

iv. Date of birth of the insured and corresponding age in completed years,

v. The address of the insured,

vi. The sums Insured,

vii. The period of insurance and the date from which the policyholder has been continuously obtaining health insurance cover from any of the insurers without break,

viii. Reference of Customer Information Sheet (CIS),

ix. The sub-limits, Proportionate Deductions and the existence of Package rates if any, with cross reference to the concerned policy section,

x. Co-pay limits if any,

xi. The pre-existing disease (PED) waiting period, if applicable,

xii. Specific waiting periods as applicable,

xiii. Deductible as applicable – general and specific, if any,

xiv. Cumulative Bonus, if any,

xv. Periodicity of payment of premium instalment,

xvi. Policy period,

xvii. Grace Period and its implication on insurance coverage,

xviii. Policy terms, conditions, exclusions, warranties,

xix. Action to be taken on the occurrence of a claim for cashless and reimbursement options separately,

xx. Procedure for claims submission, timelines and possible course of action, if timelines for claim submission are not adhered to along with all the claims

documents required for claim processing,

xxi. the list of documents that are required to be submitted by a claimant in case of a claim under the policy,

xxii. Details of TPA, if any engaged and their address, toll free number, website details,

xxiii. Details of Grievance Redressal mechanism of insurer,

xxiv. Free look period facility and portability conditions,

xxv. Policy migration facility and conditions wherever applicable,

xxvi. that, on renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate,

xxvii. Provision for cancellation of the policy,

xxviii. Procedure to register a claim/grievance,

xxix. Address and other contact details of Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the residential address or place of residence of the policyholder is located.

2. Mandatory Minimum Disclosures for Combi-Life Products

i. The product is jointly offered by "abc insurance company" (specify general/stand-alone health insurer name) and "xyz insurance company" (specify life insurer name),

ii. The risks of this 'Combi Product' are distinct and are assumed / accepted by respective insurance companies,

iii. The liability to settle the claim vests with respective insurers, i.e., for health insurance benefits "abc insurance company" (specify general/stand-alone health insurer name) and for life insurance benefits "xyz insurance company" (specify life insurer name),

iv. The policyholders of the 'Combi Product' under reference are eligible to continue with either part of the policy, discontinuing the other during the policy term,

v. Where guaranteed renewability of health insurance plan is allowed, the health insurance portion of this 'Combi Product' is entitled to that facility,

vi. Specific disclosures on the available premium payment options on these 'Combi Products',

vii. Specific disclosures about the available policy servicing facilities including claims servicing, for these 'Combi Products',

viii. Specific disclosures on the availability of services of 'Third Party Administrators (TPAs)' for health insurance portion of risk, if available,

ix. Specific disclosures on the available Grievances Redressal Options including

particulars of Ombudsman under these 'Combi products',

x. Policyholders are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy,

xi. Policy documents of 'Combi Products' shall contain the above referred points (iii) to (xi) as minimum disclosures,

xii. the list of documents that are required to be submitted by a claimant in case of a claim under the policy,

xiii. Declaration from the prospect shall be obtained and attached to proposal form that he/she has understood the disclosures mentioned above.

3. In case of pilot products, in addition to all the extant disclosure norms applicable to insurance advertisements, all the sales and publicity material pertaining to the 'pilot products' shall disclose the following:

i. The product offered is a pilot product and that it is a close-ended one,

ii. The product may be discontinued from the date of dd/mm/yyyy (to specify the maximum date on which the product be either withdrawn or converted into a regular product) or may be continued as a regular product,

iii. In the event of the discontinuation of the pilot product, the Insured would be provided the option of migration as per the extant applicable provisions,

iv. The product shall carry a tag line of "PILOT PRODUCT" to demonstrate that the health insurance product promoted is a pilot product.

SCHEDULE-D

(Refer clause 16.1)

CUSTOMER INFORMATION SHEET/KNOW YOUR POLICY- HEALTH

This document provides key information about your policy. You are also advised to go through your policy document.

Sl No	Title	Description (Please refer to applicable Policy Clause Number in next column)	Policy Clause Number
1	Name of Insurance Product/Policy	XXXXXX	
2	Policy number		
3	Type of Insurance Product/ Policy	• Indemnity (Where insured losses are covered up to the Sum Insured under the policy) • Benefit (Where an Insurance Policy pays a fixed amount under the policy on the occurrence of a covered event) • Both Indemnity and Benefit (where policy has elements of both the above)	
4	Sum Insured (Basis) (Along with amount)	• Individual Sum Insured -Where each member has a separate sum insured under the policy), or • Floater Sum Insured-Where all members under the policy have a single sum insured limit which may be utilized by any or all members	

5	Policy Coverage (What the policy covers?) (Policy Clause Number/s)	**Expenses in respect of:** Admission in Hospital beyond xx hours Pre-hospitalisation (treatment prior to admission in hospital) of xx days amounting to x% of claim Post-hospitalisation (treatment after discharge from hospital) within xx days from date of discharge amounting to x% of claim. Specified / Listed procedures requiring less than xx hours of hospitalization (day care) Undergoing specified procedure in case of xx Critical illnesses Diagnosis of an illness of specified severity Daily cash benefit of Rs. per day during admission in hospital OPD / Dental/ Maternity coverage Emergency or Travel Medical Assistance Personal Accident Cover Travel Cover (Note: This is an indicative list. Insurer must ensure that all the benefits of the policy are listed above)	
6	Exclusions (what the policy does not cover)	(Note: Insurer has to ensure that all the applicable exclusions are listed here)	

7	Waiting period Time period during which specified diseases / treatments are not covered It is counted from the beginning of the policy coverage.	Initial waiting Period: xx days for all illnesses (not applicable in case of continuous renewal or accidents) Specific Waiting periods (Not applicable for claims arising due to an accident): ○ xx months for xx diseases/procedures ○ yy months for yy diseases/procedures Pre-existing diseases: Covered after xx months	
8	Financial limits of coverage i. Sub-limit (It is a pre-defined limit and the insurance company will not pay any amount in excess of this limit) Co-payment (It is a specified amount / percentage of the admissible claim amount to be paid by policyholder / insured). iii. Deductible (It is a specified amount: - up to which an insurance company will not pay any claim, and - which will be deducted from total claim amount (if claim	The policy will pay only up to the limits specified hereunder for the following diseases/procedures: XX XX In case of a claim, this policy requires you to share the following costs: Expenses exceeding the following Sub-limits ▪ Room / ICU charges beyond ---------- ▪ For the following specified diseases: ▪ ---------- ▪ ---------- XXXX Deductible of Rs. XXX per claim / per year / both	

	amount is more than the specified amount) iv. Any other limit (as applicable)		
9	Claims/Claims Procedure	Details of procedure to be followed for cashless service as well as for reimbursement of claim including pre and post hospitalization. Turn Around Time (TAT) for claims settlement: i. TAT for preauthorization of cashless facility XXX ii. TAT for cashless final bill authorization: XXX Provide the details /web link for following: i. Network Hospital details ii. Helpline number iii. Hospitals which are blacklisted or from where no claims will be accepted by insurer iv. Downloading/getting claim form	
10	Policy Servicing	Call center number of the insurer Details of Company officials	

11	Grievances/Complaints	Details of - Grievance Redressal Officer of the insurer - Insurance company grievance portal/ Department - Ombudsman (Please provide contact details, Toll free number and email)	
12	Things to remember	Free Look cancellation: You may cancel the insurance policy if you do not want it, within xx days from the beginning of the policy. Insurer to specify the process for free look cancellation Policy renewal: Except on grounds of fraud, moral hazard or misrepresentation or non-cooperation, renewal of your policy shall not be denied, provided the policy is not withdrawn. Migration and Portability: When your policy is due for renewal, you may migrate to another policy with us or port your policy to another insurer. Insurer to specify the process for migration and portability Change in Sum Insured: Sum Insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh only for the enhanced portion of the sum insured Moratorium Period: After completion of Five continuous years under the policy no look back to be applied. This period of Five years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of Five continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health	

		insurance policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract.	
13	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may affect the claim settlement. Disclosure of other material information during the policy period.) Insurer to specify the material information	

Declaration by the Policyholder;

I have read the above and confirm having noted the

details. Place:

Date: (Signature of the Policyholder)

Note:

i. Insurer shall provide web-link where the product related documents including the Customer Information sheet are available on the website of the Insurer.

ii. In case of any conflict, the terms and conditions mentioned in the policy document shall prevail.

iii. Insurer to take confirmation of the Policyholder regarding receiving of the Customer Information Sheet