THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office : Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002

HEALTH OF PRIVILEGED ELDERS

(SENIOR CITIZEN SPECIFIED DISEASES INSURANCE)

1 WHEREAS the insured named in the Schedule hereto has by a proposal and declaration dated as stated in the Schedule (which shall be the basis of this Contract and is deemed to be incorporated herein), has applied to **THE ORIENTAL INSURANCE COMPANY LIMITED** (hereinafter called the Company) for the insurance hereinafter set forth in respect of persons(s) named in the Schedule hereto (hereinafter called the INSURED PERSON (S)) and has paid premium to the Company as consideration for such insurance to be serviced by Third Party Administrator (hereinafter called the TPA) or the Company as the case may be.

1.1 NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that, if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person (s) shall contract or suffer from any of the diseases / illness / ailment (hereinafter called 'DISEASE') specified in the policy or sustain any bodily injury through accident (hereinafter called 'INJURY')

AND

if such disease or injury shall require any such Insured Person(s) upon the advice of a duly qualified Physician / Medical Specialist / Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') to incur (a) hospitalisation expenses for medical/surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called 'HOSPITAL') as an inpatient OR (b) domiciliary treatment expenses in India under Domiciliary Hospitalisation Benefits as hereinafter defined, the Company/TPA shall pay to the Hospitals (only if treatment is taken at Network Hospital(s) with the prior written approval of Company/TPA), or to the insured person (if payment to the hospitals is not agreed to and the policy is serviced by the TPA) the amount of such expenses as are reasonably and necessarily incurred in respect thereof by or on behalf of such insured person upto the limit of liability specified in the policy and or schedule of the policy but not exceeding the sum insured in aggregate in any one period of insurance stated in the schedule hereto.

1.1A Specified Diseases / illness/ injury covered under the policy and the maximum liability of the Company in respect thereof are as follows:

Sr. No.	Name of Disease	Maximum Limit of Liability per illness (including domiciliary hospitalisation benefit, if any)
1.	Accidental Injury	100% of Sum Insured
2.	Knee Replacement	70% of Sum Insured
3.	Cardio Vascular Diseases	50% of Sum Insured
4.	Chronic Renal Failure	50% of Sum Insured
5.	Cancer	50% of Sum Insured

6.	**Hepato-Biliary Disorders**	50% of Sum Insured
7.	**Chronic Obstructive Lung Diseases**	20% of Sum Insured
8.	**Stroke**	20% of Sum Insured
9.	**Benign Prostrate**	15% of Sum Insured
10.	**Orthopaedic Diseases**	15% of Sum Insured
11.	**Ophthalmic Diseases**	10% of Sum Insured

Note: The liability of the Company under this clause is restricted to the Specified Diseases / illness/ injury **only** as mentioned above.

Company's Liability in respect of all claims admitted during the Period of insurance shall not exceed the Sum Insured per Person mentioned in the Policy / Schedule.

1.2 **FOLLOWING REASONABLE & NECESSARY EXPENSES AS PER LIMITS SPECIFIED BELOW ARE PAYABLE / REIMBURSABLE UNDER THE POLICY FOR THE SPECIFIED DISEASES / ILLNESS/ INJURY ONLY WITHIN THE OVERALL LIMIT AS SPECIFED ABOVE:**

a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1% of the Sum Insured per day.

b. I.C. Unit expenses not exceeding 2% of the Sum Insured per day.
(Stay in the Room and the stay in I.C.U., if required, should not exceed total number of days of admission in the hospital).

c. Ambulance Services Charges per illness by registered ambulance – Actual Expenses or Rs 1000/- whichever is less shall be reimbursable in case patient has to be shifted from residence to hospital in case of admission in Emergency Ward / I.C.U. Or from one Hospital / Nursing home to another Hospital / Nursing Home for hospitalisation.

d. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.

e. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray etc..

2 DEFINITIONS:

2.1'HOSPITAL/NURSING HOME: A hospital/Nursing home 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:
- has qualified nursing staff under its employment round the clock;
- has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel or a similar place.

Note: In case of Ayurvedic / Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as in-patient, in a Government Hospital / Medical College Hospital.

2.2 SURGICAL TREATMENT 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 of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

2.3 **HOSPITALISATION PERIOD:** Expenses on Hospitalisation are admissible only if hospitalisation is for a minimum period of 24 (Twenty Four) hours. However,

(A) This time limit shall not apply to following specific treatments taken in the Networked Hospital / Nursing Home where the Insured is discharged on the same day. Such treatment shall be considered to be taken under Hospitalisation Benefit.

i. Haemo Dialysis,
ii. Parentral Chemotherapy,
iii. Radiotherapy,
iv. Eye Surgery,
v. Lithotripsy (kidney stone removal),
vi. Dental surgery following an accident
vii. Coronary Angioplasty
viii. Coronary Angiography
ix. Surgery of Gall bladder, Pancreas and bile duct
x. Surgery of Prostrate.
xi. Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
xii. Arthroscopic Knee surgery.
xiii. Laproscopic therapeutic surgeries.
xiv. Surgery under General Anaesthesia.
xv. Or any such procedure agreed by TPA/Company before treatment.

(B) Further if the treatment / procedure / surgeries of above diseases are carried out in Day Care Centre, which means any institution established for day care treatment of illness and / or injuries OR a medical set -up within 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:-

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

the requirement of minimum number of beds is overlooked.

(C) This condition of minimum 24 (Twenty Four) hours Hospitalisation shall also not apply provided: medical treatment, and/or surgical procedure is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because o f technological advancement, and

ii. which would have otherwise required a hospitalization of more than 24 hours.

ABOVE ARE ADMISSIBLE SUBJECT TO TERMS & CONDITIONS OF THE POLICY.

NOTE: PROCEDURES / TREATMENTS USUALLY DONE IN OUT- PATIENT DEPARTMENT ARE NOT PAYABLE UNDER THE POLICY EVEN IF CONVERTED TO DAY CARE SURGERY / PROCEDURE OR AS IN- PATIENT IN THE HOSPITAL FOR MORE THAN 24 (Twenty Four) HOURS.

2.4 DOMICILIARY HOSPITALISATION BENEFIT: Domiciliary hospitalization means medical treatment for a period exceeding three days for such 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 o f the following circumstances:

- the condition o f 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 o f non availability o f room in a hospital.

Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover

a) Expenses incurred for pre and post hospital treatment and
b) Expenses incurred for treatment for any of the following diseases :
    i. Chronic Nephritis and Nephritic Syndrome,
    ii. Pyrexia of unknown origin for less than 10 days,
    iii. Upper Respiratory Tract infection including Laryngitis and Pharingitis,
    iv. Arthritis, Gout and Rheumatism.

Note: DOMICILIARY HOSPITALISATION BENEFIT shall not exceed Rs. 20,000/- (Twenty Thousand rupees) per insured in respect of all claims admitted during the policy period.

3 **ADDITIONAL DEFINITIONS :**

3.1 **SENIOR CITIZEN:** Means an Indian citizen who has attained the age of 60 (sixty) years as on the date of proposal.

3.2 **INSURED PERSON:** Means Person(s) named on the schedule of the policy.

3.3 **SPECIFIED DISEASES:** The diseases as mentioned in para 1.1 A only.

3.4 **ENTIRE CONTRACT:** This policy / proposal and declaration given by the insured constitute the complete contract of this policy. Only Insurer may alter the terms and conditions of this policy. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

3.5 **THIRD PARTY ADMINISTRATOR (TPA):** means any Company who has obtained licence from IRDA to practice as a third party administrator and is appointed by the Company.

3.6 NETWORK PROVIDER: means hospitals or healthcare providers enlisted by an insurer or by a TPA and insurer together, to provide medical services to an insured on payment, by a cashless facility.

3.7 HOSPITALISATION PERIOD: The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 hours except for specified procedures/ treatment where such admission could be for a period of less than 24 consecutive hours.

3.8 PRE-HOSPITALISATION EXPENSES: Medical Expenses incurred during the period upto 30 days prior to the date of admission, provided that:
i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.9 POST-HOSPITALISATION EXPENSES: Medical Expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:
i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.10 MEDICAL PRACTITIONER:. A Medical practitioner is a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

3.11 QUALIFIED NURSE: Qualified nurse is a person who holds a valid registration from the Nursing Council o f India or the Nursing Council of any state in India.

3.12 PRE EXISTING DISEASE: Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.
Further any complications arising from pre-existing ailment / disease / injuries shall be considered as a part of that pre existing health condition or disease.

3.13 IN-PATIENT: An Insured person who is admitted to hospital and stays for at least 24 (Twenty Four) hours for the sole purpose of receiving the treatment for covered ailment / illness / disease / injury / accident during the currency of the policy.

3.14 CO-PAYMENT: A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

3.15 CASHLESS FACILITY: It means a facility extended by the insurer to the insured where the payments of the costs of the treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre-authorization approved.

3.16 I.D. CARD: means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

3.17 LIMIT OF INDEMNITY: means the amount stated in the schedule against the name of each insured person which represents maximum liability for any and all claims made during the policy period in respect of that insured person in respect of hospitalization taking place during currency of the policy.

3.18 ANY ONE ILLNESS: Any one illness means continuous Period o f illness and it includes relapse within 45 days from the date of last consultation OR 105 days from the date of discharge ,whichever is earlier, from the Hospital/Nursing Home where treatment may have been taken.

3.19 PERIOD OF POLICY: This insurance policy is issued for a period of one year as shown in the schedule.

3.20 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 .
For a networked hospital means the rate pre-agreed between Network Hospital and the TPA / Company, for surgical / medical treatment that is necessary for treating the insured person who was hospitalized.

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

3.22 COMPULSORY CO-PAYMENT: Insured has to bear 20% of admissible claim amount in each and every claim.

3.23 VOLUNTARY CO-PAYMENT: The insured may opt to bear a part of the claim amount (after application of compulsory co-payment) for which following discounts are applicable, subject to a maximum of 50%

Co-payment Opted	Discount available on premium
10%	10%
20%	20%
30%	30%
40%	40%
50% & above	50%

3.24 NO CLAIM DISCOUNT: The insured shall be entitled for No Claim Discount at the rate of 5% of the renewal premium payable after every claim free policy year, subject to a maximum of 20%, as per table below, provided the policy is renewed without any break:

Discount available on renewal premium payable after one (or the first) claim free annual policy	5%
Discount available on renewal premium payable on second continuous claim free renewal of annual Policy	10%
Discount available on renewal premium payable on third continuous claim free renewal of annual Policy	15%
Discount available on renewal premium payable on fourth continuous claim free renewal of annual Policy	20%

No Claim Discount shall become 'nil' once a claim is paid or becomes payable under the policy, irrespective of the amount of claim.

For No Claim Discount, renewal of this particular policy shall only be considered and no benefit of any other insurance policy shall be allowed.

At the discretion of the Company where policy is renewed within 7 (seven) days from the expiry date, the renewal is permissible with the applicable No Claim Discount.

4 EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 Any disease / health condition / illness / ailment or any condition arising there from other than those specified in the policy as covered**.**

4.2 **Pre-existing health condition or disease or ailment / injuries:** Any ailment / disease / injuries / health condition which are pre-existing (treated / untreated, declared / not declared in the proposal form), when the cover incepts for the first time are excluded upto 2 (two) years of this policy being in force continuously.

For the purpose of applying this condition, the date of inception of the Mediclaim policy taken from the Company shall be considered, provided the renewals have been continuous and without any break in period, subject to portability condition.

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This exclusion shall also apply to any complications arising from pre existing ailments / diseases / injuries. Such complications shall be considered as a part of the pre existing health condition or disease. To illustrate if a person is suffering from hypertension or diabetes or both hypertension and diabetes at the time of taking the policy, then policy shall be subject to following exclusions. **Few of these illnesses do not relate to the coverage**

Diabetes	**Hypertension**	**Diabetes & Hypertension**
Diabetic Retinopathy	Cerebro Vascular accident	Diabetic Retinopathy

Diabetic Nephropathy	Hypertensive Nephropathy	Diabetic Nephropathy
Diabetic Foot /wound	Internal Bleed/ Haemorrhages	Diabetic Foot
Diabetic Angiopathy	Coronary Artery Disease	Diabetic Angiopathy
Diabetic Neuropathy		Diabetic Neuropathy
Hyper / Hypoglycaemic shocks		Hyper / Hypoglycaemic shocks
		Coronary Artery Disease
		Cerebro Vascular accident
		Hypertension Nephropathy
		Internal Bleeds/ Haemorrhages

4.3 Any disease covered under the policy other than those stated in clause 4.4, contracted by the Insured person during the first 30 (Thirty) days from the commencement date of the policy except treatment for accidental injuries.

4.4 **The expenses on treatment of following ailments / diseases / surgeries for first two policy years are not payable.**

i Non infective Arthritis.
ii Cataract.
iii Surgery of benign prostatic hypertrophy.
iv Surgery of gallbladder and bile duct excluding malignancy.
v Surgery of genitor urinary system excluding malignancy.
vi Gout and Rheumatism.
vii Calculus diseases.
viii Joint Replacement due to Degenerative condition.
ix Age related osteoarthritis and Osteoporosis.

If the continuity of the renewal is not maintained then subsequent cover shall be treated as fresh policy and clauses 4.2, 4.3, 4.4 shall apply afresh unless agreed by the Company and suitable endorsement is passed on the policy.

4.5 Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.

4.6 Circumcision (unless necessary for treatment of a disease included hereunder or as may be necessitated due to any accident), vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, hair transplant, plastic surgery other than as may be necessitated due to an accident or as a part of any illness / disease.

4.7 Surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc.

4.8 Convalescence, general debility, “run down” condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.

4.9 All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymohadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases..

4.10 Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.

4.11 Expenses on vitamins, tonics, mineral water and allied items unless forming part of treatment for injury or disease as certified by the attending physician.

4.12 Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.

4.13 Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalisation or primary reasons for admission. Private nursing charges, Referral fee to family doctors, Out station consultants / Surgeons fees etc.

4.14 External and / or durable Medical / Non medical equipment like Ambulatory devices i.e. Walker , Crutches, Belts ,Collars ,Caps , Splints, Slings, Braces ,Stockings etc of any kind, CPAP, CAPD, Infusion pump, Diabetic foot wear, Glucometer / Thermometer, nebuliser and similar related items etc and also any medical equipment which is subsequently used at home etc.

4.15 All non medical expenses including Personal comfort and convenience items or services such as telephone, television, Aya / barber or beauty services, diet charges, baby food, cosmetics, napkins , toiletry items etc, guest services and similar incidental expenses or services etc..

4.16 Change of treatment from one system of medicine to another unless necessitated and agreed / allowed by the TPA / Company.

4.17 Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, services or supplies etc.

4.18 Any treatment required arising from Insured's participation in any hazardous activity such as scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing, other allied similar activities etc.

4.19 Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.

4.20 Any stay in the hospital for any domestic reason or where no active regular medical treatment is given by the specialist / physician.

4.21 Out Patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies.

4.22 Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.

4.23 Any kind of Service charges, Surcharges, Admission fees / Registration charges, File Charges etc levied by the hospital.

4.24 Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalisation period.

4.25 Treatment which is continued before hospitalization and continued even after discharge for an ailment / disease / injury other than the one for which hospitalisation claim is made / admissible.

5 CONDITIONS

5.1 **ENTIRE CONTRACT:** the policy, proposal form, prospectus and declaration given by the insured shall constitute the complete contract of insurance. Only insurer may alter the terms and conditions of this policy/ contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

5.2 **COMMUNICATION:** Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator as shown in the Schedule.

5.3 **PAYMENT OF PREMIUM:** The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorised official of the Company.

5.4 The policy shall be deemed to be void ab-inito (since its inception) if the payment instrument is dishonoured for any reasons whatsoever and under this circumstance the Company shall not admit any liability whatsoever under this policy.

5.5 FREE LOOK PERIOD:

This policy shall have a free look period. The free look period shall be applicable at the inception of the fresh policy and:

1. The insured will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable
2. If the insured has not made any claim during the free look period, the insured shall be entitled to

a. A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges or;

b. where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover or;

c. Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

5.6 NOTICE OF CLAIM: Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease / illness / injury and Name and Address of the attending medical practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by Fax, Email. Such notice should be given within 48 hours of admission or before discharge from Hospital / Nursing Home, whichever is earlier, unless waived in writing by the Company.

5.7 CLAIM DOCUMENTS: Final claim along with hospital receipted original Bills/Cash memos/reports, claim form and list of documents as listed below should be submitted to the Company / TPA within 7 (seven) days of discharge from the Hospital / Nursing Home.

a. Original bills, receipts and discharge certificate / card from the hospital.
b. Medical history of the patient recorded by the Hospital.
c. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
d. Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending medical practitioner / surgeon demanding such tests.
e. Attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis and bill / receipts etc.
f. Surgeon's original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
g. Any other information required by TPA / Insurance Company.

All documents must be duly attested by the insured person.

In case of post hospitalisation treatment [limited to 60 (sixty) days] all supporting claim papers / documents as listed above should also be submitted within 7 (seven) days after completion of such treatment [upto 60 (sixty) days or actual period which ever is less] to the Company / T.P.A. In addition insured should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

NOTE: Waiver of the condition 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 for him or any other person on behalf of the insured to give such notice or file claim within the prescribed time limit. Otherwise Company / TPA has a right to reject the claim.

5.8 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME :

i) Claim in respect of Cashless Access Services shall be through the Company/TPA provided admission is in a listed hospital in the agreed list of the networked Hospitals / Nursing Homes and is subject to pre admission authorization. The Company/TPA shall, upon getting the related medical details / relevant information from the insured person / network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself shall issue a pre-authorisation letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.

ii) The Company/TPA reserves the right to deny pre-authorisation in case the hospital / insured person is unable to provide the relevant information / medical details as required by the Company/TPA. In such circumstances denial of Cashless Access should in no way be construed as denial of claim and / or deficiency of service. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company/TPA for reimbursement within 7 (seven) days of the discharge from Hospital / Nursing Home.

iii) In case any information available to the TPA / Company which makes the claim inadmissible or doubtful requiring investigations, the authorisation of cashless facility shall be withdrawn. However this shall be done by the Company/TPA before the patient is discharged from the Hospital.

5.9 NON ADMISSION OF CLAIM:

A (I): The Insurer, shall repudiate the claim if not covered / not payable under the policy. The Insurer shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the Grievance Redressal Cell of the company at its policy issuing office, concerned Divisional Office, concerned Regional Office or the Grievance Cell of the Head Office of the Company, situated at A-25/27, Asaf Ali Road, New Delhi-110002, against the repudiation.

B If the insured is not satisfied with the decision of the Grievance Cell under 5.9 (A), he / she may approach the Ombudsman of Insurance, established by the Central Government for redressal of grievances. The Ombudsman of Insurance is empowered to adjudicate on personal lines of insurance claims upto Rs.20 lacs. The insured may visit the site at http://www.ombudsmanindia.org/ for details.

5.10 Any medical practitioner authorised by the TPA/Company shall be allowed to examine the Insured Person with / without prior notice in case of any alleged injury or Disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the TPA/Company.

5.11 DISCLOSURE TO INFORMATION NORM

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

5.12 CANCELLATION CLAUSE: Company may at any time, cancel this Policy by sending the Insured 30 (Thirty) days notice by registered letter at the Insured's last known address and in such an event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. (Such cancellation by the Company shall be only on grounds of moral hazards such as intentional misrepresentation / malicious suppression of facts intended to misleading the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy). The Company shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given here below) provided no claim has occurred during the policy period up to date of cancellation.

Period on Risk	**Rate of premium to be charged**
Upto 1 Month	1/4th of the annual rate
Upto 3 Months	1/2 of the annual rate
Upto 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

5.13 ARBITRATION CLAUSE: If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 (Thirty) days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.

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

5.14 DISCLAIMER OF CLAIM: It is also hereby further expressly agreed and declared that if the TPA/Company shall disclaim liability in writing to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.15 PAYMENT OF CLAIM: The policy covers illness, disease or accidental bodily injury sustained by the insured person during the policy period any where in India and all medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency without any interest thereof.

5.16 COST OF HEALTH CHECK : The Insured shall be entitled for reimbursement of cost of Health check up undertaken once at the expiry of a block of every four continuous claim free underwriting

years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the average sum Insured during the block of four claim free underwriting years.

IMPORTANT

Both Health Check-up and No Claim Discount provisions are applicable only in respect of continuous insurance without break.

6. **PERIOD OF POLICY:** This insurance policy is issued for a period of one year.

7 PORTABILITY: This policy is portable, means the policyholder may switch from one insurer to another insurer, provided the previous policy has been maintained without any break. Portability maintains the credit gained by the insured for pre-existing conditions and time bound exclusions.
If the Insured desires to port his policy, request for the same has to be made atleast 45 days prior to renewal date.

8. RENEWAL OF POLICY:
The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.

i. Notwithstanding this, however, the decision to accept or reject for coverage any person upon renewal of this insurance shall rest solely with the Company. The company may at its discretion revise the premium rates and / or the terms & condition of the policy every year upon renewal thereof. Renewal of this policy is not automatic; premium due must be paid by the proposer to the company before the due date.

ii. The Company shall not ordinarily deny the renewal of this policy unless on moral hazard grounds of the insured such as intentional misrepresentation / malicious suppression of facts intended to misleading the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy.

iii. In case the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (conditions 4.1, 4.2 & 4.3 SHALL apply to additional sum insured) as if a separate policy has been issued for the difference.

In case of increase in Sum insured, treatment for pre-existing disease (after specified time) and for a disease / ailment / injury for which treatment has been taken in the earlier policy period, the enhanced sum insured will be applicable only after four continuous renewals with the increased sum insured.

iv. In the event of break in the policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period and any disease/ condition contracted in the break in period will not be covered and will be treated as Pre-existing condition.

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9. **PRE-ACCEPTANCE HEALTH CHECKUP:** Any person desiring to take fresh insurance cover has to submit following medical reports (and any other medical reports) required by the company from authorised Network Diagnostic Centre.

This provision shall also be applicable for renewal where there is a break in policy period.

The cost of such check up shall be borne by the insured. However in case of fresh proposals, the Company shall reimburse per person 50% cost of Medical Check up. List of the diagnostic centres will be provided.

MEDICAL TEST	PHYSICAL EXAMINATION
	URINE(MICROALBUMIN UREA)
	GLYCOCYLATED HAEMOGLOBIN
	ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)
	X-RAY BOTH KNEES (ANTEPOSTERIOR AND LATREL)
	COMPLETE EYE TEST INCLUDING FUNDUS ETC
	STRESS TEST (TMT)

10. **SUM INSURED:** The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the sum insured opted by the Insured person. Minimum sum insured that can be selected is Rs 100,000/- and higher sum insured can be selected in multiples of Rs 100,000/- upto a maximum sum insured of Rs. 5,00,000/-.

11 CONTRIBUTION: In case of insured having two or more policies during a period from one or more insurers to indemnify the treatment cost, the policyholder shall have the right to seek settlement of his claim in terms of any of his policies. In such cases,
i.The insurer shall be obliged to settle the claim without insisting on contribution clause as long as the claim is admissible within the policy limits.
ii.If the claim amount exceeds the sum insured after considering the deductions or co-pay, the policy holder shall have the right to choose insurers by whom the claim is to be settled. In such cases, contribution clause shall apply.

12 AUTHORITY TO OBTAIN RECORDS:

a) The insured person agrees to and authorises the disclosure to the insurer or the TPA or any other person nominated by the insurer of any and all Medical records and information held by any Institution / Hospital or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability there under.
b) The insurer and the TPA agree that they shall preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and shall only use it in connection with any claim made under this policy or the insurer's liability there under.

13 CHANGE OF ADDRESS: Insured must inform the company immediately in writing of any change in the address.

14 QUALITY OF TREATMENT : The insured acknowledges and agrees that payment of any claim by the insurer shall not constitute on part of the insurance company a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the insured person, it being agreed and recognized by the policy holder that insurer is not in any way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital) whether pre-authorized or not.

15 ID CARD: The card issued to the insured person by the TPA to avail cash less facility in the Network Hospital only. Upon the cancellation or non renewal of this policy, all ID cards shall immediately be returned to the TPA at the policy holders expense and the policy holder undertakes to indemnify the insurer /TPA for any liability whatsoever due to any misuse of the ID card by any person whomsoever.

16 PROTECTION OF POLICY HOLDERS INTEREST: This policy is subject to IRDA (Protection of Policyholders' Interest) Regulation.

17 In case of any grievance not redressed by the concerned Policy issuing Office, the insured person shall have a right to appeal / approach the Chief Manager Grievance Cell of the Company's Regd. Office situated at A-25/27, Asaf Ali Road, New Delhi-110002.

The Central Government has also established office of the Insurance Ombudsman for redressal of policyholders' grievances. The insured may visit the site at http://www.ombudsmanindia.org/ for details.