INDIRA GANDHI INSTITUTE OF DEVELOPMENT RESEARCH
GOREGAON (EAST), MUMBAI

TENDER DOCUMENT FOR

Group Medical Insurance Policies for Employees (Including their Dependents, Retired Employees & their Spouse) and For Students at IGIDR

NIT No: IGIDR/Tender/2022/ED/25 Date: 25th July 2022

INDIRA GANDHI INSTITUTE OF DEVELOPMENT RESEARCH

Gen. A.K. Vaidya Marg, Film city Road, Santosh Nagar, Goregaon (East), Mumbai-400065.

Telephone: 022 6909 6200/9881070122; Fax: 022 6909 6399.

INDIRA GANDHI INSTITUTE OF DEVELOPMENT RESEARCH, MUMBAI

Notice Inviting Tender

"NAME OF TENDER: Group Medical Insurance Policies For Employees and Students at INDIRA GANDHI INSTITUTE OF DEVELOPMENT RESEARCH, GOREGAON (E), MUMBAI – 400 065."

1. Institute invites bids from reputed & qualified insurance agencies for the following work:

Name of work	Period of policy
(1)	(2)
Group Medical Insurance Policies For Employees (Including their Dependents, Retired Employees & their Spouse) And Students at IGIDR	4th September 2022 to 3rd September 2023

2. IGIDR reserves its right to award the contract to the successful bidder.

3. The tender in two bid system being invited through email for the service as mentioned above from General Insurance Companies (Licensed and Registered with IRDA) dealing with Health Insurance for implementation of Group Medical Insurance Policies For Employees & their Dependents, Retired Employees & their Spouse And For Students at IGIDR".

Category	No of the members to be covered	Basic Sum Assured (INR. in Lac)
Employees & their dependent family Members, Retired employees & their spouse	186*	INR 15.00 Lac Each
Students	59*	INR 3.00 Lac Each

*Number mentioned is tentative and may increase or decrease.

4. The Tender bids in two bid system are invited through two separate **Emails: "Email-1: Signed tender document, Pre-Qualification Bid document" and "Email-2: Financial bid"**. The email subject should be mentioned as **"Email-1: Tender & Prequalification Bid for Group Medical Insurance Policies for Employees and Students at IGIDR" and "Email-2: Financial Bid for Group Medical Insurance Policies for Employees and Students at IGIDR,"** respectively**.**

5. The last date of submission of the Tender bid shall be up to **03:00 PM on 16th August 2022.**

6. The Institute reserves the right to reject any prospective application without assigning any reasons whatsoever.

REGISTRAR

SECTION-A*

LETTER OF OFFER

Date _____

To,

The Registrar,

Indira Gandhi Institute of Development Research,

Gen. A.K. Vaidya Marg, Film city Road,

Goregaon (East), Mumbai 400065.

Subject: Tender for Group Medical Insurance Policies for Employees and Students at IGIDR, Mumbai.
Reference: NIT No. IGIDR/Tender/2022/ED/25 Date: 25th July 2022

Dear Sir,

With respect to your tender mentioned above, we hereby submit our tender bid in the required format along with our Company Profile and supporting documents.

Should this tender be accepted, I/We hereby agree to abide by and fulfill the terms and provisions of the said Conditions of Contract annexed hereto so far as they may be applicable.

We have carefully reviewed the prescribed terms and conditions and accept the same without any alterations/modifications.

Yours faithfully,

Signature

Name & seal of Bidder

* The bidder should submit the Letter of Offer on their company letterhead.

SECTION-B

GENERAL INSTRUCTIONS TO BIDDER

The tender should be addressed to The Registrar, Indira Gandhi Institute of Development Research, Goregaon (East), Mumbai-400065.

1. The scan copy of the tender bid is to be submitted through email to tender@igidr.ac.in through two separate Emails. **"Email-1: Signed Tender document & Pre-Qualification Bid documents" and "Email-2: Financial bid"**. The email subject should be mentioned as **"Email-1: Tender & Prequalification Bid for Group Medical Insurance Policies for Employees and Students at IGIDR"** and **"Email-2: Financial Bid for Group Medical Insurance Policies for Employees and Students at IGIDR,"** respectively**.** All the required documents should be scanned and merged into a single PDF file or zipped into a single file and attached to the respective Emails. **The Financial bid should be attached as a PDF document protected with a password, and the password will be shared during the financial bid opening through an online meeting. The vendor should keep their password secure and be required to give it only when asked in an online meeting for financial bid opening.**

2. The bids will be received up **to 03:00 PM on 16th August 2022.** Each copy of the tender document is under their stamp and signature. No tender will be accepted after the due date under any circumstances whatsoever.

3. The Email bid with the subject "Pre-qualification Bid for Group Medical Insurance Policies for Employees and Students at IGIDR" shall be opened by REGISTRAR or his authorized representative in his office the next day **17th August 2022, at 11:30 AM through the online meeting platform**. The link to the meeting will be shared with participated bidders. If the government declares a holiday on the day of opening the bids, the bids will be opened on the next working day at the same time.

4. The Email bid with the subject: "**Financial bid for Group Medical Insurance Policies for Employees and Students at IGIDR"** of only qualified bidders will be opened. The Institute shall inform the date of financial bid opening and link for an online meeting to the qualified bidders. **The bidders should provide the password of the financial bid PDF file during the opening of the financial bid. If the bidder can NOT give a password for the financial bid at the opening, then their bid shall be rejected.**

5. Tenders shall remain valid for acceptance by the Institute for three months from the tender's opening date, which may be extended by mutual agreement. The bidder shall not cancel or withdraw the bid during this period.

6. The bidder must use only the bid forms issued by the Institute to fill in the rates. Any addition/alteration in the text of the Tender document made by the bidder shall not be valid and be treated as null and void.

7. The Tender form must be filled out in English. If any document is missing or unsigned, the tender may be considered invalid by the Institute at its discretion.

8. Rates should be quoted both in figures and in words in columns specified. Overwriting of figures is not permitted. Failure to comply with either of these conditions will render the tender void at the Institute's option. No advice, especially on any change in rate specifications after the opening of the tender, will be entertained.

9. Each Page of the Tender Documents should be stamped and signed by the authorized person or persons submitting the tender in token of his/they having acquainted himself/themselves with the General terms & conditions, specifications, special conditions of contract, etc., as laid down. Any Tender with any of the documents not so signed will be rejected.

10. The Institute does not bind itself to accept the lowest or any tender. It reserves the right to accept or reject any or all the Tenders, either in whole or part, without assigning any reasons for doing so.

11. Financial bid must include in their rate, applicable GST and any other tax and stamp duty or other levies in force levied by the Central Government or any State Government or Local Authority, if applicable.

12. The intending bidder can obtain any clarifications regarding the tender document, employee details, previous policy details, etc., if any, by contacting **Mr. Samir Parab (Administrative Officer) on his mobile number -8097171963 or email -** samir@igidr.ac.in or from the Administration office of the Indira Gandhi Institute of Development Research, Goregaon (E), Mumbai-400 065 on any Institute`s working day.

We hereby declare that we have read and understood the above instructions, and they will remain binding upon us.

Place : Signature of Bidder with seal

Date :

SECTION-'C'

GENERAL TERMS AND CONDITIONS

Upon the declaration of an intending bidder to be the Successful Bidder by the Institute, they shall be subject to the following terms and conditions that shall form part of the contract with the Institute.

1. It may be noted that no advisor/broker is involved in the tender.
2. The successful insurance agency shall provide the services strictly following the scope of work, insurer details, and as per detailed instructions of the Institute.
3. In all matters of dispute arising on the work, the matter shall be referred to **The Registrar, Indira Gandhi Institute of Development Research, Goregaon (East),** for a decision.
4. **Arbitration Clause**:

   In the event that the Successful Bidder is not satisfied by the decision of the Registrar, Indira Gandhi Institute of Development Research, the dispute shall be settled by arbitration in accordance with the provisions of the arbitration and conciliation act, 1996 or any enactment thereof. The Arbitral Tribunal shall consist of one arbitrator appointed by the Institute. The place of arbitration shall be Mumbai, and any award, whether interim or final, shall be made and deemed for all purposes between the parties to be made in Mumbai. The arbitration proceedings shall be conducted in English, and any award or awards shall be rendered in English. The procedural law of the arbitration shall be Indian law. The award of the arbitral tribunal shall be final, conclusive, and binding upon the Successful Bidder and the Institute.
5. **Payment Terms:**

   Payment shall be made to the agency after the acceptance of offer against the proforma invoice**.**
6. **Period of policy:**

   The insurance policy period shall be one year, from 04th September 2022 to 3rd September 2023.

I/We hereby declare that I/we have read and understood the above terms and conditions. The same shall bind me/us upon being declared the Successful Bidder.

Place : Signature of Bidder with seal

Date :

SECTION 'D'

SPECIAL CONDITIONS

1. The Insurance company should cover all the Employees & their dependents, retired employees & their spouse, And Students from Day 1 of policy commencement. The scheme must cover all insured pre-existing illnesses, if any, mandatorily. Coverage for pre-existing diseases/conditions will be without any waiting time, conditions or clause.

2. The policy should cover all types of hospitalization, including illness, critical illness, daycare, accidental cases, pregnancy, dental treatment, and Covid-19 cases.

3. **The Insurance company should issue two separate insurance policies For Employees (Including their dependent family members and Retired Employees & their spouse) And For Students. The Insurance Company should cover all the medical facilities extended in our current policies. (Copy of the current coverage is attached in Annexure – C).**

4. The coverage of the mid-joiners shall be from Day 1 (Date of joining) irrespective of immediate payment of premium. The premium shall accordingly be calculated on a pro-rata basis.

5. The coverage for the mid-leavers shall be till the date of leaving the Institute. The premium shall accordingly be calculated on a pro-rata basis.

6. The balance amount for the mid-leavers shall be refunded to the Institute on a pro-rata basis.

7. The Insurer must agree to work with the suggested TPA or any other TPA identified by IGIDR. A successful insurance agency should provide good options for selecting TPA for the Institute.

8. During the validity of the current policy, no revision in premium shall be considered by IGIDR based on the actual claim ratio or any enhancement in the premium pointed out by any statutory or other authority.

9. Once assigned the medical insurance for any given period, the insurance company shall have no right to terminate the operation of the policy during this period unilaterally.

10. **Exclusions & Inclusions: Exclusions & Inclusions should be specified by the insurance company as part of the technical bid.**

11. **The insurance agency should have a good network of hospitals on a pan-India basis indicating cashless facilities wherever available.**

12. Any conditional bid or a bid not in the prescribed Performa will not be accepted.

13. The insurance company will have no right to reject the membership of a member as defined by IGIDR whose membership has been approved by IGIDR.

14. TPA services being offered by the Insurance company should be able to provide a 24x7 telephone facility to cater to all the members. A single-point person with a mobile number should be available 24x7 to resolve all the issues and handle emergency situations.

15. Confidentiality of all IGIDR information/documents to be ensured at all times.

16. There will be no age limit on the insured covered by this scheme.

17. For the new employees who may join the Institute from time to time, identical coverage must be made available from day one. However, the premium paid may be based on the fractional period involved. For the employees leaving before completing the contract insurance period, the pro-rata premium amount should be refunded to the Institute from the date of their leaving the Institute.

18. For all claims (other than cashless ones), the claim would be expected to be submitted to the insurance company within 45 days of discharge from the hospital. Such claim should be settled within 30 days of submission, and payment will be made directly to the insured. The insurance company should arrange to collect the claim from the Institute on receiving the request.

19. The insurance company shall arrange to issue a membership card to each insured person at their own cost. The insurance company needs to ensure that any member with a valid identity card issued by IGIDR should get treatment for all emergency cases at various network hospitals without difficulty.

20. The Policy shall cover hospitalization for indoor patients and other surgeries/procedures that do not require hospitalization but are generally covered by health insurance policies as daycare procedures. The daycare procedures treatment such as Dialysis, Radiotherapy, K wire fixation, etc., should be covered under this policy.

21. It is expected that the Insurance Company will have arrangements with an extensive network of reputed hospitals across the country for treatment with cashless facilities.

22. The Premium shall be paid on an annual basis.

23. **The insurance companies must submit the premium for I (Premium for Sum Assured) and II (Premium for Buffer) in their financial bid**.

24. There shall be a grace period of 30 days from the due date of the premium.

25. Currently, the existing employees and students are covered under an active medical insurance policy. The sum assured for the current policy is INR 15.00 Lac per member for Employees and INR 3.00 Lac per member for students.

26. Canvassing, Fraud, and Corrupt practices: Bidders are hereby informed that canvassing in any form to influence the award notification process would result in the bidder's disqualification. Further, they shall observe the highest standard of ethics and will not indulge in any corrupt, fraudulent, coercive, undesirable, or restrictive practices, as the case may be.

27. **"Corrupt practice"** means the offering, giving, receiving, or soliciting of anything of value to influence the public official's action.

28. **"Fraudulent practice"** means a misrepresentation of facts to influence the Tender process or execution of a contract to the detriment of the scheme and includes collusive practice among bidding Insurers/Authorized Representative (before or after bid submission) designed to establish bid prices at artificially non-competitive levels and to deprive the scheme the benefit of free and open competition;

29. IGIDR Mumbai will reject a proposal for award if it determines that the Insurer/Insurers have engaged in corrupt or fraudulent practices.

30. IGIDR Mumbai will declare a firm ineligible, either indefinitely or for a stated period, to be awarded a contract if it at any time determines that the bidding Insurer/Insurers have engaged in corrupt and fraudulent practices in competing for, or in executing, a contract.

31. Action against the Tenderer: Furnishing incorrect information in the offer, failure to act according to tender condition, and non-fulfillment of any or whole of the contract may entail black listing of Insurer and taking other appropriate action against the Insurer.

32. Should provide a corporate buffer to the Institute as specified in the tender.

We hereby declare that I/we have read and understood the above terms and conditions that form part of the Formal Contract to be executed between the Institute and us. The same shall bind me/us upon being declared the Successful Bidder.

Place :

Date : Signature of Bidder with seal

SECTION-'E'

PRE-QUALIFICATION CRITERIA

- **Pre-Qualification Documents to be submitted by the bidder along with Pre-qualification Bid:**

1. The bidder should be registered under Insurance Act, 1938/IRDA and should have a valid license to carry out Medical/Health insurance business (submit the copy of renewal receipt).

2. The Insurance Company should be in existence for at least **ten** years.

3. The bidder should have a valid PAN, Goods, and Service Tax registration number (GST).

4. The bidder should have at least **one** Group medical insurance policy of at least **300** members during the last three years. The bidder should submit a copy of the policy document or self-declaration on their letterhead, having issued policies for 300 or more members in any organization.

5. The bidder should have a claim settlement ratio of **92.00%** & above (average for the last three years). Valid proof of the previous three-year claim settlement ratio should be attached, authenticated by IRDA, or published by the Insurance Company.

6. The bidder should have an average annual turnover of **INR 50.00 Crore** for the last 03 financial years. The bidder will submit the audited balance sheets, profit & loss accounts, CA Certificate, or self-declaration on company letterhead for the turnover amount for the last three financial years, i.e., FY2018-19, FY2019-20 & FY2020-21.

7. List of clients along with name & contact number of representatives and copy of the certificate of appreciation, if any.

8. Either the Registered Office or one of the Branch Offices of the bidder should be located in the territory of MMRDA.

9. The insurance agency should have a good network of hospitals on a pan-India basis indicating cashless facilities wherever available (List to be attached).

Bidders must submit documentary proof in support of meeting each of the above minimum qualification criteria. A simple undertaking by the bidder for any of the stated criteria will not suffice the purpose. All documentary proof must be listed on the letter pad of the company and enclosed in a cover, to be submitted along with the qualification bid (Envelope-1) duly stamped and signed by the authorized person of the agency.

- **Information to be furnished by the bidder:**

Sr. No.	Item	Information to be filled by Bidder
1	Name of the bidder	
2.	Address	
3.	Telephone Number: Office /Residence: Mobile Number: Fax No. Email address-	
4.	Details of Registration (number & date)	
5.	Month and Year in which the firm/company was formed/ incorporated.	
6.	Type of organization (Sole Proprietor, Partnership, Pvt Ltd., Public Ltd., etc.)	
7.	Enclose a copy of the partnership deed, Articles of Association, or Affidavit (in case of firm)	
8.	Average Annual Turnover of Last Three Financial Year (attached audited balance sheets and profit & loss statements)	FY 2018-19: FY 2019-20: FY 2020-21:
9.	Claim settlement ratio for three years (Attach a certified copy of claim settlement ratio for Medical insurance policy)	FY 2018-19: FY 2019-20: FY 2020-21:
10.	Inclusion of the policy, if any (Enclose copy)	
11.	Exclusion of the policy, if any (Enclose copy)	
12	Bank Account Details	A/C No. Bank Name: IFSC:

SECTION-'F'

TECHNICAL BID

1. **SCOPE OF WORK:**

PART-A: Group Medical Insurance policy for Employees & their dependents, Retired Employees & their spouse:

- **Statistics of Employees to be covered under an insurance policy-**

Category	**No of the members to be covered**	**Basic Sum Assured** (INR in Lac)
Faculty, Staff, their dependent family Members, Retired employees & their spouse	186*	INR 15.00 Lac Each

(* Above numbers are tentative, and they may increase or decrease during the commencement of policy)

PART-B: Group Medical Insurance policy for Students

- **Statistics of Students to be covered under an insurance policy-**

Category	**No of the members to be covered**	**Basic Sum Assured** (INR in Lac)
Students (Age- 21 to 35 Yrs)	57*	INR 3.00 Lac each
Students (Age- 36 to 45 Yrs)	02*	

(* Above numbers are tentative, and they may increase or decrease during the commencement of policy)

2. **The policy should cover all types of hospitalization, including illness, critical illness, daycare, accidental cases, pregnancy, dental treatment, and Covid-19 cases.**
3. **The Insurance Company should issue two separate policies for Employees and Students and cover all the medical facilities extended in our current policies. (Copy of the current coverage is attached in Annexure – C).**

Place :

Date : Signature of Bidder with seal

About the Institute

Indira Gandhi Institute of Development Research (IGIDR) campus is on a sprawling 14-acre plot in Goregaon East. The campus provides an ideal setting for learning and living.

The IGIDR is an advanced research institute established by the Reserve Bank of India for conducting research on development issues from a multi-disciplinary point of view. After its registration as an autonomous society on November 14, 1986, and as a public trust on January 15, 1987, the Institute was subsequently recognized as a Deemed to be University under Section 3 of the UGC Act vide Notification No.F9-7/94-U.3 dt. 5th December 1995. The Institute is fully funded by the Reserve Bank of India.

IGIDR Mumbai has state-of-the-art sports facilities on campus for its students and employees.

Place :

Date : Signature of Bidder with seal

Annexure – A*

FORMAT OF UNDERTAKING, TO BE FURNISHED ON COMPANY LETTERHEAD WITH REGARD TO BLACKLISTING/NON-DEBARMENT, BY ORGANISATION UNDERTAKING REGARDING BLACKLISTING / NON – DEBARMENT

To,
The Registrar
Indira Gandhi Institute of Development Research
Film City Road, Santosh Nagar,
Goregaon (East),
Mumbai – 400 065.

We hereby confirm and declare that we, M/s _____, is not blacklisted/ De-registered/ debarred by any Government department/ Public Sector Undertaking/ Private Sector/ or any other agency for which we have Executed/ Undertaken the works/ Services during the last 5 years.

For M/s _____

Authorized Signatory

Date:

*To be submitted on company letterhead duly signed and stamped on it.

Annexure – B*

FORMAT OF UNDERTAKING, TO BE FURNISHED ON COMPANY LETTERHEAD

UNDERTAKING

1. We undertake if we are awarded the contract as mentioned in the NIT Ref. No. IGIDR/Tender/2022/ED/25 Dated 25.07.2022, we undertake to settle all the claims of IGIDR Mumbai within 45 days from the date of the claim, and non-settlement would attract interest at the SBI lending rate for cash credits. We understand that failure to do so might adversely affect our business prospects with IGIDR Mumbai.

2. We undertake that Insurance Policies shall cover all the members from Day 1 of commencement of the policy. The scheme has to cover all pre-existing illnesses of the insured members, if any. Coverage for pre-existing diseases/conditions will be without any waiting time, clause, or conditions.

3. We undertake that compulsory cover of all the medical facilities extended in our current policy without any terms and conditions or exceptions. (Copy of the current coverage is attached in 'Annexure –C')

4. We undertake that we have received the IRDA approval for the Group Medical Insurance Policy (The photocopy of the same is attached herewith).

5. We undertake that there will be no subsequent increase in premium rates during the contract period.

6. We undertake that the secrecy of IGIDR, Mumbai information/documents will be ensured at all times.

7. We undertake to comply with all the terms and conditions of this Notice inviting tender.

Authorized Signatory

Date:

*To be submitted on company letterhead duly signed and stamped on it.

Annexure – C*

Part-A: Existing Group insurance policy for Employees:

GROUP MEDICLAIM TAILORMADE POLICY SHEDULE

UIN : OICHLGP449V022021

Policy No.	: **124600/48/2022/2648**	**Prev. Policy No.**	: -
Cover Note No.	: CN-B-103725902	Cover Note Date	: 03/09/2021
Insured's Code	: AA0000073438	Issue Office Code	: 124600
Insured's Name	: INDIRA GANDHI INST. OF DEV. RESEARCH (GSTIN: 27AAATI0014Q1ZO)	Issue Office Name	: MCDO 1 (GSTIN: 27AACT0627R4ZW)
Address	: GEN. A.K. VAIDYA MARG, FILM CITY ROAD, GOREGAON (EAST), MUMBAI 400063. MUMBAI 400063	Address	: ORIENTAL HOUSE, 4TH FLOOR, 7, J TATA ROAD CHURCHGATE MUMBAI MAHARASHTRA 400020

Agent/Broker Details

Dev.Off.Code : **NA0000002705 DIRECT (MC DO 1)**

Agent/Broker :

Address :

Tel/Fax/Email : ////

Period of Insurance : FROM 00:00 ON 04/09/2021 TO MIDNIGHT OF 03/09/2022

Collection No. & Dt. : CD A/C AA0000073438 GST INVOICE NO :2720301163 UIN :0

Co-insurance Details : NIL

TPA Details :

TPA ID : YA0000000338

TPA Name : M/s Raksha Health In

TPA Address : 15/5, MATHURA ROAD, FARIDABAD
crcm@rakshatpa.com; it@rakshatpa.com
FARIDABAD 121003 Toll Free No : 18001801444, 0129 - 4289999, 25643

Risk Details

The insurance under this policy is subject to conditions, clauses, warranties,endorsements as per forms attached .

The policy shall pay for hospitalization expenses for medical/surgical treatment at any Nursing Home/Hospital in INDIA as an in-patient defined in the policy

In the event of a claim under the policy exceeding Rs. 1 lac or a claim for refund of premium exceeding Rs. 1 lac,the insured will comply with the provisions of the AML policy of the Company.The AML policy is available in all our operaing offices as well as Company's website.
Family Size: 1 + 5 (Self + Spouse + 2 Dependent Children + 2 Parents/in-Laws).
Total 193 lives - SELF 66 + DEPENDANTS -127
SUM INSURED - RS.15 LAKHS PER PERSON
Pre Existing covered (Waiver of 4.1, 4.2 & 4.3)
Dental Treatment Root Canal only: Rs.10,000/- per person

Attached to and forming part of policy number 124600/48/2022/2648

7, 360

Telephone No : Fax No :

Pre & Post Hospitalisation : 30 days & 60 days respectively.
Maternity with 9 months waiting period waiver : Limit for both Normal and Caesarian Delivery : Rs.50,000/-
New Born Baby day one.

Room Rent & ICU : 1% & 2% of Sum Insured.No Domiciliary Hospitalisation cover.
All benefits as an impatients hospital attached to room will be restricted to the room rent which falls within the room rent allowed. The enhanced difference in room rent and its related expenses shall be borne by the insured only. Wherever the room rent based tariff for other expenses is not available, the payment will be done on the same proportion as per entitled room rent under the policy excluding medicines, consumable, implants medically prescribed by the treating doctor undor tho policy.
Corporate Buffer : Rs.20 Lacs for Critical Illness with prior approval of D.O.
GIPSA PPN RATE APPLICABLE FOR NETWORK HOSPITAL

Warranted that in case the person covered under the policy has lodged any claim under the previous policy and the sum insured is enhanced under the current policy, for a further claim for the same disease during the current policy, the earlier Limit of Sum Insured shall be applicable and not the enhanced sum insured

Warranted that in case of dishonour of premium cheque(s) the Company shall not be liable under the policy and the policy shall be void abinitio (from inception).

"We at Oriental continuously strive to ensure that you get the best possible treatment from our network hospitals. Please contact your TPA or any of the Oriental offices for our preferred hospitals in your area before going for a treatment. This will help us serve you in the best possible manner"

In witness whereof the undersigned being authorised by and on behalf of the Company has/have herein to set his/their hands at MCDO 1 (GSTIN: 27AAACT0627R4ZW) on 06-SEP-21

" In case of grievance related to any issue related to this policy the same may be addressed to the office In-Charge or the Grievance Officer at above policy address. If the grievance remains pending, it may be escalated to Grievance Officer of the concerned Regional Office ORIENTAL HOUSE,,7TH FLOOR,,7, J TATA ROAD,CHURCHGATE, MUMBAI.The next escalation in case grievance remains unresolved is CSD, Head Office, situated at Oriental House, A-25/27, Asaf Ali Road, New Delhi-110002. If the Insured is not satisfied with the resolution/reply provided by the company, he/she may approach the Office of Insurance Ombudsman, within his/her jurisdiction. The list of offices of Ombudsman is available on Company's portal."

Entered By : MAHESH T JAGASIA

Examined By : Ajay R Pote

For and on behalf of
The Oriental Insurance Company Limited

Policy Printed By : 171271 IP :

Policy Printed On : 06-SEP-21 16:03:11 MAC :

Authorised Signatory

MEDICLAIM INSURANCE POLICY (GROUP)

1 WHEREAS the insured named in the Schedule hereto has by a proposal and declaration dated 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 any insured Person shall contract any disease or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require, 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) on domiciliary treatment in India under Domiciliary Hospitalisation Benefits as hereinafter defined, the Company/ TPA will pay to the Hospitals (only if treatment is taken at Network Hospital(s) with prior consent of Company/TPA) or re-imburse to the insured person, as the case may be, the amount of such expenses. It is a precondition that these expenses are reasonably and necessarily incurred in respect thereof by or on behalf of such insured person but not exceeding the sum insured in aggregate in any one period of insurance stated in the schedule hereto.

1.2 The policy reimburses the payment of Hospitalisation and / or Domiciliary Hospitalisation expenses only for illness/diseases contracted or injury sustained by the Insured Persons. In the event of any claim becoming admissible under this policy, the Company/TPA will pay to the hospital (only if treatment is taken at network hospitals with prior consent of Company/TPA) or re-imburse to the insured, as the case may be, the amount of expenses reasonably and necessarily incurred under different heads mentioned below thereof by or on behalf of such Insured Person not exceeding the Sum Insured in aggregate in respect of Insured Person as stated in the schedule for all claims admitted during the period of insurance mentioned in the schedule.

FOLLOWING REASONABLE & CUSTOMARY EXPENSES ARE REIMBURSABLE UNDER THE POLICY

a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1 % of the Sum Insured or Rs. 5000 /- per day whichever is less.

b. I.C. Unit expenses not exceeding 2 % of the Sum Insured or Rs. 10,000 /- per day whichever is less. (Room including I.C.U. stay should not exceed total number of admission days).

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

d. 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..

e. Ambulance services - 1% of the sum insured or Rs 2000/- 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 by registered ambulance only for better medical facilities.

Note:

1. Hospitalization expenses incurred for donating an organ by the donor (excluding cost of organ if any) to the insured person during the course of organ transplant will also be payable. However in any case the liability of the Company will be limited to over all Sum Insured of the Insured Person.

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 OPERATION: Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis
and cure of diseases, relief 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 hours. However,

(A) This time limit will not apply to following specific treatments taken in the Network Hospital/Nursing Home where the Insured is discharged on the same day. Such treatment will 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. Tonsillectomy,
vii. D&C,
viii. Dental surgery following an accident
ix. Hysterectomy
x. Coronary Angioplasty
xi. Coronary Angiography
xii. Surgery of Gall bladder, Pancreas and bile duct
xiii. Surgery of Hernia
xiv. Surgery of Hydrocele.

xvi. Surgery of Prostate.
xvi. Gastrointestinal Surgery.
xvii. Genital Surgery.
xviii. Surgery of Nose.
xix. Surgery of throat.
xx. Surgery of Appendix.
xxi. Surgery of Urinary System.
xxii. Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
xxiii. Arthroscopic Knee surgery.
xxiv. Laproscopic therapeutic surgeries.
xxv. Any surgery under General Anaesthesia.
xxvi. Or any such disease / 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 hours Hospitalisation will 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 of 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 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 of the following circumstances:

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

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. Asthma
   ii. Bronchitis,
   iii. Chronic Nephritis and Nephritic Syndrome,
   iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis,
   v. Diabetes Mellitus and Insipidus,
   vi. Epilepsy,
   vii. Hypertension,
   viii. Influenza, Cough and Cold,
   ix. All Psychiatric or Psychosomatic Disorders,

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

Note: Liability of the Company under this clause is restricted as stated in the schedule attached hereto.

3. **OTHER DEFINITIONS AND INTERPRETATIONS :**

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

3.2. 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.

3.3. 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.

3.4. 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.

3.5. 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.

3.6 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.

3.7 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.

3.8 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.

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

3.10 PRE EXISTING DISEASES: 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 will be considered as a part of that pre existing health condition.

3.11ILLNESS
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a. Acute condition - An acute condition is a disease, illness, or injury that you have suffered which aims to return the person to his or her state of health immediately before suffering the disease/illness/ injury which leads to full recovery.

b. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief o f symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

3.12 INJURY

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

3.13 CONGENITAL ANOMALY

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

a. Internal Congenital Anomaly

which is not in the visible and accessible parts o f the body is called Internal Congenital Anomaly

b. External Congenital Anomaly

which is in the visible and accessible parts o f the body is called External Congenital Anomaly

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

3.15 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 Networked Hospital and the TPA for surgical / medical treatment that is necessary , customary and reasonable for treating the condition for which insured person was hospitalized.

NOTE: Any expenses (as mentioned above) which are not covered under the policy and / or which are not reasonable, customary and necessary, the same have to be borne by the insured person himself.

3.16 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.

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

3.18 DAY CARE PROCEDURE: means the course of Medical treatment / surgical procedure listed at 2.3 (A) carried out, in Networked specialised Day Care Centre which is fully equipped with advanced technology and specialised infrastructure where the insured is discharged on the same day, the requirement of minimum beds will be over looked provided other conditions are met.

3.19 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 that insured person in respect of hospitalization taking place during currency of the policy.

3.20 ANY ONE ILLNESS: Any one illness means continuous Period of 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.

3.21 MATERNITY EXPENSES AND NEWBORN CHILD COVER BENEFIT EXTENSION:

a. This is an optional cover which can be obtained on payment of 10% of the total basic premium for all the insured persons under the policy. Total basic premium means the total premium computed before applying group discount and /or High Claims Ratio Loading, Low Claim Discount.
b. Option for Maternity Expenses and Newborn Child Cover Benefit Extension has to be exercised at the time of inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during the currency of the policy.
c. Those insured persons who are already having two or more living children will not be eligible for this benefit
d. Claim in respect of only first two children and/or operations associated therewith will be considered in respect of any one insured person covered under the policy or any valid and effective renewal thereof
e. The maximum benefit allowable under this clause will be upto Rs. 50,000/-and would fall under different heads mentioned under item 1.2.. The sum insured under above benefit shall be a part of basic sum insured.

Special conditions applicable to Maternity Expenses & Newborn Child Cover Benefit Extension

a. These benefits are admissible only if the expenses are incurred in hospital/nursing home as in-patients in India.
b. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine Pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.
c. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
d. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/nursing home and treatment is taken there.
e. Pre Hospitalisation and post Hospitalisation benefits are not available under this section.
f. Newly born child shall be covered from day one upto the age of 3 months and expenses incurred for treatment taken in hospital as in patient shall only be payable subject to within the specified sum insured of Rs 50,000/- under Maternity benefit extension. Congenital diseases of newly born child shall be excluded.

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

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 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 4 years of this policy being in force continuously.

This exclusion will also apply to any complications arising from pre existing ailment / diseases / injuries. Such complications will be considered as a part of the pre existing health condition or disease.

Further to this if any 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.

Diabetes	Hypertension	Diabetes & Hypertension
Diabetic Retinopathy	Cerebro Vascular accident	Diabetic Retinopathy
Diabetic Nephropathy	Hypertensive Nephropathy	Diabetic Nephropathy

Diabetic Foot Ulcers & Infections	Internal Bleeds/ 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
		Hypertensive Nephropathy
		Internal Bleeds/ Haemorrhages

4.2 Any disease other than those stated in clause 4.3, contracted by the Insured person during the first 30 days from the commencement date of the policy except treatment for accidental external injuries.

4.3 During the period of insurance cover, the expenses on treatment of following ailment / diseases / surgeries for specified periods are not payable if contracted and / or manifested during the currency of the policy.

i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
ii	Polycystic ovarian diseases .	1 year
iii	Surgery of hernia.	2 years
iv	Surgery of hydrocele.	2 years
v	Non infective Arthritis.	2 years
vi	Undescendent Testes.	2 Years
vii	Cataract.	2 Years
viii	Surgery of benign prostatic hypertrophy.	2 Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus	2 Years
x	Fissure / Fistula in anus.	2 Years
xi	Piles.	2 Years
xii	Sinusitis and related disorders.	2 Years
xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
xiv	Surgery of genito urinary system excluding malignancy.	2 Years
xv	Pilonidal Sinus.	2 Years
xvi	Gout and Rheumatism.	2 Years
xvii	Hypertension.	2 Years
xviii	Diabetes.	2 Years
xix	Calculus diseases.	2 Years
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
xxi	Surgery of varicose veins and varicose ulcers.	2 Years
xxii	Congenital internal diseases.	2 Years
xxiii	Joint Replacement due to Degenerative condition.	4 Years
xxiv	Age related osteoarthritis and Osteoporosis.	4 Years

If the continuity of the renewal is not maintained, then subsequent cover will be treated as fresh policy and clauses 4.1., 4.2, 4 .3 will apply unless agreed by the Company and suitable endorsement passed on the policy.

4.4 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.

4.5 Circumcision (unless necessary for treatment of a disease not excluded 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, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

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

4.7 Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc unless arising from disease or injury and which requires hospitalisation for treatment.

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 and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.

4.12 Any Treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy. .

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

4.14 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,.

4.15 Genetical disorders and stem cell implantation / surgery.

4.16 External and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps , splints, slings, braces ,Stockings etc of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items etc and also any medical equipment which is subsequently used at home etc.. Exhaustive list available on the website.

4.17 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..

4.18 Change of treatment from one pathy to other pathy unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.

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

4.20 Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.

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

4.22 Any admission in the hospital for any domestic reason or which is not certified medically necessary by the specialist.

4.23 Out patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.24 Massages, Steam bathing, Shirodhara and alike treatment under Ayurvedic treatment.

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

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

4.27 Treatment which is continued before hospitalization and continued even after discharge for an ailment / disease / injury different from the one for which hospitalization was necessary.

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 (except relating to claim) 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 RENEWAL OF POLICY:

I)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.

II) Not withstanding 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.

III) The Company normally sends renewal notice but not sending it will not tantamount to deficiency in services.

5.4 **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.

5.5 **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.

5.6 **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 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 document must be duly attested by the Insured.

In case of post hospitalisation treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 7 days after completion of such treatment (upto 60 days or actual period whichever is earlier) 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 to give such notice or file claim within the prescribed time limit. Otherwise Company / TPA has a right to reject the claim..

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

i) Claim in respect of Cashless Access Services will 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 will 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. 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 days of the discharge from Hospital / Nursing Home.

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

5.8 REPUDIATION :

A 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 5.8 (A), he / she may approach the Ombudsman of Insurance, established by the Central Government for redressal of

Any medical practitioner authorised by the TPA/Company shall be allowed to examine the Insured Person 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.

5.9 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..

5.10 SUBROGATION: Subrogation shall mean the right o f the insurer to assume the rights o f the insured person to recover expenses paid out under the policy that may be recovered from any other source

5.11 **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

5.12 **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 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.

5.13 **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.

5.14 **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.

6 **BONUS - LOW CLAIM RATIO DISCOUNT:** Low claim ratio discount at the following scale will be allowed on the total premium at renewal only, depending upon the incurred claims ratio for the entire group insured under the group Mediclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group Mediclaim insurance policy has not been in

force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims Ratio under Group Policy	Discount %age
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	35
Not exceeding 25%	40

7 **MALUS - HIGH CLAIM RATIO LOADING:** The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the group Mediclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group Mediclaim policy has not been in force for three completed years, such shorter period of completed years, excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims Ratio under Group Policy	Loading %age
Between 70% and 100%	25
Between 101% and 125%	55
Between 126% and 150%	90
Between 151% and 175%	120
Between 176% and 200%	150
Above 200%	cover to be reviewed

Note: Low claim ratio discount (Bonus) or High Claim ratio loading (Malus) will be applicable to the premium at renewal of the policy depending on the incurred claims ratio for the entire group insured.

Incurred claims would mean claims paid plus claims outstanding in respect of the entire group insured under the policy during the relevant period

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

9 **RENEWAL OF POLICY:**

If the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (condition 4.1, 4.2 & 4.3 will apply to additional sum insured) as if a separate policy has been issued for the difference, subject to medical check up as per norms of the Company. The cost of Medical check up shall be borne by the insured.

10 **PRE--ACCEPTANCE HEALTH CHECKUP:** Any person beyond 45 years of age desiring to take insurance cover has to submit following medical reports from listed Network Diagnostic Centre or any other medical reports required by the company in case of fresh proposal and renewal where there is a break in policy period.

Age	45-55	ABOVE 55 Years
MEDICAL TEST	PHYSICAL EXAMINATION	PHYSICAL EXAMINATION
	URINE(MICROALBUMIN UREA)	URINE(MICROALBUMIN UREA)
	GLYCOCYLATED, HAEMOGLOBIN	GLYCOCYLATED HAEMOGLOBIN
	ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)	ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)
	ELECTRO CARDIO GRAM	X RAY KNEES ANTI POSTERIOR AND LATREL

11 **Portability** :THIS POLICY IS PORTABLE TO THE EXTENT THAT THE INSURED MEMBER MAY OPT OUT OF THE GROUP AND SWITCH FROM GROUP INSURANCE PLAN TO INDIVIDUAL/FAMILY INSURANCE COVER WITH THE SAME INSURER(THE GROUP INSURER). 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.

12 **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 is Rs 50,000/- and in multiples of Rs 25,000/- upto Rs 2, 00,000/-. Beyond the Sum Insured of Rs. 200000/- in multiples of Rs. 50000/- upto Rs 500000/-.

13 **AUTHORITY TO OBTAIN RECORDS:**

a) The insured person hereby 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 thereunder.

b) The insurer and the TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to a) above and will only use it in connection with any claim made under this policy or the insurer's liability thereunder

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

15 **QUALITY OF TREATMENT :** The insured hereby acknowledges and agrees that payment of any claim by or on behalf of 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.

16 **ID CARDS:** The card issued the Insured Person by the TPA to avail cashless 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 expenses and the policy holder and each insured person agrees to hold and keep harmless, the insurer and the TPA against any or all costs, expenses, liabilities and claims (whether justified or not) arising in respect of the actual or alleged use, misuse of such ID cards prior to their return.

17 **IRDA REGULATION NO.5:** This policy is subject to regulation 5 of IRDA (Protection of Policy Holder interest) regulation.

Part-B: Existing Group Insurance policy for Students

GROUP MEDICLAIM TAILORMADE POLICY SHEDULE

UIN : OICHLGP449V022021

Policy No.	: 124600/48/2022/2647	**Prev. Policy No.**	: -
Cover Note No.	: -	Cover Note Date	: -
Insured's Code	: AA0000073438	Issue Office Code	: 124600
Insured's Name	: INDIRA GANDHI INST. OF DEV. RESEARCH (GSTIN: 27AAATI0014Q1ZO)	Issue Office Name	: MCDO 1 (GSTIN: 27AAACT0627R4ZW)
Address	: GEN. A.K. VAIDYA MARG, FILM CITY ROAD, GOREGAON (EAST), MUMBAI 400063. MUMBAI 400063	Address	: ORIENTAL HOUSE, 4TH FLOOR, 7, J TATA ROAD CHURCHGATE MUMBAI MAHARASHTRA 400020

Agent/Broker Details

Dev.Off.Code	: **NA0000002705 DIRECT (MC DO 1)**
Agent/Broker	:
Address	:
Tel/Fax/Email	: ////

Period of Insurance : FROM 00:00 ON 04/09/2021 TO MIDNIGHT OF 03/09/2022

Collection No. & Dt. : CD A/C AA0000073438 GST INVOICE NO :2720301020 UIN :0

Co-insurance Details : NIL

TPA Details :

TPA ID	:	YA0000000338
TPA Name	:	M/s Raksha Health In
TPA Address	:	15/5, MATHURA ROAD, FARIDABAD crcm@rakshatpa.com; it@rakshatpa.com FARIDABAD 121003

Toll Free No : 18001801444, 0129 - 4289999, 256437

Risk Details

The insurance under this policy is subject to conditions, clauses, warranties,endorsements as per forms attached .

The policy shall pay for hospitalization expenses for medical/surgical treatment at any Nursing Home/Hospital in INDIA as an in-patient defined in the policy

In the event of a claim under the policy exceeding Rs. 1 lac or a claim for refund of premium exceeding Rs. 1 lac,the insured will comply with the provisions of the AML policy of the Company.The AML policy is available in all our operaing offices as well as Company's website.
SELF ONLY. TOTAL STUDENTS: 133,
WAIVER OF CLAUSE 4.1,4.2 & 4.3. Room Rent : 1% & 2% of the Sum Insured. Sum Insured Rs.3 lac per lives
PRE & POST HOSPITALISATION: 30 DAYS & 60 DAYS RESPECTIVELY. Ambulance Charges Rs.1,000/-
11 STUDENTS VIZ. SR. NO. 61 TO 65 & 128 TO 133 COVERED UPTO 31.01.2022

Attached to and forming part of policy number 124600/48/2022/2647

This Document is Digitally Sign

Signer: GEETHA SANTHOSEE
Date: Mon, Sep 6 2021 16:04
Location: NOIDA
Reason: Signing Policy As OIC

7, 360

Telephone No :

Fax No :

Warranted that in case the person covered under the policy has lodged any claim under the previous policy and the sum insured is enhanced under the current policy, for a further claim for the same disease during the current policy, the earlier Limit of Sum Insured shall be applicable and not the enhanced sum insured

Warranted that in case of dishonour of premium cheque(s) the Company shall not be liable under the policy and the policy shall be void abinitio (from inception).

"We at Oriental continuously strive to ensure that you get the best possible treatment from our network hospitals. Please contact your TPA or any of the Oriental offices for our preferred hospitals in your area before going for a treatment. This will help us serve you in the best possible manner"

In witness whereof the undersigned being authorised by and on behalf of the Company has/have herein to set his/their hands at MCDO 1 (GSTIN: 27AAACT0627R4ZW) on 06-SEP-21

" In case of grievance related to any issue related to this policy the same may be addressed to the office In-Charge or the Grievance Officer at above policy address. If the grievance remains pending, it may be escalated to Grievance Officer of the concerned Regional Office ORIENTAL HOUSE,,7TH FLOOR,,7, J TATA ROAD,CHURCHGATE, MUMBAI.The next escalation in case grievance remains unresolved is CSD, Head Office, situated at Oriental House, A-25/27, Asaf Ali Road, New Delhi-110002. If the insured is not satisfied with the resolution/reply provided by the company, he/she may approach the Office of Insurance Ombudsman, within his/her jurisdiction. The list of offices of Ombudsman is available on Company's portal."

Entered By : C.G.HAWLE

Examined By : Ajay R Pote

For and on behalf of
The Oriental Insurance Company Limited

Policy Printed By : 171271 IP :

Policy Printed On : 06-SEP-21 16:01:32 MAC :

Authorised Signatory

MEDICLAIM INSURANCE POLICY (GROUP)

1 WHEREAS the insured named in the Schedule hereto has by a proposal and declaration dated 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 any insured Person shall contract any disease or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require, 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) on domiciliary treatment in India under Domiciliary Hospitalisation Benefits as hereinafter defined, the Company/ TPA will pay to the Hospitals (only if treatment is taken at Network Hospital(s) with prior consent of Company/TPA) or re-imburse to the insured person, as the case may be, the amount of such expenses. It is a precondition that these expenses are reasonably and necessarily incurred in respect thereof by or on behalf of such insured person but not exceeding the sum insured in aggregate in any one period of insurance stated in the schedule hereto.

1.2 The policy reimburses the payment of Hospitalisation and / or Domiciliary Hospitalisation expenses only for illness/diseases contracted or injury sustained by the Insured Persons. In the event of any claim becoming admissible under this policy, the Company/TPA will pay to the hospital (only if treatment is taken at network hospitals with prior consent of Company/TPA) or re-imburse to the insured, as the case may be, the amount of expenses reasonably and necessarily incurred under different heads mentioned below thereof by or on behalf of such Insured Person not exceeding the Sum Insured in aggregate in respect of Insured Person as stated in the schedule for all claims admitted during the period of insurance mentioned in the schedule.

FOLLOWING REASONABLE & CUSTOMARY EXPENSES ARE REIMBURSABLE UNDER THE POLICY

a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1 % of the Sum Insured or Rs. 5000 /- per day whichever is less.

b. I.C. Unit expenses not exceeding 2 % of the Sum Insured or Rs. 10,000 /- per day whichever is less. (Room including I.C.U. stay should not exceed total number of admission days).

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

d. 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..

e. Ambulance services - 1% of the sum insured or Rs 2000/- 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 by registered ambulance only for better medical facilities.

Note:

1. Hospitalization expenses incurred for donating an organ by the donor (excluding cost of organ if any) to the insured person during the course of organ transplant will also be payable. However in any case the liability of the Company will be limited to over all Sum Insured of the Insured Person.

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 OPERATION: Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis
and cure of diseases, relief 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 hours. However,

(A) This time limit will not apply to following specific treatments taken in the Network Hospital/Nursing Home where the Insured is discharged on the same day. Such treatment will 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. Tonsillectomy,
vii. D&C,
viii. Dental surgery following an accident
ix. Hysterectomy
x. Coronary Angioplasty
xi. Coronary Angiography
xii. Surgery of Gall bladder, Pancreas and bile duct
xiii. Surgery of Hernia
xiv. Surgery of Hydrocele.

xv. Surgery of Prostate.
xvi. Gastrointestinal Surgery.
xvii. Genital Surgery.
xviii. Surgery of Nose.
xix. Surgery of throat.
xx. Surgery of Appendix.
xxi. Surgery of Urinary System.
xxii. Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
xxiii. Arthroscopic Knee surgery.
xxiv. Laproscopic therapeutic surgeries.
xxv. Any surgery under General Anaesthesia.
xxvi. Or any such disease / 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 hours Hospitalisation will 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 of 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 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 of the following circumstances:
- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non availability of room in a hospital.

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. Asthma
   ii. Bronchitis,
   iii. Chronic Nephritis and Nephritic Syndrome,
   iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis,
   v. Diabetes Mellitus and Insipidus,
   vi. Epilepsy,
   vii. Hypertension,
   viii. Influenza, Cough and Cold,
   ix. All Psychiatric or Psychosomatic Disorders,

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

Note: Liability of the Company under this clause is restricted as stated in the schedule attached hereto.

3. **OTHER DEFINITIONS AND INTERPRETATIONS :**

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

3.2. 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.

3.3. 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.

3.4. 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.

3.5. 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.

3.6 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.

3.7 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.

3.8 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.

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

3.10 PRE EXISTING DISEASES: 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 will be considered as a part of that pre existing health condition.

3.11ILLNESS
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a. **Acute condition** – An acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/ injury which leads to full recovery.

b. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief o f symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

3.12 INJURY

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

3.13 CONGENITAL ANOMALY

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

a. Internal Congenital Anomaly

which is not in the visible and accessible parts o f the body is called Internal Congenital Anomaly

b. External Congenital Anomaly

which is in the visible and accessible parts o f the body is called External Congenital Anomaly

3.14 **IN-PATIENT:** An Insured person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

3.15 **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 Networked Hospital and the TPA for surgical / medical treatment that is necessary , customary and reasonable for treating the condition for which insured person was hospitalized.

NOTE: Any expenses (as mentioned above) which are not covered under the policy and / or which are not reasonable, customary and necessary, the same have to be borne by the insured person himself.

3.16 **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.

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

3.18 **DAY CARE PROCEDURE**: means the course of Medical treatment / surgical procedure listed at 2.3 (A) carried out, in Networked specialised Day Care Centre which is fully equipped with advanced technology and specialised infrastructure where the insured is discharged on the same day, the requirement of minimum beds will be over looked provided other conditions are met.

3.19 **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 that insured person in respect of hospitalization taking place during currency of the policy.

3.20 ANY ONE ILLNESS: Any one illness means continuous Period of 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.

3.21 MATERNITY EXPENSES AND NEWBORN CHILD COVER BENEFIT EXTENSION:

a. This is an optional cover which can be obtained on payment of 10% of the total basic premium for all the insured persons under the policy. Total basic premium means the total premium computed before applying group discount and /or High Claims Ratio Loading, Low Claim Discount.
b. Option for Maternity Expenses and Newborn Child Cover Benefit Extension has to be exercised at the time of inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during the currency of the policy.
c. Those insured persons who are already having two or more living children will not be eligible for this benefit
d. Claim in respect of only first two children and/or operations associated therewith will be considered in respect of any one insured person covered under the policy or any valid and effective renewal thereof
e. The maximum benefit allowable under this clause will be upto Rs. 50,000/-and would fall under different heads mentioned under item 1.2.. The sum insured under above benefit shall be a part of basic sum insured.

Special conditions applicable to Maternity Expenses & Newborn Child Cover Benefit Extension

a. These benefits are admissible only if the expenses are incurred in hospital/nursing home as in-patients in India.
b. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine Pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.
c. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
d. Pre-natal and post-natal expenses are not covered unless admitted in Hospital/nursing home and treatment is taken there.
e. Pre Hospitalisation and post Hospitalisation benefits are not available under this section.
f. Newly born child shall be covered from day one upto the age of 3 months and expenses incurred for treatment taken in hospital as in patient shall only be payable subject to within the specified sum insured of Rs 50,000/- under Maternity benefit extension. Congenital diseases of newly born child shall be excluded.

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

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 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 4 years of this policy being in force continuously.

This exclusion will also apply to any complications arising from pre existing ailment / diseases / injuries. Such complications will be considered as a part of the pre existing health condition or disease.

Further to this if any 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.

Diabetes	Hypertension	Diabetes & Hypertension
Diabetic Retinopathy	Cerebro Vascular accident	Diabetic Retinopathy
Diabetic Nephropathy	Hypertensive Nephropathy	Diabetic Nephropathy

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

4.2 Any disease other than those stated in clause 4.3, contracted by the Insured person during the first 30 days from the commencement date of the policy except treatment for accidental external injuries.

4.3 During the period of insurance cover, the expenses on treatment of following ailment / diseases / surgeries for specified periods are not payable if contracted and / or manifested during the currency of the policy.

i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
ii	Polycystic ovarian diseases .	1 year
iii	Surgery of hernia.	2 years
iv	Surgery of hydrocele.	2 years
v	Non infective Arthritis.	2 years
vi	Undescendent Testes.	2 Years
vii	Cataract.	2 Years
viii	Surgery of benign prostatic hypertrophy.	2 Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus	2 Years
x	Fissure / Fistula in anus.	2 Years
xi	Piles.	2 Years
xii	Sinusitis and related disorders.	2 Years
xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
xiv	Surgery of genito urinary system excluding malignancy.	2 Years
xv	Pilonidal Sinus.	2 Years
xvi	Gout and Rheumatism.	2 Years
xvii	Hypertension.	2 Years
xviii	Diabetes.	2 Years
xix	Calculus diseases.	2 Years
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
xxi	Surgery of varicose veins and varicose ulcers.	2 Years
xxii	Congenital internal diseases.	2 Years
xxiii	Joint Replacement due to Degenerative condition.	4 Years
xxiv	Age related osteoarthritis and Osteoporosis.	4 Years

If the continuity of the renewal is not maintained, then subsequent cover will be treated as fresh policy and clauses 4.1., 4.2, 4 .3 will apply unless agreed by the Company and suitable endorsement passed on the policy.

4.4 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.

4.5 Circumcision (unless necessary for treatment of a disease not excluded 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, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

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

4.7 Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc unless arising from disease or injury and which requires hospitalisation for treatment.

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 and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.

4.12 Any Treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy. .

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

4.14 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,.

4.15 Genetical disorders and stem cell implantation / surgery.

4.16 External and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps , splints, slings, braces ,Stockings etc of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items etc and also any medical equipment which is subsequently used at home etc.. Exhaustive list available on the website.

4.17 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..

4.18 Change of treatment from one pathy to other pathy unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.

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

4.20 Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.

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

4.23 Any stay in the hospital for any domestic reason or where hospitalization is not required in the opinion of the specialist.

4.23 Out patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.24 Massages, Steam bathing, Shirodhara and alike treatment under Ayurvedic treatment.

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

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

4.27 Treatment which is continued before hospitalization and continued even after discharge for an ailment / disease / injury different from the one for which hospitalization was necessary.

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 (except relating to claim) 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 RENEWAL OF POLICY:

I)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.

II) Not withstanding 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.

III) The Company normally sends renewal notice but not sending it will not tantamount to deficiency in services.

5.4 **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.

5.5 **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.

5.6 **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 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 document must be duly attested by the Insured.

In case of post hospitalisation treatment (limited to 60 days) all supporting claim papers / documents as listed above should also be submitted within 7 days after completion of such treatment (upto 60 days or actual period whichever is earlier) 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 to give such notice or file claim within the prescribed time limit. Otherwise Company / TPA has a right to reject the claim..

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

i) Claim in respect of Cashless Access Services will 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 will 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. 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 days of the discharge from Hospital / Nursing Home.

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

5.8 REPUDIATION :

A 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 5.8 (A), he / she may approach the Ombudsman of Insurance, established by the Central Government for redressal of

Any medical practitioner authorised by the TPA/Company shall be allowed to examine the Insured Person 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.

5.9 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..

5.10 SUBROGATION: Subrogation shall mean the right o f the insurer to assume the rights o f the insured person to recover expenses paid out under the policy that may be recovered from any other source

5.11 **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

5.12 **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 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.

5.13 **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.

5.14 **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.

6 **BONUS - LOW CLAIM RATIO DISCOUNT:** Low claim ratio discount at the following scale will be allowed on the total premium at renewal only, depending upon the incurred claims ratio for the entire group insured under the group Mediclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group Mediclaim insurance policy has not been in

force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims Ratio under Group Policy	Discount %age
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	35
Not exceeding 25%	40

7 **MALUS - HIGH CLAIM RATIO LOADING:** The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the group Mediclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group Mediclaim policy has not been in force for three completed years, such shorter period of completed years, excluding the year immediately preceding the date of renewal will be taken into account.

Incurred Claims Ratio under Group Policy	Loading %age
Between 70% and 100%	25
Between 101% and 125%	55
Between 126% and 150%	90
Between 151% and 175%	120
Between 176% and 200%	150
Above 200%	cover to be reviewed

Note: Low claim ratio discount (Bonus) or High Claim ratio loading (Malus) will be applicable to the premium at renewal of the policy depending on the incurred claims ratio for the entire group insured.

Incurred claims would mean claims paid plus claims outstanding in respect of the entire group insured under the policy during the relevant period

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

9 **RENEWAL OF POLICY:**

If the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (condition 4.1, 4.2 & 4.3 will apply to additional sum insured) as if a separate policy has been issued for the difference, subject to medical check up as per norms of the Company. The cost of Medical check up shall be borne by the insured.

10 **PRE--ACCEPTANCE HEALTH CHECKUP:** Any person beyond 45 years of age desiring to take insurance cover has to submit following medical reports from listed Network Diagnostic Centre or any other medical reports required by the company in case of fresh proposal and renewal where there is a break in policy period.

Age	45-55	ABOVE 55 Years
MEDICAL TEST	PHYSICAL EXAMINATION	PHYSICAL EXAMINATION
	URINE(MICROALBUMIN UREA)	URINE(MICROALBUMIN UREA)
	GLYCOCYLATED, HAEMOGLOBIN	GLYCOCYLATED HAEMOGLOBIN
	ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)	ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)
	ELECTRO CARDIO GRAM	X RAY KNEES ANTI POSTERIOR AND LATREL

11 **Portability** :THIS POLICY IS PORTABLE TO THE EXTENT THAT THE INSURED MEMBER MAY OPT OUT OF THE GROUP AND SWITCH FROM GROUP INSURANCE PLAN TO INDIVIDUAL/FAMILY INSURANCE COVER WITH THE SAME INSURER(THE GROUP INSURER). 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.

12 **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 is Rs 50,000/- and in multiples of Rs 25,000/- upto Rs 2, 00,000/-. Beyond the Sum Insured of Rs. 200000/- in multiples of Rs. 50000/- upto Rs 500000/-.

13 **AUTHORITY TO OBTAIN RECORDS:**

a) The insured person hereby 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 thereunder.

b) The insurer and the TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to a) above and will only use it in connection with any claim made under this policy or the insurer's liability thereunder

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

15 **QUALITY OF TREATMENT :** The insured hereby acknowledges and agrees that payment of any claim by or on behalf of 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.

16 **ID CARDS:** The card issued the Insured Person by the TPA to avail cashless 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 expenses and the policy holder and each insured person agrees to hold and keep harmless, the insurer and the TPA against any or all costs, expenses, liabilities and claims (whether justified or not) arising in respect of the actual or alleged use, misuse of such ID cards prior to their return.

17 **IRDA REGULATION NO.5:** This policy is subject to regulation 5 of IRDA (Protection of Policy Holder interest) regulation.