Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
For more details, log on to: www.bajajallianz.com | E-mail: bagichelp@bajajallianz.co.in or
Call at: Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)
Issuing Office:

Caringly yours

BAJAJ ALLIANZ CREDIT LINKED GROUP HOSPITAL CASH POLICY

Policy Wordings

SECTION A) PREAMBLE

Whereas the Policy Holder has made to Bajaj Allianz General Insurance Company Ltd (hereinafter called the "Company" or "Insurer"), a proposal which is hereby agreed to be the basis of this Master Policy and the Certificate of Insurance to be issued thereunder, and has paid the premium specified in the Policy Schedule, now the Company agrees, subject always to the following terms, conditions, exclusions, and limitations, to pay the Insured Person, the Sum Assured against daily allowance as specified in the Certificate of Insurance, in case of hospitalization is incurred within the Cover period.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

1. **Accident, Accidental :**
An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

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

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

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

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

7. **Hospital:**
A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the Insurance Company's authorized personnel.

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

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

10. **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.

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

12. **Intensive Care Unit**
Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require

life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

13. **Maternity expenses:**
Maternity expenses means;
a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b) expenses towards lawful medical termination of pregnancy during the Policy Period.

14. **Medical Practitioner/ Physician** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license provided he is not in any way related to the Insured Beneficiary.

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

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

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

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

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

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

SECTION B) DEFINITIONS- SPECIFIC DEFINITIONS

1. **Bajaj Allianz Network Hospitals / Network Hospitals**- mean the Hospitals which have been empanelled by the Company as per the latest version of the schedule of Hospitals maintained by the Company [as updated by the Company from time to time], which is available to the Insured Person on request and also available on website of the Company.

2. **Certificate of Insurance** means the document issued by the Company to the Insured Person as per these terms and conditions detailing the commencement date and expiry date of the cover, Insured Person(s) name, address, age, coverage, sums insured, condition(s), exclusions and or endorsement(s).

3. **Daily Allowance** means the amount specified in the Policy Schedule

4. **Group** The definition of a group as per the provisions of Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016, read with group guidelines issued by IRDAI vide circular 015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005, as amended/modified/further guidelines issued, from time to time

5. **Insured Person/ Insured Beneficiary** mean the loan borrowers of Policy Holder for whom the Policy Holder has taken the Group Insurance Policy basis which Certificate of Insurance is issued by the Company to the Insured Person/Insured Beneficiary.

6. **Master Policy shall** mean the group Policy issued to the Policy Holder containing the terms and conditions of the insurance coverage and under which Certificates of Insurance shall be issued to the Insured Beneficiary. The validity of the Master Policy shall be for a period of twelve months as mentioned in the Group Policy Schedule.

7. **Policy** means the proposal, the Certificate of Insurance, the Master Policy/ Bajaj Allianz Group Hospital Cash Insurance Policy Schedule, the Policy documents,
these Terms and Conditions and any endorsements attaching to or forming part hereof either on the commencement date or during the Policy Period.

8. **Policy Holder** is the Organization or Entity which has taken the Policy on behalf of all Insured Persons/Insured Beneficiary.

9. **Policy Period**: means period for which the Insured Person/Insured Beneficiary is covered under the Certificate of Insurance.

10. **Master Policy Period**: means period for which the Master Policy is valid in the name of Insured.

11. **Policy Schedule** means the Bajaj Allianz Group Hospital Cash Insurance Policy Schedule and any annexure to it read with respective Certificate of Insurance.

12. **Sum Assured** means the amount stated in the Certificate of Insurance against each relevant Section, which shall be the Company's maximum liability under this Policy.

13. **You, Your, Yourself** the Insured Person/Insured Beneficiary as set out in the Certificate of Insurance.

14. **We, Our, Ours, the Company, Insurer** means the Bajaj Allianz General Insurance Company Limited.

SECTION C) COVERAGE

Eligibility

- Loan Borrowers of Ratnakar Bank Limited (RBL) and their Spouse can be covered under this Group Policy

Policy Period under Certificate of Insurance:

- 1 Year

OPERATIVE PART

In the event of Insured Person being hospitalized for the treatment of Accidental Injury or Sickness or Maternity treatment within the Policy Period, the Company will pay daily allowance of INR 1000, for each consecutive period of 24 hours of Hospitalization in Room and/ or Intensive Care Unit (ICU) of a Hospital for a maximum period of 30 days during each Policy Period.
Note: Daily Allowance for Hospitalization due to Maternity treatment for the delivery of baby (including caesarean section) and/or Medical Termination of Pregnancy [MTP] will be limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the Insured Person.

SECTION D) EXCLUSIONS - STANDARD EXCLUSIONS

The Company will not be liable to make any payment for any claim for daily allowance, directly or indirectly caused by, based on, arising out of or attributable to any of the following:

1. Obesity/Weight Control (Excl06)
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);

a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnea
   iv. Uncontrolled Type2 Diabetes

2. Cosmetic or plastic Surgery (Excl08)
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
3. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- (Excl12)
4. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. (Excl14)
5. Unproven Treatments (Excl16)
   Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

SECTION D) EXCLUSIONS - SPECIFIC EXCLUSIONS

1. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.
2. Circumcision unless required for the treatment of Illness or Accidental Injury, cosmetic or aesthetic treatments of any description, treatment or surgery for change of life/gender.
3. Any form of plastic surgery unless necessary for the treatment of cancer, burns or accidental Injury.
4. Dental treatment or Dental surgery of any kind unless as a result of Accidental Injury to natural teeth and also requiring hospitalization.
5. Convalescence, general debility, rest cure, congenital external diseases or defects or anomalies, stem cell implantation or surgery, or growth hormone therapy.
6. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)
7. Ailments requiring treatment due to use or abuse of any substance, drug or alcohol and treatment for de-addiction.
8. Any condition directly or indirectly caused by or associated with Human Immunodeficiency Virus or Variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS.
9. Medical Expenses relating to any hospitalisation primarily and specifically for diagnostic, X-ray or laboratory examinations and investigations.
10. Any claim directly or indirectly caused by or contributed to by nuclear weapons and/or materials.
11. Vaccination or inoculation unless forming a part of post bite treatment.

12. Any fertility, sub fertility, impotence, assisted conception operation or sterilization procedure.
13. Treatment for any other system other than modern medicine (also known as Allopathy)
14. Venereal disease or any sexually transmitted disease or sickness.
15. Treatment for any mental illness or psychiatric illness, Parkinson's and Alzheimer's disease.
16. Any natural peril including but not limited to avalanche, earthquake, volcanic eruptions or any kind of natural hazard.
17. Radioactive contamination.

SECTION E) CONDITIONS - STANDARD GENERAL TERMS AND CLAUSES

1. Disclosure of information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.
(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability

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

3. Moratorium Period:

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

4. Claim Settlement. (provision for Penal interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

5. Multiple Policies

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

6. Renewal of Policy

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

7. Fraud

i. If any claim made by the Insured beneficiary, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured beneficiary or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
ii. Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
iii. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured beneficiary or by his agent or the hospital/ doctor/any other party acting on behalf of the Insured beneficiary, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured beneficiary does not believe to be true;
b) the active concealment of a fact by the Insured beneficiary having knowledge or belief of the fact;
c) any other act fitted to deceive; and

d) any such actor omission as the law specially declares to be fraudulent
The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured beneficiary / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer

8. Possibility of Revision of Terms of the Policy Including the Premium Rates:
The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

9. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

10. Portability
The Insured beneficiary will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed
Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

11. Migration
The Insured beneficiary will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

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

13. Free Look Period
The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.
The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.
If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

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

15. Cancellation

i. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below

PERIOD ON RISK	RATE OF PREMIUM REFUNDED
Upto one month	75% of annual rate
Upto three months	50%of annual rate
Upto six months	25% of annual rate
Exceeding six months	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

16. Grievance Redressal Procedure

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

1. Our toll-free number 1-800-209- 5858 or 020-30305858, say Say "Hi" on WhatsApp on +91 7507245858
2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website www.bajajallianz.com/branch-locator.html
3. Register your grievances / complaints on our website www.bajajallianz.com/about-us/customer-service.html
4. E-mail

a) Level 1: Write to bagichelp@bajajallianz.co.in and for senior citizens to seniorcitizen@bajajallianz.co.in
b) Level 2: In case you are not satisfied with the response given to you at Level 1 you may write to our Grievance Redressal Officer at ggro@bajajallianz.co.in
c) Level 3: If in case, your grievance is still not resolved, and you wish to talk to our care specialist, please give a missed call on +91 80809 45060 OR SMS To 575758 and our care specialist will call you back

5. If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at www.cioins.co.in/ombudsman.html

The contact details of the Ombudsman offices are mentioned in **Annexure I**

SECTION E) CONDITIONS – SPECIFIC TERMS AND CLAUSES

17. Communications

Any communication meant for the Company must be in writing and be delivered to the Company's Servicing Office address shown in the Policy Schedule. Any communication meant for the Insured Person will be sent by the Company to the Insured Person's address shown in the Certificate of Insurance.

18. Entry Age

- Age of entry is from 18 years to lifetime.

19. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except the Company.
Any change that the Company make will be evidenced by a written endorsement signed and stamped by the Company

20. Addition /Deletion of Insured Person(s):

No person other than those persons named as the Insured Person(s) or those categories of the Insured Persons specified in the Policy Schedule shall be covered under this Policy unless and until his/her name or the category has been notified in writing to the Company, any additional premium due has been paid and the Company's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person or category of persons as an Insured Persons.
Cover under Certificate of Insurance shall be withdrawn from any Insured Person(s) named or any category of Insured Beneficiaries Insured immediately upon the Policy Holder delivering written notice of the same to the Company.

21. Territorial Limits & Governing Law

i. The Company cover only insured events arising during the Policy Period, as well as treatment availed, within India. The Company's liability to make any payment shall be to make payment within India and in Indian Rupees only.
ii. The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by an endorsement on the Policy Schedule.
iii. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

22. Special Conditions relating to Group Policy

All group policies are subject to the following conditions:

1. The Policy Holder will maintain sufficient deposit or provide a Bank Guarantee to strictly comply with the requirement of section 64VB.
2. New names can be added to the existing group policies by charging pro-rata premium for the unexpired Policy Period.
3. For deletion of names from Group Policies during the currency of the Policy, refund of pro- Rata premium can be allowed only if there is no claim in respect of the particular Insured Person at the expiry of the policy only.

23. Arbitration and Reconciliation

i. 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 decision of a sole arbitrator 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 the arbitrators comprising of two arbitrators, one 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 in English under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996. The law of the arbitration will be Indian law, and the seat of the arbitration and venue for all hearings shall be in Pune.

ii. 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 claim under the Policy.
iii. 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.
iv. It is also hereby further expressly agreed and declared that if the Company shall disclaim liability 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 or proceeding before a Court of law or any other competent statutory forum/tribunal, then all benefits under the Policy shall be forfeited and the rights of Insured shall stand extinguished and the liability of the Company shall also stand discharged.
v. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

SECTION E) CONDITIONS – OTHER TERMS AND CONDITIONS

24. Claims Procedure

All Claims will be settled by In house claims settlement team of the company and no TPA is engaged. However, Company reserves right to engage TPA.

After the Occurrence of an Insured Event that may result in a claim, then as a condition precedent to the Company's liability, the Insured Person must comply with the following:

i. The Insured Person or someone claiming on the Insured Person's behalf must inform the Company within 48 hours* of hospitalization in case emergency hospitalization and 48 hours* prior to hospitalization in case of planned hospitalization
ii. The Company shall make payment when the Insured Person or Insured Person's representative claiming on his/ her behalf have provided the Company with necessary documentation and information.
iii. The Insured Person or someone claiming on his/her behalf must promptly and in any event within 30 days* of discharge from a Hospital give the Company the documentation as listed out in greater detail below and other information the Company ask for to investigate the claim or the Company's obligation to make payment for it.
iv. In the event of the death of the Insured Person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 30 days*
v. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted
vi. The Company shall make payment to the Insured Person and if the Insured Person is totally incapacitated or deceased the Company shall make payment to the nominee and if there is no nominee to the legal heir/s, executor and any payment by the Company in this way will be a complete and final discharge of the Company's liability to make payment.
vii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per Policy terms and conditions, Company shall offer a settlement of the claim to the Insured Person. Upon acceptance of an offer of settlement by the Insured Person, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured Person. We will settle the claim within thirty (30) days of the receipt of the last necessary document. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.
viii. If the Company, for any reasons decides to reject the claim under the Policy the reasons regarding the rejection shall be communicated to the Insured Person in writing within 30 days of the receipt of documents. The Insured Person may take recourse to the Grievance Redressal procedure stated under policy.

*Note: Waiver of conditions (I), (iii) and (iv) 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 Person was placed it was not possible from him/her or any other person to give notice or file claim within the prescribed time limit.

List of claim documents

- Hospital Cash Claim Form duly signed by the Insured Person / Nominee (in case of death of Insured person)
- Copy of Discharge Summary / Discharge Certificate.
- Copy of Final Hospital Bill
- NEFT Details
- In cases where a fraud is suspected, we may call for any additional document(s) in addition to the documents listed above

All documents related to claims should be submitted to:
Health Administration Team
Bajaj Allianz General Insurance Co. Ltd
2nd Floor, Bajaj Finserv Building, Viman Nagar, Pune 411014
Toll Free no: 1800 209 5858

Annexure I
Contact details of the Ombudsman offices

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu

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Office Details	Jurisdiction of Office Union Territory,District)
BENGALURU - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL - Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR – Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI - Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)
DELHI – Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

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Office Details	Jurisdiction of Office Union Territory,District)
Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	
HYDERABAD - Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM – Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW – Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar..
MUMBAI - Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA - Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi,

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Office Details	Jurisdiction of Office Union Territory,District)
4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA – Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).