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

SURAKSHA CHAKRA

Policy Wordings

SECTION A) PREAMBLE

Whereas the Insured described in the Schedule hereto (hereinafter called 'the Insured') by a Proposal and declaration which shall be the basis of this Contract and is deemed to be incorporated herein has applied to Bajaj Allianz General Insurance Company Limited (hereinafter called 'the Company') for the insurance hereinafter contained and has paid the premium as stated in the Schedule hereto as consideration for the indemnity hereinafter contained. This Policy records the entire agreement between us and sets out what we insure, how we insure it, and what we expect of you.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

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

2. **Cashless facility:**
Cashless facility means a facility extended by the Insurer to the Insured where the payments, of the costs of 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 pre-authorization is approved.

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

4. **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

5. **Day care centre:**
A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -up with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-
   i. has qualified nursing staff under its employment,
   ii. has qualified medical practitioner(s) in charge,
   iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
   iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

6. **Day Care Treatment:**
Day care treatment means medical treatment, and/or surgical procedure which 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.

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

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

8. **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.

9. **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.

10. **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.

SURAKSHA CHAKRA

11. 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.

12. 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.

13. Injury/Bodily 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.

14. 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.

15. 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.

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

17. Medical expenses:
Medical Expenses means those expenses that an Insured has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured had not been Insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

18. Medical Practitioner/Doctor/ Physician:
Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy or Ayurvedic and or such other authorities set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license

19. Medically Necessary Treatment:
Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

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

20. 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.

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

22. 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.

23. 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.

24. Post-hospitalization Medical Expenses:
Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:

a. Such Medical Expenses are for the same condition for which the Insured Person's hospitalization was required, and
b. The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.

25. Pre-Existing Disease:
Pre- existing disease means any condition, ailment or injury or disease

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement **Or**

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

26. Pre-hospitalization Medical Expenses:
Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

27. Qualified Nurse:
Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

28. Reasonable and Customary charges
Reasonable and Customary charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

29. 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.

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

SECTION B) DEFINITIONS- SPECIFIC DEFINITIONS

1. Acquired Immune Deficiency Syndrome
means the meanings assigned to it by the World Health Organization. Acquired Immune Deficiency Syndrome shall include HIV (Human Immunodeficiency Virus), encephalopathy (dementia), HIV Wasting Syndrome, and ARC (AIDS Related Complex).

2. Adventure Sports
Adventure sports (also called action sports, aggro sports, and Extreme sports) are a popular term for certain activities perceived as having a high level of inherent danger. These activities often involve speed, height, a high level of physical exertion, and highly specialized gear such as racing on wheels or horseback, big game hunting, mountaineering, winter sports, Skydiving, Parachuting, Scuba Diving , Riding or Driving in Races or Rallies, Mountain Climbing, hunting or equestrian activities, rock climbing, pot holing, bungee jumping, skiing, ice hockey, ballooning, hand gliding, diving or under-water activity river rafting, canoeing involving rapid waters, polo, yachting or boating outside coastal waters.

3. Age
means completed years as at the commencement date of the policy.

4. Bajaj Allianz Network Hospitals / Network Hospitals/Network Provider
means the Hospitals which have been empanelled by Us as per the latest version of the schedule of Hospitals maintained by Us, which is available to You on request. For updated list please visit our website www.bajajallianz.com

5. Insured/ Insured Person:
Insured means the person named in the Schedule

6. Nominee
Nominee is the person selected by the policyholder to receive the benefit in case of death of the insured thus giving a valid discharge to the insurer on settlement of claim under an insurance policy.

7. Permanent Total Disability
Medical practitioner certified total, continuous and permanent:
a. loss of the sight of both eyes
b. physical separation of or the loss of ability to use both hands or both feet
c. physical separation of or the loss of ability to use one hand and one foot
d. loss of sight of one eye and the physical separation of or the loss of ability to use either one hand or one foot

8. Permanent Partial Disability
Medical practitioner certified total and continuous loss or impairment of a body part or sensory organ

9. Policy
This Policy Document, the Schedule and the Proposal, declaration and applicable Endorsements under the Policy. The Policy contains the details of the extent of cover available to the Insured, the Exclusions under the cover and the terms, conditions, warranties and limitations.

10. Policy Schedule
means the policy schedule attached to and forming part of the policy.

11. Policy Period
The period between and including the start and end dates shown in the schedule

12. Proposal and Declaration Form
means any initial or subsequent declaration made by the Insured Person and is deemed to be attached and which forms a part of this Policy

13. Scheduled Airline means any civilian aircraft operated by a civilian scheduled air carrier holding a certificate, license or similar authorization for civilian scheduled air carrier transport issued by the country of the aircraft's registry, and which in accordance therewith flies, maintains and publishes tariffs for regular passenger service between named cities at regular and specified times, on regular or chartered flights operated by such carrier

14. Sum Insured
means the sum as specified in the Schedule to this Policy against the name of Insured Person, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period against the respective benefit(s) for which the sum is mentioned in the Schedule to this Policy

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

16. We, Us, Our, Ours means the Bajaj Allianz General Insurance Company Limited.

SECTION C) BENEFITS COVERED UNDER THE POLICY

OPERATIVE PARTS

Part I: PERSONAL ACCIDENT COVER

a) DEATH
If during the Policy Period, the Insured Person sustains Accidental Bodily Injury which directly and independently of all other causes results in Death of the Insured Person within twelve (12) months from the Date of accident, then the Company agrees to pay the Section I Sum Insured stated in the Policy Schedule, to the Insured Person's assignee, as the case may be (as per the Proposal Form read with the provisions of Section 38 Insurance Amendment Act 2015) and in the absence of an assignee to the Nominee or legal representative. Provided however in case the assignment is partial assignment/conditional assignment, then the payment of Sum Insured upon Death of the Insured shall depend upon and subject to terms and conditions of such partial assignment/conditional assignment.

Additional Benefits:
If the claim under Section I (a): Death is accepted for the Insured Person, then the Company will pay for the following additional expenses which will be over and above the Sum Insured:

i. Transportation of mortal remains
The Company will make an additional payment of 1% of the sum insured as specified in policy schedule under Section I as a lump sum benefit amount towards the expenses of transporting the body remains of the Insured Person from the place of death to a hospital or cremation ground or burial ground or to the Insured Person's residence.

ii. Funeral Expenses
The Company will make an additional payment of 1% of the Sum insured as specified in policy schedule under Section I as a lump sum benefit amount towards Funeral Expense of the deceased Insured Person.
The claim amount shall be paid to the nominee or legal representative of the Insured Person.

Extensions:

a. **Disappearance**
Disappearance: In the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, it shall be deemed after twelve (12) months, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as the result of an Accident. If at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, all payments shall be reimbursed in full to the Company.
Disappearance: In the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, it shall be deemed after twelve (12) months, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as the result of an Accident. If at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, all payments shall be reimbursed in full to the Company.

b) PERMANENT TOTAL DISABILITY
If during the Policy Period, the Insured Person sustains Accidental Bodily Injury which directly and independently of all other causes results in permanent total disability within twelve (12) months from the Date of accident, then the Company agrees to pay 125% of Section I Sum insured stated in the Policy Schedule.
For the purpose of this cover, Permanent Total Disability shall mean either of the following:

i. loss of the sight of both eyes
ii. physical separation of or the loss of ability to use both hands or both feet
iii. physical separation of or the loss of ability to use one hand and one foot
iv. loss of sight of one eye and the physical separation of or the loss of ability to use either one hand or one foot

Additional Benefits:
If claim under Permanent Total Disability of the insured person is accepted, then the company will pay the following additional benefit which will be over and above the Sum Insured:

i. Lifestyle Modification Benefit:
The Company will make an additional payment of 2% of the Section I Sum insured as a lump sum benefit amount towards lifestyle modifications such as modification of place of residence and / or modification of the vehicle for Insured Person.
If we become liable to make payment under Death / or Permanent Total Disability due to accidental bodily injury, then this insurance will cease as far as the Insured member is concerned.

c) PERMANENT PARTIAL DISABILITY

If during the Policy Period, the Insured Person sustains Accidental Bodily Injury which directly and independently of all other causes results in Permanent Partial Disability within twelve (12) months from the Date of accident, then the Company agrees to pay the percentage shown in the table below applied to the Sum Insured as stated under the Section I of the Policy Schedule.

Hearing of both ears	75%
An arm at the shoulder joint	70%
A leg above mid-thigh	70%
An arm above the elbow joint	65%
An arm beneath the elbow joint	60%
A leg up to mid-thigh	60%
A hand at the wrist	55%
A leg up to beneath the knee	50%
An eye	50%
A leg up to mid-calf	45%
A foot at the ankle	40%
Hearing of one ear	30%
A thumb	20%
An index finger	10%
Sense of smell	10%
Sense of taste	5%
Any other finger	5%
A large toe	5%
Any other toe	2%

For Permanent Partial Disability listed in the above table, the disability percentage certified by the treating doctor would be considered for the claim process.
If the Permanent Partial Disability is not listed in the table, then the disability percentage certified by the Government Civil Surgeon would be considered for claim process. The Company will pay the percentage shown in the certificate, applied to the Sum Insured as stated under the Section I of the Policy Schedule

If more than one Permanent Partial Disability loss has resulted due to accidental Injury, the claim amount payable for all such losses put together should not exceed the total Sum Insured under this section.

If we become liable to make payment under Death / or Permanent Total Disability due to accidental bodily injury, then this insurance will cease as far as the insured member is concerned.

Note:
The additional benefits payable under Section I will be over and above the sum insured.

Part II - ACCIDENTAL HOSPITALIZATION EXPENSES

If You are hospitalized for a minimum period of 24 hours on the advice of a Doctor because of Accidental Bodily Injury sustained during the Policy Period, then We will reimburse You, the In-patient Treatment- Medical Expenses incurred up to a maximum sum insured mentioned in the schedule for this section which would include:

- Room rent, boarding expenses
- Nursing
- Intensive care unit
- Consultation fees
- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
- Medicines, drugs and consumables,
- Diagnostic procedures,
- The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.
- Physiotherapy expenses as recommended by the treating Doctor

Day Care procedure coverage:

Waiver of 24hours hospitalization would be considered under Accidental Hospitalization Expenses for the surgeries/procedures due to technological advancement provided such procedures comply with the standard definition of Day Care Centre and Day Care treatment mentioned in the Policy definitions. The Pre and Post Hospitalisation expenses payable under day care procedure shall include expenses incurred on Physiotherapy also.
If the claim under Accidental Hospitalization Expenses (including day care procedure) due to Accident of the Insured Person is accepted, then the Company will also pay below expenses:

i) Pre Hospitalization

If the Company has accepted an inpatient Hospitalization claim under Accidental Hospitalization Expenses then the Company will also reimburse the Medical Expenses incurred during the 60 days immediately before the Insured Person was hospitalized for Accidental Bodily Injury, provided that such Medical Expenses were incurred for the same injury for which subsequent Hospitalization was required.

ii) Post-Hospitalization

If the Company has accepted an inpatient Hospitalization claim under Accidental Hospitalization Expenses then the Company will also reimburse the Medical Expenses incurred during the 90 days immediately after the Insured was discharged post Hospitalization provided that, such costs are incurred in respect of the same injury for which the earlier Hospitalization was required.

Part III – ROAD AMBULANCE COVER

This section covers the following:

a. If due to an Accidental Bodily Injury sustained by the Insured Person during the Policy Period, he/she has been transferred to the nearest hospital from the spot of Accident by an ambulance service offered by a healthcare or ambulance service provider, we will reimburse the actual expenses incurred for ambulance services.

b. The Company will also reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider for transferring the Insured Person from the Hospital where he/she was admitted initially to another hospital with higher medical facilities provided that the treating doctor recommends Insured Person's transfer to a higher medical centre for further treatment.

Provided that the maximum amount payable by the Company in respect of (a) and (b) together or singly shall not exceed the Sum Insured stated in the Policy Schedule against this Section.

Specific Conditions :

a. Expenses for Road ambulance transportation are restricted within India Only.
b. Return transportation to the Insured's home by ambulance is excluded

Part IV - HOSPITAL CASH BENEFIT

The Company will pay per day benefit amount for each complete calendar day that the Insured Person had to be hospitalized for medical reasons because of the Accidental Bodily injury met with. Per day benefit would be as specified under the Policy Schedule for a maximum period of 60 days per Policy Period.
For the purpose of this benefit, each compete calendar day shall mean a period of 24 hrs from the time of admission as in patient in the hospital.

Specific Condition Applicable to Hospital Cash Benefit

The final settlement of claim amount will be decided based on the final hospital bill having details of number of days the insured was hospitalized.

Part V – LOAN PROTECTOR COVER

If the Insured Person sustains Accidental Bodily Injury during the Policy Period that results in his/ her Death or Permanent Total Disability within 12 months and the claim is accepted and paid under Section I, then the Company will pay the outstanding Loan amount of the Insured Person's loan account as on the date of accident, subject to a maximum of the Sum Insured shown under the Policy Schedule for this Section. The outstanding Loan amount would not include any arrears due to any reasons whatsoever. The claim payable under this cover shall be in addition to the benefit payable under the Section I Death or Permanent Total Disability.

Part VI: LOSS OF INCOME DUE TO DISABILITY FROM ACCIDENT

If the insured person sustains Accidental Bodily Injury during the Policy Period which directly and independently of all causes temporarily and completely prevents the insured person from performing each and every duty pertaining to his employment or occupation, then the company will make a weekly payment as per the weekly benefit amount shown under the heading "Loss of income due to Disability from Accident" in the Policy schedule.
The company shall make weekly payment/s for the disability period as specified by the treating doctor for a maximum period of 100 weeks at the rate of INR 1000 per week.

Specific Conditions:

a. The bodily injury sustained should be detectable by means of clinical examination and radiological scanning or imaging ;
b. Injuries to the spine, the ligamentous system, cartilage and nervous system should be detectable by means of radiological scanning or imaging or neurological fallout testing
c. If the bodily injury sustained is not detectable by means of clinical examination and radiological scanning and imaging or neurological fallout testing , then the company shall not be liable in respect of the insured person for any claim under this cover ;
d. We will stop making payments when we are satisfied that you can engage in your occupation again, or when we have made payments for a maximum period of 100 weeks from the date you met with the Accidental Bodily Injury, whichever is earlier;
e. In case the temporary total disablement is for a period less than a week, the benefit payable shall be calculated on proportionate basis in relation to the weekly benefit.
f. In the event of a dispute arising with regards to the duration of Temporary total disability, the duration shall be finally determined by a physician mutually appointed by both the parties, who certifies the final date upon which the insured person recovered and fit to perform each and every duty pertaining to his / her employment or occupation.

Part VII: COMA DUE TO ACCIDENTAL BODILY INJURY

If the Insured Person meets with an Accidental Bodily Injury during the Policy Period which directly and independently of all other causes results in the Insured Person being in a Hospital in a Comatose State, within one (1) calendar month from the Date of Accident, then the Company agrees to pay the lump sum benefit as mentioned in the Policy Schedule.

Definition of Coma/ Comatose State:

A state of unconsciousness with no reaction or response to external stimuli or internal needs, this diagnosis must be supported by evidence of all of the following:

a. No response to external stimuli continuously for at least 96 hours;
b. Life support measures are necessary to sustain life; and
c. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
d. Condition has to be confirmed by a specialist medical practitioner.

SECTION D) EXCLUSIONS - STANDARD EXCLUSIONS

1. Exclusion Applicable to Accidental Hospitalization Cover:

1) 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.

2) 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)

3) 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.

2. Exclusion Applicable to Hospital Cash Benefit

1) 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.

2) 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)

3. General Exclusions (Applicable to all Sections)

1) Hazardous or Adventure sports: Code- Excl09
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

2) Breach of law (Excl10)
Expenses for treatment directly arising from or consequent upon any Insure Person committing or attempting to commit a breach of law with criminal intent.
3) Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Excl12)

4) Maternity (Excl 18) :
a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SECTION D) EXCLUSIONS - SPECIFIC EXCLUSIONS

1. Exclusion Applicable to Accidental Hospitalization Cover:
1) Any Hospitalization for an existing disability from a previous Accident which has occurred prior to the first inception of this Policy.
2) Any stay in Hospital for an Injury due to Accident without undertaking any treatment.
3) Any Hospitalization for Accidental Injury aggravated by an existing disability or pre-existing illness / condition / injury.
4) Any Hospitalization due to an Accidental Injury where the treatment is undertaken by a family member and self- medication or any treatment that is not scientifically recognized.
5) Vaccination and inoculation of any kind unless forming part of treatment for Injury due to an Accident as prescribed by the Medical Practitioner.
6) Treatment taken from persons not registered as Medical Practitioners under respective Medical Councils.
7) Any other medical or surgical treatment except as may be necessary solely as a result Injury.
8) Any treatment taken outside India.
9) Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization.

2. Exclusion Applicable to Hospital Cash Benefit:
1) Any Hospitalization for an existing disability from a previous Accident which has occurred prior to the first inception of this Policy.
2) Any stay in Hospital for an Injury due to Accident without undertaking any treatment.
3) Any Hospitalization for Accidental Injury aggravated by an existing disability or pre-existing illness / condition / injury.
4) Any Hospitalization due to an Accidental Injury where the treatment is undertaken by a family member and self-medication or any treatment that is not scientifically recognized.
5) Vaccination and inoculation of any kind unless forming part of treatment for Injury due to an Accident as prescribed by the Medical Practitioner.
6) Treatment taken from persons not registered as Medical Practitioners under respective Medical Councils.
7) Any other medical or surgical treatment except as may be necessary solely as a result Injury.
8) Any treatment taken outside India.

3. Exclusion Applicable to Coma Due To Accidental Bodily Injury
a. Coma resulting directly from alcohol or drug abuse or any other disease other than Accidental Bodily Injury is excluded.

4. General Exclusions (Applicable to all Sections)
The Company will not be liable to make any payment under this Policy under any circumstances, for any claim directly or indirectly attributable to, or based on, or arising out of, or connected with any of the following:

1) Any Pre-existing Condition(s) and complications arising out of or resulting therefrom;
2) Through suicide, attempted suicide (whether sane and insane) or intentionally self-inflicted injury or illness,
3) Mental or nervous disorder , anxiety , stress or depression,
4) While under the influence of liquor or drugs , alcohol or other intoxicants,
5) Through deliberate or intentional, unlawful or criminal act, error, or omission, participation in an actual or attempted felony , riot , crime , misdemeanour , civil commotion,
6) Whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world ,
7) Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs,
8) As a result of any curative treatments or interventions that you carry out or have carried out on your body,
9) Arising out of your participation in any police ,naval, military or air force operations whether peace or in war in the form of military exercises or war games or actual engagement with the enemy, Whether foreign or domestic,
10) Your consequential losses of any kind or your actual or alleged legal liability.
11) Venereal or sexually transmitted diseases,
12) HIV (Human Immunodeficiency Virus) and/or any HIV related illness including AIDS (Acquired Immune Deficiency Syndrome) and/or mutant derivatives or variations thereof however caused,
13) War (whether declared or not), civil war, invasion, act of foreign enemies, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraint or detainment, confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority, or
14) Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from burning nuclear fuel,
15) The radioactive, toxic, explosive or other dangerous properties of any explosive nuclear equipment or any part of that equipment,
16) Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft; or Scheduled Airlines; or Whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world,
17) Any claim caused by osteoporosis (porosity and brittleness of the bones due to loss of protein from the bones matrix) or pathological fracture (any fracture in an area where pre-existing Disease has caused the weakening of the bone) if osteoporosis or bone Disease diagnosed prior to the Policy Effective Date,
18) No benefit under this policy would be paid, unless the nature & extent of injury is established medically with appropriate investigation reports & certified by the treating doctor
19) Expenses incurred on neck belts, wrist bandages, walking sticks, abdomen belts, CPAP and any other similar external aid /devices, the use of which has been necessitated following an accident.

SECTION E) GENERAL TERMS AND CLAUSES - 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.

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. 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.
(Explanation “Bank rate” shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

4. 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.

5. 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.

6. 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.

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. 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.

9. 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

10. Multiple Policies

If two or more policies are taken by You during a period from one or more insurers to indemnify treatment costs, You shall have the right to require a settlement of your claim in terms of any of your policies.

a. In all such cases the insurer who has issued the chosen policy 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.
b. Claims under other Policy/ies may be made after exhaustion of Sum Insured in the earlier chosen Policy / Policies.
c. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

11. Migration of Policy:

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. 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

13. 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

14. 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.

15. 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:**

16. Cancellation

i. The policyholder may cancel this policy by giving 15days'written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Period in Risk	Premium Refund		
	Policy Period 1 Year	Policy Period 2 Year	Policy Period 3 Year
Within 15 Days	Pro Rata Refund		
Exceeding 15 days but less than 3 months	65.00%	75.00%	80.00%
Exceeding 3 months but less than 6 months	45.00%	65.00%	75.00%
Exceeding 6 months but less than 12 months	0.00%	45.00%	60.00%
Exceeding 12 months but less than 15 months		30.00%	50.00%
Exceeding 15 months but less than 18 months		20.00%	45.00%
Exceeding 18 months but less than 24 months		0.00%	30.00%
Exceeding 24 months but less than 27 months			20.00%
Exceeding 27 months but less than 30 months			15.00%
Exceeding 30 months but less than 36 months			0.00%

Note:

- The first slab of Number of days "within 15 days" in above table is applicable only in case of new business.
  In case of renewal policies, period is risk "Exceeding 15 days but less than 3 months" should be read as "within 3 months".

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.

SECTION E) GENERAL TERMS AND CLAUSES - SPECIFIC TERMS AND CLAUSES

17. Reasonable Care

The Insured person shall take all reasonable steps to safeguard against any accident or injury that may give rise to any claim under this policy.

18. Electronic Transactions

The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

19. Notice of charge
Subject to/Apart from Assignment clause in these Terms and Conditions, the Company shall not be bound to notice or be affected by any notice of any trust, charge, lien or other dealing with or relating to this policy but the receipt of the Insured or his legal personal representative shall in all cases be an effectual discharge to the company.

20. Entire Contract - Changes
This Policy, together with the Proposal Form, as well as any forms, riders and endorsements and papers hereto, constitutes the entire contract of insurance.
No change in this Policy shall be valid until approved by Our authorized officer and such approval is endorsed hereon. No agent has authority to change this Policy or to waive any of the provisions of this Policy.

21. Notification of Changes
It is a condition precedent to Our liability to make any payment under this Policy that You shall give Us written notice immediately of any change in the address, nature of job, state of health and any other changes affecting You or any Insured Person.

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

23. No constructive Notice
Any of the circumstances in relation to these conditions coming to the knowledge of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

24. Special Provisions
Any special provisions subject to which this policy has been entered into and endorsed in the policy or in any separate instrument shall be deemed to be part of this policy and shall have effect accordingly.

25. Territorial Limits

a. Worldwide coverage is applicable for the following Sections:
Section I: Personal Accident Section
Section V: Loan Protector Cover
Section VII: Coma due to Accidental Bodily Injury

b. Following covers are restricted to within India Only:
Section II: Accidental Hospitalization Expenses
Section III: Road Ambulance Cover
Section IV: Hospital Cash Benefit
Section VI: Loss of Income due to Disability from Accident

Our liability to make any payment shall be within India and in Indian Rupees only

26. Consideration
The Policy is issued subject to payment of premium in advance. No payment shall be valid unless made under our official receipt. The cover shall not be valid prior to the date and time of receipt of premium.

27. Automatic Termination of Cover
The cover for the Insured Person shall terminate immediately in the event of settlement of claim under Section I – Personal Accident – Death or Permanent Total Disablement.

28. Physical Examination
Any medical official or other agent of the company shall be allowed to examine the Insured Person(s) in case of alleged injury or disablement when and as often as may be reasonably be required on behalf of the Company .

29. Paying a Claim

a. You agree that We shall only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information.

b. We will make payment to Assignee/Partial Assignee/Conditional Assignee, as the case may be, (as per the provisions of Section 38 of Insurance Amendment Act 2015) or in the absence of assignee to You or Your Nominee. If there is no Assignee or Nominee and You are incapacitated or deceased, We will pay Your heir, executor or validly appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.

c. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, we shall offer within a period of 30 days settlement of the claim to the insured. Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. 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.

d. If We, for any reasons decide to reject the claim under the policy the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents. You may take recourse to the Grievance Redressal procedure stated under the Policy.

30. Assignment and Transfer of Insurance Policies (Subject to always that any assignment shall always be subject to provisions of Section 38 of Insurance Act 1938, as amended from time to time)

1. A transfer or assignment of a policy of insurance, wholly or in part, whether with or without consideration, may be made by an endorsement upon the policy itself or by a separate instrument, signed in either case by the transferor or by the assignor or his duly authorised agent and attested by at least one witness, specifically setting forth the fact of transfer or assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made.
2. The Company may, accept the transfer or assignment, or decline to act upon any endorsement made under sub-clause 29(1) hereinabove, where it has sufficient reason to believe that such transfer or assignment is not *bona fide* or is not in the interest of the policyholder or in public interest or is for the purpose of trading of insurance policy.
3. The Company shall, before refusing to act upon the endorsement, record in writing the reasons for such refusal and communicate the same to the policyholder not later than thirty days from the date of the policyholder giving notice of such transfer or assignment.
4. Any person aggrieved by the decision of the Company to decline to act upon such transfer or assignment may within a period of thirty days from the date of receipt of the communication from the Company containing reasons for such refusal, prefer a claim to the Authority.
5. Subject to the provisions in sub-clause 29(2) hereinabove, the transfer or assignment shall be complete and effectual upon the execution of such endorsement or instrument duly attested but except, where the transfer or assignment is in favour of the Company, shall not be operative as against the Company, and shall not confer upon the transferee or assignee, or his legal representative, any right to sue for the amount of such policy or the moneys secured thereby until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or a copy thereof certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to and received by the Company with written acknowledgement by the Company:
   Provided that where the Company maintains one or more places of business in India, such notice shall be delivered only at the place where the policy is being serviced.
6. The date on which the notice referred to in sub-clause 29(5) hereinabove is delivered to the Company shall regulate the priority of all claims under a transfer or assignment as between persons interested in the policy; and where there is more than one instrument of transfer or assignment the priority of the claims under such instruments shall be governed by the order in which the notices referred to in sub-clause 29(5) hereinabove are delivered:
   Provided that if any dispute as to priority of payment arises as between assignees the dispute shall be referred to the Authority.
7. Upon the receipt of the notice referred to in sub-clause 29(5) hereinabove, the Company shall record the fact of such transfer or assignment together with the date thereof and the name of the transferee or the assignee and shall, on the request of the person by whom the notice was given, or of the transferee or assignee, on payment of such fee as may be specified by the regulations, grant a written acknowledgement of the receipt of such notice; and any such acknowledgement shall be conclusive evidence against the Company that he has duly received the notice to which such acknowledgement relates.
8. Subject to the terms and conditions of the transfer or assignment, the insure shall, from the date of the receipt of the notice referred to in sub-clause 29(5) hereinabove, recognize the transferee or assignee named in the notice as the absolute transferee or assignee entitled to benefit under the policy, and such person shall be subject to all liabilities and equities to which the transferor or assignor was subject at the date of the transfer or assignment and may institute any proceedings in relation to the policy, obtain a loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to such proceedings.
   Explanation.—Except where the endorsement referred to in sub-clause 29(1) hereinabove expressly indicates that the assignment or transfer is conditional in terms of sub-clause 29(10) hereunder, every assignment or transfer shall be deemed to be an absolute assignment or transfer and the assignee or transferee, as the case may be, shall be deemed to be the absolute assignee or transferee respectively.
9. Any rights and remedies of an assignee or transferee of a policy of life insurance under an assignment or transfer effected prior to the commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by the provisions of this clause 29.
10. Notwithstanding any law or custom having the force of law to the contrary, an assignment in favour of a person made upon the condition that—

a) the proceeds under the policy shall become payable to the policyholder or the nominee or nominees in the event of either the assignee or transferee predeceasing the insured; or
b) If the insured surviving the term of the policy, the Conditional Assignment shall be valid:
   Provided that a conditional assignee shall not be entitled to obtain a loan on the policy or surrender a policy.

11. In the case of the partial assignment or transfer of a policy of insurance under sub-clause 29(1) hereinabove, the liability of the Company shall be limited to the amount secured by partial assignment or transfer and such policyholder shall not be entitled to further assign or transfer the residual amount payable under the same policy.

31. Limitation Period

It being expressly agreed and declared that if the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of disclaimer have been made the subject matter of a suit in court of law then the claim for all such purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder

32. Arbitration

a. If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted), such difference shall independently of all other question be referred to the decision of a sole arbitrator to be appointed in writing by the parties to 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. The law of the arbitration will be Indian law, and the seat of arbitration and venue for all hearings shall be within India.
b. 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.
c. 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 the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.
d. 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 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.
e. In the event that these arbitration provisions shall be held to be invalid then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

33. Applicable Law
Indian law governs the construction, interpretation and meaning of the provisions of this Policy and the relationship between us. The section headings in this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

34. Change in Plan
The Insured member can apply for change in Plan at the time of renewal of the Policy and subject to specific approval and acceptance by the Company

35. Policy Period
The policy can be opted for 1 year, 2 years & 3 years

36. Policy Disputes
Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law. Each party agrees to submit such dispute to a Court of competent jurisdiction and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court

SECTION E) GENERAL TERMS AND CLAUSES - OTHER TERMS AND CONDITIONS

37. Making a Claim:

i. Reimbursement Claim Procedure of All Sections
All Claims will be settled by In house claims settlement team of the company and no TPA is engaged
If the Insured Person meets with any Accidental Bodily Injury that may result in a claim, then as a condition precedent to our liability:

a. Policyholder or the Insured Person or someone claiming on his/her behalf must inform us in writing immediately and in any event within 30 days from the date of the accident and submit all documents to us within 30 days from the date of intimation.
b. Insured Person must immediately consult a Doctor and follow the advice and treatment that he recommends.
c. Insured Person must take reasonable steps to lessen the consequence of Bodily injury.
d. Insured Person should allow examination by our medical advisors if we ask for this.
e. Policyholder or Insured Person or someone claiming on his/her behalf must promptly give us documentation and other information we ask for to investigate the claim or our obligation to make payment for it.
f. In case of the Insured Person's death, someone claiming on his/her behalf must inform us in writing immediately and send us a copy of the post mortem report (if conducted) within 30 days.

*Note: Waiver of conditions (a) and (f) may be considered in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in which the Insured Person was placed, it was not possible for the Insured Person or any other person claiming on his/her behalf to give notice or file claim within the prescribed time limit.

List of Claim documents:

List of Claims Document Specific to Personal Accident Cover

List of Claim documents for Death

- Duly Completed Claim Form signed by Nominee of the Insured Person .
- Copy of address proof (Ration card or electricity bill copy).
- Attested copy of Death Certificate.
- Burial Certificate (wherever applicable).
- Attested copy of Statement of Witness, if any lodged with police authorities.
- Attested copy of FIR / Panchanama / Inquest Panchanama.
- Attested copy of Post Mortem Report (only if conducted).
- Attested copy of Viscera report if any(Only if Post Mortem is conducted).
- NEFT details & cancelled cheque of the Insured Person
- Original Policy copy along with Original Assignment endorsement (if any)

List of Claim documents for Permanent Total Disability and Permanent Partial Disability

- Duly Completed Claim Form signed by Insured Person.
- Attested copy of disability certificate from Civil Surgeon of Government Hospital stating percentage of disability.
- Hospital Discharge summary and case sheet / indoor case paper
- Attested copy of FIR. (If required)
- All X-Ray / Investigation reports and films supporting to disability.
- NEFT details & cancelled cheque of Insured Person.
- Original Policy copy along with Original Assignment endorsement (if any)

List of Claims Document Specific to Accidental Hospitalization Expenses

- First Consultation letter from the Doctor
- Duly completed claim form signed by the Claimant
- Hospital Discharge Card
- Hospital Bill giving detailed break up of all expense heads mentioned in the bill. Clear break ups have to be mentioned for OT Charges, Doctor's Consultation and Visit Charges, OT Consumables, Transfusions, Room Rent, etc.
- Money Receipt, duly signed with a Revenue Stamp
- All original Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc.

- Other documents as may be required by the Company to process the claim

List of Claim Document Specific to Road Ambulance Cover

- First Consultation letter from the Doctor
- Duly completed claim form signed by the Claimant
- Treating Doctor certificate to transfer the Injured person to a higher medical centre for further treatment
- Original bills and receipts paid for the transportation from Registered Ambulance Service Provider
- All original Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc.
- Other documents as may be required by the Company to process the claim.

List of Claims Document Specific to Hospital Cash Benefit Section

- First Consultation letter from the Doctor
- Duly completed claim form signed by the Claimant
- Hospital Discharge Card
- Hospital Bill Money Receipt, duly signed with a Revenue Stamp
- All Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc.
- Other documents as may be required by the Company to process the claim

List of Claim Document Specific to Loan Protector Cover

- Loan disbursement letter along with the payment record till the date of Accident.
- Current outstanding Loan certificate from financer, along with the documents submitted for claim under Death or Permanent Total Disability.
- Attested copy of Death Certificate.
- Attested copy of FIR / Panchanama / Inquest Panchanama.
- All X-Ray / Investigation reports and films supporting to disability.
- Claim form with NEFT details & cancelled cheque duly signed by Insured or his/her Nominee in case of Insured's Death
- Original Policy Copy along with Original Assignment endorsement (if any)

List of Claim Document Specific to Loss of Income due to Disability from Accident

- Attested copy of FIR. (If required)
- All X-Ray / Investigation reports and films supporting to disability.
- Claim form with NEFT details & cancelled cheque duly signed by Insured
- Original Policy copy.
- For Employed persons: Certificate from HR with details of medical leave availed during the period of Injury
- Certificate from the treating doctor mentioning the extent of Injury along with the period of disability
- Certificate from Treating doctor with date of full recovery & resuming of duties

List of Claims Document Specific to Coma Due to Accidental Injury Section

- Hospital Discharge Card or Certificate from the Hospital regarding the Condition of the patient and the treatment being provided.
- Attested copy of FIR / Panchanama / Inquest Panchanama
- Duly completed claim form signed by the Claimant
- All original Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc.
- Certificate from the Attending Doctor confirming the Comatose State

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

Note: In case the Insured is claiming for the same event under an indemnity based policy of another insurer and is required to submit the original documents related to his treatment with that particular insurer, then the Insured may provide the Company with the attested Xerox copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it. If the insured requests for original documents, the same can be returned subject to the submission of self attested copies.

ii. Cashless Claims Procedure:
Applicable only for Accidental Hospitalization Expenses Cover
Cashless treatment is only available at Network Hospitals. In order to avail of cashless treatment, the following procedure must be followed by You:

a. Prior to taking treatment and/or incurring Medical Expenses out of any Accidental Injury, at a Network Hospital, the Insured Person must call Us and request pre-authorization by way of the written form which the Company will provide. Waiver of this condition shall be considered in case of emergency hospitalisation arising out of accidental bodily injury

b. After considering the Insured's request and after obtaining any further information or documentation the Company have sought, the Company may if satisfied send to the Insured Person or the Network Hospital, an authorization letter. The authorization letter, the ID card issued to the Insured along with this Policy and any other information or documentation that the Company have specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Insured's admission to the same.

c. If the procedure above is followed, the Insured Person will not be required to directly pay for the Medical Expenses raised out of Accidental Bodily Injury, in the Network Hospital that the Company is liable to indemnify under Accidental Hospitalization Expenses Section and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. Insured Person shall, in any event, be required to settle all other expenses directly.

Annexure I
Contact details of the Ombudsman offices

Office Details	Jurisdiction of Office Union Territory, District
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - 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 - 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 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.

SURAKSHA CHAKRA

Office Details	Jurisdiction of Office Union Territory, District
CHANDIGARH - 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 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI - Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna 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 - Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

SURAKSHA CHAKRA

Office Details	Jurisdiction of Office Union Territory, District
HYDERABAD - 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 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - 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 - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.

SURAKSHA CHAKRA

Office Details	Jurisdiction of Office Union Territory, District
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 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 - 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 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.

SURAKSHA CHAKRA

Office Details	Jurisdiction of Office Union Territory, District
PUNE - Shri Vinay Sah 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, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure II: Accidental Hospitalization Expenses

List I: List of Non-Medical Items

SL No	Item	
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Not Payable
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL / INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Not Payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Not Payable
21	SERVICE CHARGES WHERE NURSING CHARGES ALSO CHARGED	Not Payable
22	TELEVISION CHARGES	Not Payable
23	SURCHA RGES	Not Payable
24	ATTENDANT CHARGES	Not Payable
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not Payable

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26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Not Payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
36	SPACER	Not Payable
37	SPIROMETRE	Not Payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/S HOULDER IMMOBILIZER	Not Payable
47	LUMBOSACRAL BELT	Not Payable
48	NIMBUS BED OR WATER OR AIR BED CHARGES	Not Payable
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Not Payable
52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES	Not Payable
53	SUGAR FREE Tablets	Not Payable
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Not Payable
55	ECG ELECTRODES	Not Payable
56	GLOVES	Not Payable
57	NEBULISATION KIT	Not Payable
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT , RECOVERY KIT, ETC]	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Not Payable
64	PAN CAN	Not Payable
65	TROLLY COVER	Not Payable
66	UROMETER , URINE JUG	Not Payable
68	VASOFIX SAFETY	Not Payable

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List II - Items that are to be subsumed into Room Charges

S. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED /INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CARDLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINEFCTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCTDENTAL EXPENSES / MtSC. CHARGES (NOT EXPLATNED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III- Items that are to be subsumed into Procedure Charges

S. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES(for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD ,CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPE AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES,HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV - Items that are to be subsumed into costs of treatment

S. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALIZATION FOR EVALUATION/DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/CAPD EQUIPMENTS
7	INFUSION PUMP-COST
8	HYDROGEN PERPOXIDE\SPIRIT\DISINFECTION ETC
9	NUTTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
10	HIV KIT

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11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG