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Issuing Office:

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), a proposal which is hereby agreed to be the basis of this Group Policy issued in the name of Proposer and Certificate of Insurance to be issued thereunder in the name of Insured Beneficiary, and the Insured Beneficiary and or Proposer on behalf of Insured Beneficiary has paid the premium specified in the Schedule, now the Company agrees, subject always to the following terms, conditions, exclusions, and limitations, to pay the Insured Beneficiary subject always to the daily allowance up to the Sum Assured for the maximum period specified in the Certificate of Insurance during the Cover Period. The term You/ Your / Insured Person in this document refers to the individual group members who will be treated as Insured Beneficiary and the term Proposer/Policy Holder/ Group Manager / Group Organizer in this document refers to Person/ Organization who has signed the proposal form and in whose name the Group Policy is issued. Also the term Insurer/ Us/ Our/ Company in this document refers to Bajaj Allianz General Insurance Company Ltd.

SECTION B) DEFINITIONS- STANDARD DEFINITIONS

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

2. AYUSH Hospital:
An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

3. AYUSH Day Care Centre:
AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health Centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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

5. 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

6. Deductible
Deductible means a cost-sharing requirement under a health insurance Policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital cash policies which will apply before any benefits are payable by the Insurer. A Deductible does not reduce the sum insured.

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

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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.

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
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. ICU Charges:
ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

17. 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.

18. Medical Practitioner/Doctor/ Physician:
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.

19. 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.

20. 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.

21. 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.

22. 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. **AYUSH Treatment** refers to medical expenses incurred on hospitalisation under Ayurveda, Yoga and Naturopathy Unani, Siddha and Homeopathy systems

2. **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 Beneficiary on request and also available on website of the Company.

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

4. **Convalescence** means the gradual recovery of health and strength after illness or injury. It refers to the later stage of an infectious disease or illness when the patient recovers and returns to normal.

5. **Daily Allowance** means the amount specified in the Certificate of Insurance.

6. **Group** The definition of a group is 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.

7. **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.

8. **"Insured Member/s"** means loan borrow and co-borrower/s of loan from 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 Beneficiary.

9. **Loan** means the sum of money lent at interest or otherwise to the Insured by any Bank/Financial Institution and shall be identified by the Loan Account Number as specified in the Schedule.

10. **Master Policy/Group Policy** shall mean the Proposal, Group Policy Schedule/"Bajaj Allianz Group Hospital Cash Policy" Schedule, along with these Terms and Conditions, issued to the Policy Holder containing these terms and conditions of the insurance coverage and under which Certificates of Insurance will be issued to the respective Insured Beneficiary/ies and any endorsements attaching to or forming part thereof either on the commencement date or during the Cover Period.

11. **Proposer /Policy Holder/ Group Manager / Group Organizer/ Group Administrator** is the Organization or Entity which has taken the Master Policy on behalf of all Insured Persons/Insured Beneficiary.

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

13. **Master Policy Period**: Master Policy Period means period for which the Master Policy is valid in the name of Group Manager.

14. **Master Policy Schedule/Group Policy Schedule-** Group Policy Schedule means the "Bajaj Allianz Group Hospital Cash Policy" Schedule and any annexure to it read with respective Certificate of Insurance.

15. **Sum Assured/Sum Insured- 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.

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

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

SECTION C) COVERAGE

Operative Part
In the event of Accidental Bodily Injury or Sickness first occurring or manifesting itself during the Cover Period requiring hospitalisation of Insured Beneficiary, the Company will pay:

I. Hospital Daily Allowance

1. The Daily Allowance as stated in the Certificate of Insurance, for each continuous and completed period of 24 hours of Hospitalisation
2. Two times the Daily Allowance as stated in the Certificate of Insurance ,for each continuous and completed period of 24 hours required to be spent by the Insured Beneficiary in the Intensive Care Unit of a Hospital during any period of Hospitalisation
3. One day Daily Allowance as stated in the Certificate of Insurance, for Day Care Treatment carried out in the Day Care Centre. This benefit will not be payable if Insured Beneficiary opt for optional cover 6: Day Deductible Cover.

Note:

i. During the hospitalization period if the Insured Beneficiary is transferred from Normal room to ICU or vice versa the benefit would be payable only under one heading as specified above, as per the hospital bill for the respective day.
ii. Our maximum liability shall be restricted to the daily allowance till opted length of stay and Waiting Period mentioned in the Certificate of Insurance.

II. Optional Benefits:

You can opt for any of the below listed Optional Covers and below terms and conditions of respective Optional Covers will be applicable which are opted by you and displayed on your Certificate of Insurance:

Optional Cover 1	Maternity Hospital Cash Benefit
Optional Cover 2	Convalescence Benefit
Optional Cover 3	Accident Hospital Cash Benefit
Optional Cover 4	Waiver of Pre-Existing and Disease Specific Waiting Period
Optional Cover 5	Waiver Of 30 days waiting period cover

Optional Cover 6	Day Deductible Cover

Optional Cover 1- Maternity Hospital Cash Benefit:
In consideration of payment of additional premium by the Proposer / Insured Person to the Company and realization/receipt thereof by the Company, it is hereby agreed and declared that Group Hospital Cash Policy is extended to pay daily allowance as specified in the Certificate of Insurance for each continuous and completed period of 24 hours of hospitalization underwent for normal delivery or caesarean section and complications of maternity (including and not limited to medical complications) for a maximum period as stated in the Certificate of Insurance during each Cover Period.

Options available to Maternity Hospital Cash Benefit

1. Option 1:- Benefit payable after 12 months of waiting period
2. Option 2:- No waiting period.

Special conditions applicable to Maternity Hospital Cash Benefit:
This Hospital Cash Benefit is applicable for each continuous and completed period of 24 hours of Hospitalisation arising from or traceable to pregnancy, child birth including normal/ caesarean section, for a maximum of number of days as per the Schedule. When Maternity Expenses Benefit is opted for in the Certificate of Insurance, <<Section D-I Standard Exclusions Excl. 18 >> of the Master Policy stands deleted. Option for this Benefits has to be exercised at the inception of the Cover Period

Optional Cover 2- Convalescence Benefit
In consideration of payment of additional premium by the Proposer/ Insured Person to the Company and realization thereof by the Company, it is hereby agreed and declared that Group Hospital Cash Policy is extended to pay lump sum amount as mentioned in Certificate of insurance in case Insured Beneficiary's continuous and completed hospitalization beyond consecutive 7 or 10 day as opted.

Options available to Convalescence Benefit:
Insured Beneficiary has to choose any one preference from each of below 2 listed options-

I. Hospitalisation Period
i. Option 1:- Benefit payable after Hospitalisation more than 7 consecutive days
ii. Option 2:- Benefit payable after Hospitalisation more than 10 consecutive days

II. Sum Insured Options
i. Option 1: 5 times of per day benefit
ii. Option 2: 10 times of per day benefit
iii. Option 3: 20 times of per day benefit

Special conditions applicable to Convalescence Benefit:
This benefit will be payable only once during Cover Period This benefit is payable only if there is an admissible claim under any of the daily benefits.
When this benefit is opted for in the Certificate of Insurance, << Section D-I Specific Exclusion Sub clause 4>> >> of the Group Policy stands deleted.

Optional Cover 3- Accident Hospital Cash Benefit
In consideration of payment of additional premium by the Proposer/ Insured Person to the Company and realization thereof by the Company, it is hereby agreed and declared that Group Hospital Cash Policy is extended to pay daily allowance as specified below due to hospitalization of Insured Beneficiary necessitated solely by the reason of Accidental Injury for a maximum period as stated in the Certificate of Insurance during each Cover Period.

Special conditions applicable to Accident Hospital Cash Benefit Extension:

1. Two times the Daily Allowance for each continuous and completed period of 24 hours required to be spent by the Insured Person in the Hospital
2. Two times the Daily Allowance for Day Care Treatment carried out in the Day Care Centre during the Cover Period.

Optional Cover 4- Waiver of Pre-Existing and Specific Disease Waiting Period Cover:
In consideration of payment of additional premium by the Proposer/ Insured Person, to the Company and realization thereof by the Company, it is hereby agreed and declared that Group Hospital Cash Policy is extended to reduce waiting period mentioned in Section D-I Standard Exclusions (Excl. 01) and (Excl. 02) i.e. Pre-Existing And Disease Specific Waiting Period up to the option opted by Insured Beneficiary.

Options available to Waiver of Pre-Existing and Disease Specific Waiting Period:

1. Option 1: No waiting period
2. Option 2: waiting period of 12 months
3. Option 3: waiting period of 24 months
4. Option 4: waiting period of 36 months

Special conditions applicable to Pre-Existing Disease and Specific Disease waiting period Cover:

1. When Pre-Existing Disease and Specific Disease waiting period Cover is opted for in the Certificate of Insurance, Exclusion, <<Section D-I Standard Exclusions Excl. 01>> shall be reduced by the number of years as per the option opted.

Optional Cover 5- Waiver of 30 days waiting period Cover
In consideration of payment of additional premium by the Proposer/ Insured Person to the Company and realization thereof by the Company, it is hereby agreed and declared that Group Hospital Cash Policy is extended to waive the waiting period applicable for Section D-I Standard Exclusions (Excl. 03) i.e. 30 days exclusion clause.

Special conditions applicable to Waiver of 30 days waiting period Cover:

1. When 30 days waiting period Cover is opted for in the Certificate of Insurance, Exclusion, << Section D-I Standard Exclusions Excl. 03>> of the Master Policy stands deleted.

Optional Cover 6- Day Deductible Cover
The Company hereby agrees and declared that upon opting this optional cover, We will provide discount mentioned in Section E CONDITIONS-SPECIFIC TERMS AND CLAUSES sub clause- 12, and time bound deductible of day(s) as specified in the Certificate of Insurance will be applicable for any claim under Section C-I i.e. Hospital Daily Allowance.

1. Special conditions applicable to Day Deductible Cover:

1. Our liability to pay each and every claim under any Benefit will be in excess of opted Day Deductible
2. Number of days stated in the Certificate of Insurance shall be deducted in respect of each and every Claim made under this Master Policy. Deductible will be applicable for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once subject to the terms and conditions of the Master Policy.

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:

I. Waiting Period

1. Pre-existing Diseases waiting period (Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Group Hospital Cash Policy with us.
b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c) If the Insured is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the Policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. Specified disease/procedure waiting period (Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first Group Hospital Cash Policy with Us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e) If the Insured is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

List of specific diseases/procedures is as below

1. Any type gastrointestinal ulcers	2. Cataracts,
2. Benign prostatic hypertrophy	13. Hernia of all types
3. All types of sinuses	14. Fistulae,
4. Haemorrhoids	15. Fissure in ano
5. Dysfunctional uterine bleeding	16. Fibromyoma
6. Endometriosis	17. Hysterectomy
7. Stones in the urinary and biliary systems	18. Surgery for any skin ailment
8. Surgery on ears/tonsils/ adenoids/ paranasal sinuses	19. Surgery on all internal or external tumours/cysts/ nodules/polyps of any kind including breast lumps with exception of Malignant tumor or growth.
9. Joint replacement surgery,	20. Congenital internal diseases or anomalies
10. Surgery for prolapsed inter vertebral disc (unless necessitated due to an accident)	21. Laser treatment for correction of eye sight due to refractive error.
11. Hypertrophied turbinate	22. Surgery to correct deviated nasal septum

3. 30-day waiting period (Excl03)

a) Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however apply if the Insured has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

II. General Exclusions

1. Investigation & Evaluation- (Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. 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.
*Note: This exclusion will stand deleted in case Optional Cover 1 Maternity Hospital Cash Benefit is opted.

3. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Excl12)

4. Rest Cure, rehabilitation and respite care-(Excl05)
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

5. 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

6. 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.

7. 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)

8. 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.

9. Sterility and Infertility: (Excl17)
Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

SECTION D) EXCLUSIONS - SPECIFIC EXCLUSIONS

I. General 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 nationalization 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. Dental treatment or Dental surgery of any kind unless as a result of Accidental Injury to natural teeth and also requiring hospitalization.
4. Expenses incurred on Convalescence benefit.
5. 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. Any claim directly or indirectly caused by or contributed to by nuclear weapons and/or materials.
8. Vaccination or inoculation unless forming a part of post bite treatment.
9. Treatment for any other system other than modern medicine (also known as Allopathy) and AYUSH Therapies
10. Venereal disease or any sexually transmitted disease or sickness.
11. Any natural peril including but not limited to avalanche, earthquake, volcanic eruptions or any kind of natural hazard.
12. 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 sixty continuous months of coverage (including portability and migration) no look back would be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the 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. 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.

8. 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.

9. 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

iv. 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

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://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

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://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

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 thirty 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 of Master Policy/ Certificate of Insurance

i. The Master Policy/Certificate of Insurance may be cancelled by or on behalf of the Company by giving the Policy Holder/Insured Beneficiary at least 15 days of written notice and if no claim has been made then the Company shall refund a pro-rata premium for the unexpired Cover Period, subject to however retaining the short period premium. Under normal circumstances, Policy will not be cancelled except for reasons of mis-representation/false statements, fraud, non-disclosure of material facts or non-cooperation.
ii. The Master Policy may be cancelled by the Policy Holder at any time before the expiry of the Master Cover Period by giving at least 15 days written notice to the Company.
iii. The Certificate of Insurance may be cancelled by the Insured Beneficiary at any time before the expiry of the Cover Period by giving at least 15 days written notice to the Company and if no claim has been made then the Company will refund premium on short term rates for the unexpired Cover Period as per the rates detailed below.

Policy Term	1 Year	2 Years	3 Years	4 Years	5 Years
Within 30 Days	Pro Rata basis				
Exceeding 30 days but less than 3 months	65%	80%	80%	85%	85%
Exceeding 3 months but less than 6 months	45%	65%	75%	80%	80%
Exceeding 6 months but less than 12 months	0%	45%	60%	65%	70%
Exceeding 12 months but less than 15 months		30%	50%	60%	65%
Exceeding 15 months but less than 18 months		20%	45%	55%	60%
Exceeding 18 months but less than 24 months		0%	30%	45%	50%
Exceeding 24 months but less than 27 months			20%	40%	50%
Exceeding 27 months but less than 30 months			15%	30%	45%

Exceeding 30 months but less than 36 months			0%	20%	35%
Exceeding 36 months but less than 39 months				15%	30%
Exceeding 39 months but less than 42 months				10%	25%
Exceeding 42 months but less than 48 months				0%	15%
Exceeding 48 months but less than 51 months					10%
Exceeding 51 months but less than 54 months					5%
Exceeding 54 months but less than 60 months					0%

However, if any claim has been made, then no refund will be given for cancellation of policy.

i. For the avoidance of doubt, the Company shall remain liable for any claim that was made prior to the date upon which this Master Policy/ Certificate of Insurance is cancelled except in cases such cancellation is on account of Fraud, mis-representation/false statements or non-disclosure of material facts by the Insured/Insured Beneficiary.

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 **Annexure II**.

SECTION E) CONDITIONS- SPECIFIC TERMS AND CLAUSES

17. Entry Age

- Age of entry is from 18 years to lifetime.

18. Paying a Claim

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

ii. We will make payment to You or Your Nominee. If there is no 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.

iii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per Certificate of Insurance read with Master Policy terms and conditions, we shall offer within a period of 30 days a settlement of the claim to the Insured Beneficiary. Upon acceptance of an offer of settlement by the Insured Beneficiary, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured Beneficiary. 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.

iv. However, where the circumstances of a claim warrant an investigation, the Company will 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 will settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

v. If the insurer, for any reasons decides to reject the claim under the Certificate of Insurance read with the Master Policy the reasons regarding the rejection shall be communicated to the Insured Beneficiary in writing within 30 days of the receipt of documents. The Insured Beneficiary may take recourse to the Grievance Redressal procedure stated under this Master Policy terms and conditions.

19. Basis of claims payment

i. We shall make payment in India in Indian Rupees only.

ii. The Company shall only make payment under this Policy to the Insured Beneficiary or in the event of death or total incapacitation of the Insured Beneficiary to the proposer/ nominee. Any payment made in good faith by the Company as aforesaid shall operate as a complete and final discharge of the Company's liability to make payment under the Certificate of Insurance for such claim.

iii. Deductible will be applicable for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once subject to the terms and conditions of Certificate of Insurance read with this Master Policy.

20. Territorial Limits & Governing Law

i. The Company cover only insured events arising during the Cover 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.

GROUP HOSPITAL CASH POLICY

ii. The Master 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 Master Policy Schedule/Certificate of Insurance.
iii. The construction, interpretation and meaning of the provisions of the Master Policy shall be determined in accordance with Indian law. The section headings of this Master Policy are included only for descriptive purposes and do not form part of this Master Policy for the purpose of its construction or interpretation.

21. Communications

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

22. Addition /Deletion of Insured Beneficiary(s):

No person other than those persons named as the Insured Beneficiary(s) or those categories of the Insured Beneficiaries specified in the Certificate of Insurance 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 Beneficiary(s)

Cover under Certificate of Insurance shall be withdrawn from any Insured Beneficiary(s) named or any category of Insured Beneficiaries insured immediately upon the Policy Holder delivering written notice of the same to the Company.

23. Cover Period-

Cover Period will be for one year.
In case if Master Policy is offered to Banks and/or Financial Institutions to cover their loan borrowers, Cover Period can be opted for 1/ 2 / 3 / 4 / 5 yrs subject to maximum of loan period.

24. Endorsements

This Master Policy constitutes the complete contract of insurance. This Master 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.

25. Special Conditions relating to Group Policy

Group Policy is 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 Group Policy by charging premium for the Cover Period.
3. For deletion of names from Group Policies during the currency of the Cover Policy, refund of pro- Rata premium can be allowed only if there is no claim in respect of the particular Insured Beneficiary at the time of such deletion of names.

26. Discounts and Loading:

i. **Group Size Discount:**

The discount or loading would be applicable as mentioned below for the group proposals in lieu of Group size

Group Size Band	Discount
Less than 50	Nil
50 to 1000	5%
1001 to 5000	10%
5001 to 10000	15%
10000 to 50000	20%
50001 and more	25%

ii. **Frequency based Discount/ Loading:**

The discount or loading would be applicable as mentioned below for the group proposals based on the claims experience of the group.

Frequency	Discount
0.00-3.00%	10%
3.01%-5.00%	5%
Frequency	**Loading**
7.00%-10.00%	5%
Above 10.00%	10%

iii. **Long Term Discount:**

Terms in years	2	3	4	5
Discount	4.0%	7.0%	10.0%	12.0%

iv. **Day Deductible Discount**

Day Deductible	
Deductible Options	**Discount**
1 Day	**10%**

27. Dispute Resolution (Applicable only in cases where this Policy is issued under Commercial Lines of Business)

"The Insurer and Insured may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this Policy. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996."

Note : 1. Wherever this Policy is issued under retail lines of business, Arbitration clause shall not be applicable.
2. Arbitration clause shall not be applicable in case of Policies issued under commercial lines of business where Insured has specifically consented for no arbitration clause and no arbitration terms have been annexed to the Policy Schedule/Policy.

SECTION E) CONDITIONS- OTHER TERMS AND CLAUSES

28. 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 Beneficiary must comply with the following:

i. The Insured Beneficiary or someone claiming on the Insured Beneficiary'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 Beneficiary or Insured Beneficiary's representative claiming on his/ her behalf have provided the Company with necessary documentation and information.
iii. The Insured Beneficiary 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 Beneficiary, 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

*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 Beneficiary 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 Beneficiary / Nominee (in case of death of Insured Beneficiary)
- Photo Copy of Discharge Summary / Discharge Certificate.
- Photo 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
- Aadhaar card & PAN card Copies is as per the IRDAI guidelines read with

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

Schedule of benefits

Following benefits are available as per the plan opted and are available on per Insured Beneficiary per Policy Year basis.

Base Benefits	**Daily allowance (INR)**	**Length of stay (No. of Days)**
Hospital Daily Allowance	Min: Rs.100 per day	7 days/10 days/15 days/30 days/60 days/90 days/120 days/180 days
	Max: Rs.10000 per day	
	Note:- The Daily Allowance options are available in multiples of Rs. 100	
Optional Benefits	**Daily allowance (INR)**	**Length of stay (No. of Days)**
Optional Cover 1: Maternity Hospital Cash Benefit	Option 1: After 12 months of waiting period	7 days/10 days/15 days/30 days/60 days/90 days/120 days/180 days
	Option 2: From Day 1 i.e. without any waiting period	
	Min: Rs.100 per day	
	Max: Rs.10000 per day	
	Note:- The Daily Allowance options are available in multiples of Rs. 100	

Optional Cover 2: Convalescence Benefit		
	Option 1: for Hospitalisation more than 7 consecutive days	
	Option 2: for Hospitalisation more than 10 consecutive days	
Sum Insured options	Option 1: 5 times of per day benefit	
	Option 2: 10 times of per day benefit	
	Option 3: 20 times of per day benefit	
	Minimum per day limit is Rs. 100 per day	
	Max. Sum Insured: 25000	
Optional Cover 3: Accident Hospital CashBenefit		
	The Daily Allowance benefit will be paid twice	
	Min: Rs.100 per day	7 days/10 days/15 days/30 days/60 days/90 days/120 days/180 days
	Max: Rs.10000 per day	
	Note:- The Daily Allowance options are available in multiples of Rs. 100	7 days/10 days/15 days/30 days/60 days/90 days/120 days/180 days
Optional Cover 4: Waiver of Pre-Existing And Disease Specific Waiting Period	Option 1: From Day 1 i.e. without any waiting period	
	Option 2: After 12 months of waiting period	
	Option 3: After 24 months of waiting period	
	Option 4: After 36 months of waiting period	
Optional Cover 5: Waiver Of 30 days waiting period cover	Option 1: From Day 1 i.e. without any waiting period	7 days/10 days/15 days/30 days/60 days/90 days/120 days/180 days
Optional Cover 6: Day Deductible Cover	Option 1: 1 day, i.e. benefit will be paid for hospitalisation of more than 1 day	7 days/10 days/15 days/30 days/60 days/90 days/120 days/180 days

Annexure II:
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
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,	Madhya Pradesh Chattisgarh.

Office Details	Jurisdiction of Office Union Territory, District)
1st floor, “Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	
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 – 4646394 / 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 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town 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 - 23237539 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). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
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 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI – Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building,	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

Office Details	Jurisdiction of Office Union Territory, District)
Opp to Maharaja's College,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 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 - 4002082 / 3500613 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.: 022 - 69038800/ 27/ 29/ 31/ 32/ 33 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 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 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, 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- 24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Note: Address and contact number of Governing Body of Insurance Council:
Council for Insurance Ombudsmen, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
E-mail: inscoun@cioins.co.in, Tel: 022 -69038800/69038812, Website: https://www.cioins.co.in