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:

M-CARE (GROUP)
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 the Insured Beneficiary and or Proposer on behalf of Insured Beneficiary has paid and the Company has received and realized 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 limits] up to the Sum Insured for the maximum period specified in the Certificate of Insurance during the Cover Period.

The term You/ Your / Insured Beneficiary in this document refers to the individual group members who will be treated as Insured Beneficiary and the term 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. **Cashless facility:**
Means a facility extended by the Company to the Insured/Insured Person(s), as the case may be, where the payments, of the costs of treatment undergone by the Insured/Insured Person(s), as the case may be, in accordance with the Policy Schedule read with standard Terms and Conditions, are directly made to the network provider by the Company to the extent pre-authorization approved subject to Limitation of Benefits.

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

3. **AYUSH Hospital:**
An AYUSH Hospital is a healthcare facility where in 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 least5 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.

4. **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

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

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

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

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

9. **Disease/Illness**
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

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

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

11. Medical Practitioner/Doctor/ Physician:
Medical Practitioner/Doctor/ Physician is a person who holds a valid registration/license 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 or holds a valid registration/license from the medical council of respective countries mentioned in Section D Exclusions [for treatment in respective countries] and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his registration/license.

12. 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.

13. 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.

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

15. OPD treatment:
OPD treatment means one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

16. 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.

17. 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.

18. 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.

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:**
Bajaj Allianz Network Hospitals / Network Hospitals 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

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(ies)** name, address, age, commencement date and expiry date of the cover, coverage, sums insured, condition(s), exclusions and or endorsement(s).

4. **Family-** Includes the Insured Beneficiary and his/her Immediate Family members.

5. **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 circular015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005, as amended/modified/further guidelines issued, from time to time

6. **Immediate Family members**; means Insurer Beneficiary's lawfully wedded spouse, and dependent children & parents.

7. **Limit of Benefit** represents Sum Insured or Our maximum liability to make payment for claim of the Insured or foreach and every claim per Insured Beneficiary and collectively for all **Insured Beneficiary(ies)** (for floater policies)mentioned in the Certificate of Insurance annually during

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the Cover Period and in the aggregate for the **Insured Beneficiary(ies)** named in the Certificate of Insurance annually during the Cover Period, and also means the amount stated in the Certificate of Insurance against each Cover.

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

9. **Master Policy/Group Policy** shall mean the Proposal, Group Policy Schedule/"M-Care (Group)" 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.

10. **Master Policy Schedule/Group Policy Schedule- Group** Policy Schedule means the "M-Care (Group)" Policy Schedule and any annexure to it.

11. **Insured Beneficiary/ Insured Beneficiary(ies)** means the individual customer/s of Insurer and his/her Family members, named in the Certificate of Insurance provided that individual customer/s of Insured and or his/her Family Members shall not be older than 65 years of age at the time of commencement of the Certificate of Insurance.

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

13. **Policy Schedule:**
Policy Schedule means the proposal, insurance contract as evidenced by Policy Schedule read with these standard Terms and Conditions and any annexure to Policy Schedule and any endorsements attaching to and/or forming part of Policy Schedule, either at the commencement or during the Policy Period. Policies shall be construed accordingly.

14. **Cover Period**: means the period as specified in the Certificate of Insurance issued to the respective Insured Beneficiary(ies) during which the Insured Beneficiary(ies) is covered as per Certificate of Insurance read with Terms and Conditions of the Master Policy.

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

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

SECTION C) OPERATIVE PART

Scope of cover:
If the Insured Beneficiary is diagnosed as suffering from a Vector Borne disease listed below which first occurs or manifests itself during the Cover Period, the Company shall pay a lump sum Benefit to the Beneficiary , as specified under the Certificate of Insurance, subject to the Sum Insured, limits, terms, conditions definitions and exclusions contained or otherwise expressed in the Policy Schedule read with these Terms and Conditions.

Coverage

1. **Dengue Fever**
Subject to Limit of Benefits, the Company shall pay the benefit as specified in the Certificate of Insurance in the event of Insured Beneficiary being hospitalized during the Cover Period with the diagnosis of Dengue which is confirmed by Medical Practitioner along with laboratory examinations results countersigned by a Pathologist/microbiologist indicating –
1. Immunoglobulins /Polymerase Chain Reaction (PCR) test showing positive results for Dengue
2. Concurrent to the above two conditions the final diagnosis should be confirmed as Dengue Fever

2. **Malaria**
The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Beneficiary being hospitalized during the Cover Period, with the diagnosis of Malaria which is confirmed by a medical practitioner with confirmatory tests indicating presence of Plasmodium falciparum/ vivax/ malariae in the his/her blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

3. **Filariasis**
(Payable only once in lifetime)
The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Beneficiary being hospitalized during the Cover Period, with the diagnosis of Filariasis commonly known as elephantiasis, and same must be confirmed by a Medical Practitioner with laboratory examination with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following Clear and visible manifestation of
the disease:
1. lymphoedema,
2. elephantiasis and
3. scrotal swelling
4. Concurrent to the above three conditions the final diagnosis should be confirmed as Filariasis

Note-
1. If the Insured Person is already infected with Filariasis prior to first Policy inception then this benefit will not be extended for lifetime
2. Once the Sum Assured is paid for any Insured Person, no other claim for this particular condition shall be paid to the Insured Beneficiary in his/her entire lifetime.

4. **Kala Azar**
The Company shall pay the benefit as specified in the Certificate of Insurance in the event of Insured Beneficiary being hospitalized during the Cover Period with the diagnosis of Visceral Leishmaniosis, also known as kala-azar which is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver and anaemia and same must be confirmed by a Medical Practitioner by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for kala azar indicating presence of this disease.

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5. **Chikungunya**
The Company shall pay the benefit as specified in the Certificate of Insurance in the event of Insured Beneficiary being hospitalized during the Cover Period with the diagnosis of Chikungunya which is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue and rash and same must be confirmed by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies.

6. **Japanese Encephalitis**
The Company shall pay the benefit as specified in the Certificate of Insurance in the event of Insured Beneficiary being hospitalized during the Cover Period with the diagnosis of Japanese Encephalitis is which is characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis and same must be confirmed by a Medical Practitioner by positive serological test for Japanese Encephalitis by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

7. **Zika Virus**
The Company shall pay the benefit as specified in the Certificate of Insurance in the event of Insured Beneficiary being hospitalized during the Cover Period with the diagnosis of Zika virus disease which have symptoms like mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache and same must be confirmed by a registered medical practitioner by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results.

Note
Benefit Payout

- **Individual Sum Assured policies**
If We pay the claim for any of the listed vector borne diseases then this Policy shall cease for the Named Insured or Insured Person, as the case may be.

- **Floater Sum Assured Policy**

i. Family floater Policy covering 2 members
If We pay the claim for any one of the named Insured Person for the listed vector borne diseases then the Policy shall cease for both the named Insured Persons

ii. Family Floater Policy covering more than 2 members
If We pay the claim for any one of the Named Insured Person for the listed vector borne diseases then the Policy shall cease for the Named Insured Person for whom the claim has been paid, and the Policy shall continue for rest of the Insured Beneficiary(ies) covered under the Policy, however after payment of second claim for other Insured Persons the Policy would cease for all Insured Beneficiary

SECTION D) EXCLUSIONS UNDER THE POLICY - SPECIFIC EXCLUSIONS

I. Waiting Period

1. Any of the listed vector borne disease diagnosed within the first 15 days of the date of commencement of the Policy is excluded. This exclusion shall not apply to an Insured/Insured Persons, as the case may be, for whom coverage has been renewed without a break, for subsequent years provided there are NIL claims in the previous Policies.
2. If the Policy is opted after occurrence of any of the listed vector borne diseases, a 60 days waiting period shall be applicable for the specific ailment from date of previous admission.
However once a benefit is paid under the Policy Schedule during the Policy Period and the Named Insured renews the Policy, in such scenario for the renewal Policy, 60 days waiting period from date of previous admission would apply for the specific ailment of which a claim has been paid.
3. If the Policy is renewed within 60 days from the date of admission of the previously paid claim for the named Insured/Insured Persons, as the case maybe, a 60 days cooling off period shall apply for the same ailment in the renewed policy opted, however there would be no waiting period for other listed vector borne diseases.
4. If the Policy is renewed post 60 days from the date of admission of the previously paid claim for the named Insured/Insured Persons, as the case may be, then a fresh waiting period of 15 days shall apply for all listed vector borne diseases.

II. General Exclusions

1. Any Treatment taken for any illness other than for vector borne diseases as listed in Section C
2. Admission to hospital for less than 24 hours
3. Diagnosis and treatment outside India. However, this exclusion shall not be applicable in the below listed countries:

New Zealand	Japan
Singapore	Canada
Switzerland	Dubai
USA	Hong Kong
Malaysia	Countries of the European Union

SECTION E) GENERAL 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

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3. 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.

4. 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.

5. 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.

6. 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

7. 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.)

8. Cancellation

(A) Cancellation by the Policyholder The Policyholder can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired policy period as detailed below:

1. Cancellation of policy where full premium received at policy inception -

• Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

• Multi-year Policy:

o For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.

o For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

2. Cancellation of policy where Premium Received on Instalment Basis The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

(B) Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

(C) Cancellation by the Company The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Policyholder/insured person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

9. 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

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2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website www.bajajallianz.com/branch-locator.html
3. Register your grievances / complaints on our website www.bajajallianz.com/about-us/customer-service.html
4. E-mail

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

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

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

SECTION E) GENERAL CONDITIONS – SPECIFIC TERMS AND CLAUSES

10. Payment of Claims

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. 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.
ii. 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 a settlement of the claim to you. Upon acceptance of an offer of settlement by you, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by you. In the cases of delay in the payment, We 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.
iii. 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.
iv. 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 complete set of documents. You may take recourse to the Grievance Redressal procedure.

11. Basis of Claims Payment

i. Individual Sum Assured Policies-
If We pay the claim for any of the listed vector borne diseases then this Policy shall cease for the named Insured/Insured Persons(s), as the case may be.
ii. Floater Sum Assured Policy:

a. Family floater policy covering 2 members-
If We pay the claim for any one of the named Insured Person for the listed vector borne diseases then this Policy shall cease for both the named Insured Persons

b. Family Floater Policy covering more than 2 members-
If We pay the claim for any one of the named Insured Person for the listed vector borne diseases then this Policy shall cease for the named insured for whom the claim has been paid, the Policy shall continue for rest of the members covered under the Policy, however after payment of second claim for other Insured Persons the Policy would cease for all members

iii. If a claim is admitted against Lymphatic Filariasis, upon renewal of policy, coverage will be available for all conditions except Lymphatic Filariasis. For Lymphatic Filariasis, once the sum assured is paid for any life, no other claim for this particular condition shall be paid to the Insured Person in the entire lifetime of the policyholder.

12. 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.

13. Renewal with Nil Claims

i. Under normal circumstances, lifetime renewal benefit is available under the Policy except on the grounds of fraud, misrepresentation or moral hazard or non-co-operation by the Insured/Insured Person or if any false statement is made.
ii. In case of our own Company's renewal a grace period of 30 days is permissible and the Policy will be considered as continuous for the purpose of waiting period. Any claim incurred as a result of Insured disease contracted during the break period will not be admissible under the Policy.
iii. For renewals received after completion of 30 days grace period, a fresh application of health insurance should be submitted to Us, it would be processed as per a new business proposal.
iv. Premium payable or any changes in terms & conditions on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA

14. Renewal upon admission of a claim:

i. Upon payment of claim the Insured has option to renew the Policy with immediate effect or on a later date as per below terms & conditions
a. If the Policy is renewed within 60 days from the date of admission of the previously paid claim for the named insured a 60 days cooling off period shall apply for the same ailment in the new Policy opted, however there would be no waiting period for other listed vector borne diseases
b. If the Policy is renewed post 60 days from the date of admission of the previously paid claim for the named insured then a fresh waiting period of 15 days shall apply for all listed vector borne diseases

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ii. For Lymphatic Filariasis, once the sum assured is paid for any life, no other claim for this particular condition shall be paid to the Named insured in the entire lifetime.

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For example,

Scenario 1- Individual Policy and family floater with Self + Spouse

If Policyholder has bought the Policy on 01 Jan 2018 and Malaria is diagnosed on 01 Feb 2018. He will be paid full sum assured (subject to fulfilment of other terms and conditions) and the Policy will terminate.

He will now have an option to renew the cover for 100% of sum assured for all covered conditions immediately after the termination of the previous Policy. He will be covered for all conditions except Malaria from day 1 of the new Policy. However he will be covered for Malaria with effect from 03 April 2018 (60 days post date of previous admission i.e. 01 Feb 2018).

Scenario 2- Family Floater with Self, Spouse and Children

If Insured has bought the family floater policy for himself, his wife and 2 children on 01 Jan 2018 and Malaria is diagnosed on 01 Feb 2018. He will be paid full sum assured (subject to fulfilment of other terms and conditions) and the coverage would cease for named insured, however the Policy shall continue for rest of the members covered under the Policy, however after payment of second claim for other Insured Persons the Policy would cease for all members.

For both scenarios mentioned above the named insured against whom a claim has been paid will now have an option to renew the cover for 100% of sum assured for all covered conditions immediately after the termination of the previous Policy. He will be covered for all conditions except Malaria from day 1 of the new Policy. However he will be covered for Malaria with effect from 03 April 2018 (60 days post date of previous admission i.e. 01 Feb 2018).

15. Insured

No person other than a person named as an Insured/Insured Person shall be covered under this Policy unless and until his name has been notified in writing to the Company. Cover under this Policy shall be withdrawn from any person named as an Insured/Insured Person immediately upon the Named Insured delivering written notice of the same to the Company. The Named Insured agrees to and shall hold the Company harmless against any and all
claims, costs and expenses that may result because of the incorrect or unintentional cancellation of this insurance in relation to any Insured/Insured Person.

16. Entire Contract

The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.

17. Portability Conditions

i. Retail Policies: As per the Portability Guidelines issued by IRDA, applicable benefits shall be passed on to customers who were holding similar retail Vector Borne Diseases policies of other non-life insurers.
ii. Group Policies: As per the Portability Guidelines issued by IRDA, applicable benefits shall be passed on to customers who were insured under a Group M-Care Policy of Company and are availing an M-Care Policy of Company. However, such benefits shall be applicable only in the event of discontinuation/ non-renewal of the Group M-Care Policy (applicable for both employer-employee relationships and non-employer-employee relationships) and/or the particular customer leaving the group on account of resignation/ retirement (applicable for employer-employee relationships) or termination of relationship with the Group Administrator (applicable for non-employer-employee relationships).

18. Territorial Limits & Governing Law

The Company's liability to make any payment shall be in Indian Rupees only.

SECTION E) GENERAL CONDITIONS – OTHER TERMS AND CONDITIONS

19. Claim 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/Insured Persons, as the case may be, must comply with the following:

i. The Insured//Insured Persons, as the case may be or someone claiming on the him/her 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//Insured Persons, as the case may be, or theirrepresentative claiming on his/ her behalf have provided the Company with necessary documentation and information.
iii. The Insured/Insured Persons, as the case may be, 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. 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) and (iii) may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible from him/her or any other person to give notice or file claim within the prescribed time limit.

A. Cashless Claims Procedure:

Cashless treatment is only available at Network Hospitals subject to cashless authorisatin and Limit of Benefits. In order to avail of cashless treatment, the following procedure must be followed by You or your representative:

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You must call Us and request pre-authorisation by way of the written form.
ii. In case of Emergency hospitalization, You/the Insured Person/ Insured Representative shall intimate such admission within 24 hours of such hospitalization
iii. On receipt of your pre-authorization form duly filled and signed by you, our representative then will respond, within 2 hours, with Approval, Rejection or an more information.

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iv. If the procedure above is followed, You will not be required to directly pay for the bill amount in the Network Hospital that We are liable under Section C Coverage above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorisation does not guarantee that all costs and expenses will be covered. The maximum amount payable would be restricted as specified under the plan opted shown on the Schedule subject to Limitation of Benefits. 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.
v. In case the hospital bill amount is lower than the payable benefit, We will directly pay You the difference between the benefit payable and the hospital bill amount. However, if the hospital bill amount is higher than the payable benefit/Limitation of Benefit, You will be required to settle the balance hospital bill on Your own.
vi. After considering Your request and after obtaining any further information or documentation We have sought, We may, if satisfied, send You or the Network Hospital, an authorisation letter. The authorisation letter, the ID card issued to You along with this Policy and any other information or documentation that We have specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Your admission to the same.

B. Reimbursement Claims Procedure:
If Pre-authorisation as per III A, above is denied by Us or if treatment is taken in a Hospital other than a Network Hospital or if You do not wish to avail cashless facility, then:
i. You or someone claiming on Your behalf must inform Us in writing immediately within 48 hours of diagnosis of any of the listed vector borne ailments
ii. You must immediately consult a Doctor and follow the advice and treatment that he recommends.
iii. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary at Our cost.
iv. You or someone claiming on Your behalf must promptly and in any event within 30 days of diagnosis of any of the listed vector borne ailment /discharge from the Hospital (if admitted) give Us the documentation as per the claims documents list specified below.

Claim documents to be submitted for claim:
i. Claim Form duly signed by the insured along with NEFT Form signed by the Claimant
ii. Copy of Discharge Summary / Discharge Certificate
iii. Attested copies of Indoor case papers (if available)
iv. Copy of Final Hospital Bill
v. All required Investigation Reports
vi. Medical certification from specialist
vii. In cases where a fraud is suspected, We may call for any additional document(s) in addition to the documents listed above.
viii. Aadhar card & PAN card Copies is as per the IRDAI guidelines read with.

Annexure I:
Contact details of the Ombudsman offices

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 – 25501201 /02 /05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
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, 1st floor, "Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR – Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 – 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH -	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and

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Office Details	Jurisdiction of Office Union Territory, District)
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	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, Opp to Maharaja's College,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 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 –	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda,

Office Details	Jurisdiction of Office Union Territory, District)
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	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

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