

M-CARE

Policy Wordings

SECTION A) PREAMBLE

Our agreement to insure You is based on Your Proposal to Us, which is the basis of this agreement, and Your payment and our receipt and realization of the prescribed premium. This Policy records the entire agreement between the Company and You and sets out what We insure, how We insure it, and what We expect of You and what You can expect of Us.

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. 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.

4. 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.

5. 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.

6. 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.

7. Disease/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.

8. Medical Advice:

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

9. 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.

10. 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.

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11. 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.

12. Non- Network Provider:

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

13. 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.

14. 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.

15. 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.

16. 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. 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

2. Family- Includes the Insured; his/her lawfully wedded spouse, and dependent children & parents

3. Limit of Benefit represents Sum Insured or Our maximum liability to make payment for claim of the Insured or for each and every claim per Insured Person and collectively for all Insured Persons (for floater policies) mentioned in the Policy Schedule annually during the Policy Period and in the aggregate for the Insured Persons(s) named in the Policy Schedule annually during the Policy Period, and also means the amount stated in the Policy Schedule against each Cover.

4. Insured/Named Insured means (i) the proposer who proposes for himself as sole Insured, or (ii) in case of family floater, the proposer who proposes for himself and Insured Persons named in the Policy Schedule. Provided that in either case the Insured shall be not more than 65 years of age.

5. Insured Person means the Insured's Family members, named in the Policy Schedule provided that Family Members of Insured shall not be older than 65 years of age at the time of commencement of the Policy.

6. Policy 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.

7. Policy Period refers to Policy period from Risk Inception Date [RID] to Risk End Date [RED], within/during which the insurance risk Cover for Insured Persons is issued by the Company under the Policy Schedule.

8. Policy Schedule means the insurance policy schedule together with these standard Terms and Conditions and any annexure attached to it.

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

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

SECTION C) OPERATIVE PART

Scope of cover:

If the Insured or the Insured Person(s), as the case may be diagnosed as suffering from a Vector Borne disease listed below which first occurs or manifests itself during the Policy Period, the Company shall pay a lump sum Benefit, as specified under the Policy Schedule, subject to Sum Insured limits, terms, conditions, definitions and exclusions contained or otherwise expressed in the Policy Schedule.

M-CARE**Coverage****1. Dengue Fever**

Subject to Limit of Benefits, the Company shall pay the benefit as specified in the Policy Schedule in the event of Insured or the Insured Person(s), as the case may be being hospitalized during the the Policy 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 Person being hospitalized during the the Policy 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 Person being hospitalized during the the Policy 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 Person in his/her entire lifetime.

4. Kala Azar

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the the Policy Period, with the diagnosis of Visceral Leishmaniasis, 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.

5. Chikungunya

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the the Policy 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 Policy Schedule in the event of Insured Person being hospitalized during the the Policy 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 Policy Schedule in the event of Insured Person being hospitalized during the the Policy 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 Persons covered under the Policy, however after payment of second claim for other Insured Persons the Policy would cease for all Insured Persons

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SECTION D) EXCLUSIONS UNDER THE POLICY - SPECIFIC EXCLUSIONS

No payment will be made by the Company for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

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

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

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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 fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

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

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://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

8. Cancellation

- i. We may cancel this insurance by giving You at least 15 days written notice, and if no claim has been made then We shall refund a pro-rata premium for the unexpired Policy Period.
- ii. You may cancel this insurance by giving Us at least 15 days written notice, and if no claim has been made then the We shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below

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

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
- 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.

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- 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. Arbitration and Reconciliation and Dispute Resolution:

- i. If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to decision of a sole arbitrator in writing by the Insured/Insured Persons/Company ["Party/Parties"] or if they cannot agree upon a single arbitrator within 30 days of any Party invoking arbitration, the same shall be referred to a panel of the arbitrators comprising of two arbitrators, one appointed by each of the Parties to the dispute/ difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996. The law of the arbitration will be Indian law, and the seat of the arbitration and venue for all hearings shall be Pune, India.
- ii. It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.
- iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained
- iv. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.
- v. It is also hereby further expressly agreed and declared that if the Company shall disclaim/repudiate the claim and liability to the Insured/Insured Persons for any claim under Policy issued to them, and such claim shall not, within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit or proceeding before a Court of law or any other competent statutory forum/tribunal, then all benefits under the Policy shall be forfeited and the rights of Insured/Insured Persons shall stand extinguished and the liability of the Company shall also stand discharged.

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
- 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.

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).

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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 their representative 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 authorisation 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-authorization 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.
- 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-authorization 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.

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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-authorization 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)
<p>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</p>	<p>Gujarat, Dadra & Nagar Haveli, Daman and Diu</p>
<p>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, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in</p>	<p>Karnataka.</p>
<p>BHOPAL - Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in</p>	<p>Madhya Pradesh Chattisgarh.</p>
<p>BHUBANESHWAR – Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in</p>	<p>Orissa.</p>

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Office Details	Jurisdiction of Office Union Territory, District)
<p>CHANDIGARH - Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in</p>	<p>Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.</p>
<p>CHENNAI - Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in</p>	<p>Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry)</p>
<p>DELHI – Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in</p>	<p>Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.</p>
<p>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</p>	<p>Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.</p>
<p>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</p>	<p>Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.</p>
<p>JAIPUR - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in</p>	<p>Rajasthan.</p>
<p>ERNAKULAM – Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.</p>	<p>Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.</p>

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Office Details	Jurisdiction of Office Union Territory, District)
Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	
KOLKATA – Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW – Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar..
MUMBAI - Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA - Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddha 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 Buddha 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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).