GROUP PERSONAL ACCIDENT - POLICY TERMS AND CONDITIONS

1. Preamble

This is a contract of insurance between You and Us which is subject to the receipt of the full premium in advance and the terms, conditions and exclusions of this Policy. This Policy has been issued on the basis of the Disclosure to information norm, including the information provided by You in respect of the Insured Person/s in the Proposal form and accompanying documentation.

2. Definitions

2.1 Standard definitions

2.1.1 **Accident** or **Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

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

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

AYUSH Hospitals referred above shall also obtain either pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

2.1.3 **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems.

2.1.4 **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

2.1.5 **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

2.1.6 **Day Care Center** means any institution established for Day Care Treatment of Illness and/or Injuries or a medical set-up with a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criterion as under:

a. has Qualified Nursing staff under its employment;
b. has qualified Medical Practitioner(s) in charge;
c. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
d. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

2.1.7 **Day Care Treatment** refers to medical treatment, and/or Surgical Procedure which is:

a. undertaken under General or Local Anaesthesia in a Hospital/Day Care Center in less than 24 hrs because of technological advancement, and
b. which would have otherwise required a Hospitalization of more than 24 hours.

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

2.1.8 **Deductible** means a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

2.1.9 **Disclosure of Information** means 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. (Note: "Material facts" for the purpose of this Policy shall mean all important, essential and relevant information sought by the Company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk)

2.1.10 **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

a. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
b. the patient takes treatment at home on account of non availability of room in a Hospital.

2.1.11 **Emergency care (Emergency)** means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Person's health.

2.1.12 **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period..

2.1.13 **Hospital** means any institution established for Inpatient 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:

a. has Qualified Nursing staff under its employment round the clock;
b. has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 Inpatient beds in all other places;
c. has qualified Medical Practitioner(s) in charge round the clock;
d. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

2.1.14 **Hospitalization** or **Hospitalized** means the admission in a Hospital for a minimum period of 24 consecutive Inpatient Care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

2.1.15 **Injury** means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

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

2.1.17 **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 or 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

2.1.18 **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.1.19 **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

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

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

2.1.22 **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his licence.

2.1.23 **Medically Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

a. is required for the medical management of the Illness or Injury suffered by the insured;
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a Medical Practitioner;
d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.1.24 **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credit gained for pre-existing conditions and specific waiting periods from one health insurance policy to another with the same insurer.

2.1.25 **Network Provider** means Hospital enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.

2.1.26 **Non-Network** means any Hospital, Day Care Center or other provider that is not part of the network.

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

2.1.28 **OPD Treatment** means the 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.

2.1.29 **Pre-existing Disease** means any condition, ailment, injury or disease

a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer, or
b. For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

2.1.30 **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:

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

2.1.31 **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the Hospital, provided that:

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

2.1.32 **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing disease and specific waiting periods from one insurer to another.

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

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

2.1.35 **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.

2.1.36 **Specific Waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break

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

2.2 Specific Definitions

2.2.1 **Break in Policy** means the period of gap that occurs at the end of the existing policy term/instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

2.2.2 Contribution means essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

2.2.3 Dependents means the Primary Insured's family members listed below:

a. Legally married spouse as long as he or she continues to be married to the Primary Insured;
b. Dependent Children
c. Father and Mother

2.2.4 Dependent Children means unmarried children (natural or legally adopted), less than 21 years of age at the time inception and at every renewal of the Policy with Us who are financially dependent on the Primary Insured or proposer and do not have their independent sources of income.

2.2.5 Insured Person means the Primary Insured and those of his Dependents named as insured in the Schedule of Insurance Certificate.

2.2.6 Aggregate Limit of Liability per Event means the amount specified in the Schedule of Insurance Certificate which represents Our maximum, total and cumulative liability for any and all claims made in respect of all Insured Persons under the Policy arising out of or in relation to an Accident or event. If the total value of such unpaid claims in respect of all Insured Persons exceed the Aggregate Limit of Liability per Event, the amounts payable on such outstanding claims shall be reduced pro rata as necessary to ensure that the Aggregate Limit of Liability per Event is not exceeded

2.2.7 Policy means these terms and conditions, any annexure thereto and the Schedule of Insurance Certificate (as amended from time to time), the information statements in the proposal form or the Information Summary Sheet and the policy wording (including endorsements, if any).

2.2.8 Policy Period means the period between the date of commencement and the expiry date specified in the Schedule of Insurance Certificate.

2.2.9 Principal Sum Assured means the amount specified in the Schedule of Insurance Certificate of an Insured Person for the benefits listed in Clause 3.1, 3.2, 3.3 and 3.4 of the Policy document and as 4.1 of the endorsements. Where the Insured Person has opted for more than 100% of the coverage amount under Clause 3.2 of the Policy document the Principal Sum Assured would mean the opted percentage amount for Clause 3.2. For an opted benefit Our maximum total and cumulative liability for any and all claims made by that Insured Person under the Policy will be limited to the Principal Sum Assured.

2.2.10 Primary Insured means Your group member who is named as the Primary Insured and as an Insured Person in the Schedule of Insurance Certificate.

2.2.11 Product Benefits Table means the Product Benefits Table issued by Us and accompanying this Policy and annexure thereto.

2.2.12 Schedule of Insurance Certificate means the Schedule of Insurance issued by Us, and, if more than one, then the latest in time.

2.2.13 Subrogation means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

2.2.14 Temporary Total Disability means a disability (other than a psychological condition) arising out of an Accident due to which the Insured Person is unable to attend to his usual occupation for a duration of not less than three (3) continuous working days.

2.2.15 We/Our/Us/Insurer means Niva bupa Health Insurance Company Limited

2.2.16 You/Your/Policyholder means the person named in the Schedule of Insurance Certificate who has concluded this Policy with Us.

Any reference to any statute shall be deemed to refer to any replacement or amendment to that statute.

3. Basic Benefits:

The following Basic Benefits shall be available only if specified to be applicable in the Schedule of Insurance Certificate, subject to the terms, conditions and limitations of the Basic Benefit under the Policy. This Policy provides benefits up to the Principal Sum Assured subject to any specific limits stated in the Product Benefit Table, the terms, conditions, limitations and specific and general exclusions mentioned in the Policy and as shown in the Schedule of Insurance Certificate and eligibility for the insurance plan opted for as specified in the Product Benefit Table and subject always to the Aggregate Limit of Liability per Event\

3.1 Accidental Death

If an Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period which solely and directly results in the Insured Person's death within three hundred and sixty five (365) days from the occurrence of such Accident We will pay the Principal Sum Assured specified in the Schedule of Insurance Certificate, provided that:

a. We will deduct any amounts already paid under the Basic Benefits or the Variable Accidental Medical Reimbursement under Optional Benefit 1 in respect of the Insured Person from any amount payable under Clause 3.1; and
b. We shall not be liable to make any payment under Clause 3.1 if We have already paid or accepted any claims under Clause 3.2 or 3.3 or 3.4 or the Variable Accidental Medical Reimbursement under Optional Benefit 1 in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Principal Sum Assured.

3.2 Accidental Permanent Total Disability (PTD)

If an Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period which solely and directly results in the Insured Person's Permanent Total Disability within three hundred and sixty five (365) days from the occurrence of such Accident We will make payment in accordance with the grid below provided that:

a. The Permanent Total Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us; and
b. We will admit a claim under Clause 3.2 only if the Permanent Total Disability continues for a continuous period of at least six (6) calendar months from the commencement of the disability and such disability is permanent at the end of this period; and
c. If the Insured Person dies before a claim has been admitted under Clause 3.2, We shall not be liable to make any payment under Clause 3.2; and
d. We shall not be liable to make payment under Clause 3.2 in respect of an Insured Person for any and all Policy Periods more than once in the Insured Person's lifetime; and
e. We will deduct any amounts already paid under the Basic Benefits or the Variable Accidental Medical Reimbursement under Optional Benefit 1 in respect of the Insured Person from any amount payable under Clause 3.2; and
f. We shall not be liable to make any payment under Clause 3.2 if We have already paid or accepted any claims under Clause 3.3 or 3.4 or the Variable Accidental Medical Reimbursement under Optional Benefit 1 in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the percentage of the Principal Sum Assured as shown in the Schedule of Insurance Certificate

Table 1:

Condition for Permanent Total Disability	**% of Sum Insured**

Actual loss by physical separation or total and permanent loss of use of both hands	100%
Actual loss by physical separation or total and permanent loss of use of both feet	
Loss of sight in both eyes	
Actual loss by physical separation or total and permanent loss of use of one hand and one foot	
Actual loss by physical separation or total and permanent loss of use of one hand and sight in one eye	
Actual loss by physical separation or total and permanent loss of use of one foot and sight in one eye	
Loss of speech and loss of hearing in both ears	
Permanent and incurable paralysis of all limbs	
Permanent total loss of mastication	
The Insured Person suffers Injuries which do not fall within any of the categories specified above but are such that the Insured Person is unlikely to ever be able to physically engage in any occupation or employment or business for remuneration or profit.	

3.3 Accidental Permanent Partial Disability (PPD)

If an Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period which solely and directly results in the Insured Person's Permanent Partial Disability within three hundred and sixty five (365) days from the occurrence of such Accident, We will make payment in accordance with the grid below provided that:

a. The Permanent Partial Disability is proved with a disability certificate issued by a Medical Board duly constituted by the Central or the State Government being presented to Us; and
b. We will admit a claim under Clause 3.3 only if the Permanent Partial Disability continues for a period of at least six (6) continuous calendar months from the commencement of the disability and such disability is continuous and permanent at the end of this period; and
c. If the Insured Person dies before a claim has been admitted under Clause 3.3, We shall not be liable to make any payment under Clause 3.3; and
d. If We have admitted a claim under Clause 3.2, then We shall not admit any claim under Clause 3.3 in respect of the Insured Person; and
e. We will deduct any amounts already paid under the Basic Benefits or the Variable Accidental Medical Reimbursement under Optional Benefit 1 in respect of the Insured Person from any amount payable under Clause 3.3 to the extent that the sum of such amounts already paid and the amount payable under Clause 3.3 is in excess of the Principal Sum Assured.
f. We shall not be liable to make any payment under Clause 3.3 if We have already paid or accepted any claims under Basic Benefits or the Variable Accidental Medical Reimbursement under Optional Benefit 1 in respect of that Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the Principal Sum Assured.

Table 2:

Nature of Permanent Partial Disability	% of the Principal Sum Assured payable
Total and irreversible loss of hearing in both ears	50%
Total and irreversible loss of speech	50%

Actual loss by physical separation or total and permanent loss of use of one hand	50%
Actual loss by physical separation or total and permanent loss of use of one foot	50%
Total and irreversible loss of sight in one eye	50%
Actual loss by physical separation or total and permanent loss of use of four fingers and thumb of one hand	40%
Actual loss by physical separation or total and permanent loss of use of four fingers	30%
Total and irreversible loss of hearing in one ear	30%
Actual loss by physical separation or total and permanent loss of use of thumb and index finger of the same hand	25%
Actual loss by physical separation of all toes	20%
Actual loss by physical separation or total and permanent loss of use of thumb	15%
Actual loss by physical separation or total and permanent loss of use of index finger	10%
Non union of fractured leg or kneecap	10%
Shortening of leg by at least 5 cm	7.5%
Actual loss by physical separation or total and permanent loss of use of middle finger	6%
Actual loss by physical separation or total and permanent loss of use of ring finger	5%
Actual loss by physical separation or total and permanent loss of use of little finger	4%
Actual loss by physical separation of great toe (both phalanges)	5%
Actual loss by physical separation of great toe (one phalanx)	2%
Actual loss by physical separation of any toes other than the great toe, provided that more than one toe is lost	1% each
Loss of metacarpals - first or second (additional) or third, fourth or fifth (additional)	3%

3.4 Temporary Total Disability (TTD)

If the Primary Insured suffers an Injury solely and directly due to an Accident occurring during the Policy Period which solely and directly results in the Primary Insured's Temporary Total Disability, We will pay the lowest of the Primary Insured's weekly earning and Rs.100, 000 per week for each week that the Temporary Total Disability continues, or the amount as specified in the Schedule of Insurance Certificate. It is agreed and understood that:

a. For the purpose of Clause 3.4, "weekly earning" shall not include any overtime, bonuses, tips, commissions, allowances or special compensations or any components of variable pay that the Primary Insured may have otherwise been eligible to receive.
b. We will make payment under Clause 3.4 for only a part of the week if the Primary Insured has suffered Temporary Total Disability for that part of the week.
c. We shall not be liable to make any payment under Clause 3.4 in respect of more than 100 continuous weeks in any Policy Period, subject always to the Principal Sum Assured.

d. The amount payable under Clause 3.4 is calculated on a per day basis and shall be payable from the first day of onset of the Temporary Total Disability provided that the Temporary Total Disability continues for at least 3 continuous days
e. We will make payment of the amount due under Clause 3.4 when the Primary Insured's Temporary Total Disability has ceased unless the Temporary Total Disability continues for a continuous period of more than 30 days in which case We will make payment of the amount due under Clause 3.4 at the end of every calendar month until the Temporary Total Disability ceases.
f. We will deduct any amounts already paid under the Basic Benefits or the Variable Accidental Medical Reimbursement under Optional Benefit 1 in respect of the Primary Insured from any amount payable under Clause 3.4 to the extent that the sum of such amounts already paid and the amount payable under Clause 3.4 is in excess of the Principal Sum Assured.
g. We will not issue a Policy with Temporary Total Disability as a standalone benefit.

4. Optional Benefits (available only with Basic Benefits)

This Policy may also provide optional benefits if these are specified to be applicable in the Schedule of Insurance Certificate subject to the terms, conditions and limitations of the optional benefits.

All Optional Benefits issued with this Policy or endorsed to the Schedule of Insurance Certificate shall be subject to the terms, conditions and exclusions of this Policy, except to the extent expressly varied by the endorsement. All other Policy terms, conditions and exclusions shall remain unchanged. Any of the Optional Benefits below shall be applicable only if the Policyholder expressly opts for the Optional Benefit and We have issued an endorsement to the Schedule of Insurance Certificate.

4.1 Accidental Medical Reimbursement

If the Insured Person is Hospitalised during the Policy Period solely and directly due to an Injury sustained arising from an Accident occurring during the Policy Period, We will pay:

a. The Fixed Medical Expenses incurred subject to the maximum amount specified in the Schedule of Insurance Certificate, provided that not more than 20% of the amount payable under Clause 4.1.a shall be in respect of Out-patient Treatment.
b. The lowest of the following in respect of Variable Medical Expenses incurred:
    i. Actual Variable Medical Expenses incurred;
    ii. An amount equal to 10% of the Principal Sum Assured amount;
    iii. The percentage of the admissible claim amount under Clause 3.1 or Clause 3.2 or Clause 3.3 or Clause 3.4 specified in the Schedule of Insurance Certificate;

We shall not be liable to make any payment under Clause 4.1.b unless a claim has been admitted under Clause 3.1 or Clause 3.2 or Clause 3.3 or Clause 3.4 .

We will deduct any amounts already paid under the Basic Benefits or Clause 4.1.b in respect of the Insured Person from any amount payable under this clause to the extent that the sum of such amounts already paid and the amount payable under Clause 4.1.b is in excess of the Principal Sum Assured.

For the purpose of this Optional Benefit:

(a) Fixed Medical Expenses means those Medical Expenses incurred by an Insured Person due to an Injury sustained from an Accident occurring during the Policy Period
(b) Variable Medical Expenses means those Medical Expenses incurred by an Insured Person due to an Injury sustained arising from an Accident occurring during the Policy Period when a claim is payable under any of the Basic Benefits.

4.2 Education Allowance for children

In case of the Accidental Death or Permanent Total Disability of the Primary Insured We will make a onetime payment of the amount specified in the Schedule of Insurance Certificate for the education of the Primary

Insured's Dependent children provided that We shall not be liable to make payment under Clause 4.2 for more than 2 Dependent children in the Policy Period.

4.3 Residential Accommodation and Vehicle Modification Allowance

In case of Permanent Total Disability of the Insured Person, We will reimburse, the expenses incurred towards the modification of residential accommodation and the vehicle of the Insured Person to adapt to the altered lifestyle of the Insured Person necessitated by the Permanent Total Disability condition, subject to the amount payable under Clause 4.3 being the lower of 5% of the Principal Sum Assured and the amount specified in the Schedule of Insurance Certificate.

4.4 Family Transportation Allowance

If the Accident has occurred outside the city of residence of the Insured Person specified in the Schedule of Insurance Certificate and such Accident results to Accidental Death or Permanent Total Disability of the Insured Person, We will indemnify the transportation costs of 1 Family member of the Insured Person from the city of residence to the place of occurrence of the Hospitalisation of the Insured Person, provided that:

a. The Family member's journey to the place of occurrence of the Hospitalisation of the Insured Person commences not later than 5 days from the occurrence of the Accident;
b. We shall only reimburse up to the costs of economy air fare on the most direct route under Clause 4.4.
c. We shall not be liable to make payment under Clause 4.4 in excess of the amount specified in the Schedule of Insurance Certificate. For the purpose of Clause 4.4, NCR, Mumbai (with suburbs), Hyderabad (with suburbs) and Pune (with suburbs) shall be considered individually as 1 city.

For the purpose of this Optional Benefit Family means any one of the relationships with the Insured Person: spouse, father, mother, father-in-law, mother-in-law, brother, sister-in-law, sister, brother-in-law, son or daughter.

4.5 Last rites Expenses

In the event of the Accidental Death of the Insured Person, We will make a onetime payment of Rs. 5,000 towards the funeral expenses of that Insured Person.

4.6 Waiver for Permanent Exclusion

a. Coverage for Adventure Sports

The following clause shall be added to the Policy as follows and shall be integrated into and construed as a part of Clause 4 :-

b. Coverage for Adventure Sports

Exclusion 4(ix) shall be deleted entirely.

c. Terrorism Coverage

The following clause shall be added to the Policy as follows and shall be integrated into and construed as a part of Clause 4:-

d. Terrorism Cover

Exclusion 4(xv) shall be deleted entirely.

4.7 Coverage for Parents

It is expressly agreed and understood that the Sum Assured for each Dependent parent who is an Insured Person shall be equal to the percentage of the Principal Sum Assured of the Primary Insured specified in the Schedule of Insurance Certificate.

4.8 Broken Bones coverage

If an Insured Person suffers an Injury solely and directly due to an Accident occurring during the Policy Period which solely and directly results in a fracture of the Insured Person's bones within thirty (30) days from the occurrence of such Accident, We will make payment in accordance with the grid below provided that We shall not be liable to make any payment in excess of the amount specified in the Schedule of Insurance Certificate provided that:

a. We shall not be liable to make any payment under Clause 4.8 unless the fracture is medically recognized and a physician has certified in writing the extent and nature of the fracture;

b. If an Injury results in more than one fracture specified in the grid below, We will be liable to pay the amount payable for each such fracture, subject to availability of the Broken Bones Sum Assured specified in the Schedule of Insurance Certificate and the amount specified in the Schedule of Insurance Certificate.

Nature of Fracture	% of Broken Bones Sum Assured payable	
	If treated with surgery under anesthesia	It treated without surgery
Fracture of skull, vertebral column (excluding coccyx)	100%	50%
Fracture of pelvis, thigh or knee cap	50%	25%
Fracture of lower leg (excluding small bones of hand and foot, fingers and toes), ankle, arm or forearm, elbow, facial bones	30%	15%
Fractures of rib or ribs, nose, collar bone, lower jaw, shoulder bone, small bones of hand and foot (excluding fingers and toes)	10%	5%
Fractures of fingers or toes, coccyx	6%	3%

4.9 Corporate Floater (For Employer-Employee groups only)

If a claim has been made in respect of the Primary Insured under Clause 3.1 or Clause 3.2 or Clause 3.3, then on Your prior written request, in addition to any amount payable under the Basic Benefits, We will make payment from the Corporate Floater Sum Assured of the lower of the amount specified in the Schedule of Insurance Certificate and the percentage of the admitted claim amount specified in the Schedule of Insurance Certificate provided that:

a. The Corporate Floater Sum Assured has not already been exhausted; and

b. The Insured Person's claim is made under Clause 3.1 or Clause 3.2 or Clause 3.3 only.

c. The Corporate Floater Sum Assured is Our maximum, total and cumulative liability for any and all claims made in respect of all Insured Persons during the Policy Period.

4.10 Elimination Period

For all Claims arising under Clause 3.4 We will be liable to pay the benefit amount only after the expiry of the elimination period specified in the Schedule of Insurance Certificate.

4.11 Any One Year (AOY) Loss Limit

Our maximum, total and cumulative liability in respect in any and all claims made in respect of any and all Insured Persons in a Policy Period shall not exceed the Any One Year Limit specified in the Schedule of Insurance Certificate.

If the Any One Year Limit is exhausted before the expiry of the Policy Period, You may request a reinstatement of the Any One Year Limit in writing provided that:

a. You pay the additional premium specified by Us in advance, provided that the minimum premium payable shall not be for a period of less than 30 days and in each reinstatement of the Any One Year Limit, You shall pay only for the remaining portion of the Policy Period;

b. Each reinstatement of the Any One Year Limit shall not exceed the previous amount claimed under the Policy and the sum of all reinstatements of the Any One Year Limit during the Policy Period shall not exceed the original Any One Year Limit.

c. All reinstatements are at Our sole discretion and subject to Our underwriting guidelines.

4.12 Benefits available in special conditions

We will provide the benefits shown in the Schedule of Insurance Certificate under this policy only under the conditions specified below:

The Basic Benefits and all Optional Benefits applicable under this Policy shall only apply to any Accident occurring in respect of the Primary Insured solely and directly in the course of the Primary Insured's employment and in the course of his official duties.

a. The Basic Benefits and all Optional Benefits applicable under this Policy shall only apply to any Accident occurring in respect of the Primary Insured when the Primary Insured is out of the office premises but solely and directly in the course of his official duties.

b. The Basic Benefits and all Optional Benefits applicable under this Policy shall only apply to any Accident occurring in respect of the Primary Insured solely and directly when the Primary Insured is travelling in the course of the Primary Insured's employment and in the course of his official duties

5. Permanent Exclusions

A permanent exclusion will be applied on any medical or physical condition or treatment of an Insured Person, if specifically mentioned in the Policy Schedule and has been accepted by You. This option as per company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person. We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically mentioned elsewhere in the Policy.

5.1 Standard exclusions

i. Investigation & Evaluation (Code-Excl04)

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

ii. Rest Cure, rehabilitation and respite care (Code-Excl05)

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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

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

iii. Obesity/ Weight Control (Code-Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor.
b. The surgery/Procedure conducted should be supported by clinical protocols.
c. The member has to be 18 years of age or older and;
d. Body Mass Index (BMI);
   i. greater than or equal to 40 or
   ii. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      1. Obesity-related cardiomyopathy
      2. Coronary heart disease
      3. Severe Sleep Apnea
      4. Uncontrolled Type2 Diabetes

iv. Change-of-Gender treatments (Code-Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. Cosmetic or plastic Surgery (Code-Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vi. Hazardous or Adventure sports (Code-Excl09)

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

vii. Breach of law (Code-Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

viii. Excluded Providers (Code-Excl11)

Expenses incurred towards treatment in any Hospital or by any Medical Practitioner or any other provider specifically excluded by Us and disclosed in Our website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

ix. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**

x. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code-Excl13)**

xi. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or Day Care procedure **(Code-Excl14)**

xii. **Refractive Error (Code-Excl15)**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

xiii. **Unproven Treatments (Code-Excl16)**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

xiv. **Sterility and Infertility (Code-Excl17)**
Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

xv. **Maternity Expenses (Code-Excl18)**

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an Accident) and lawful medical termination of pregnancy during the Policy Period.

5.2 Specific exclusions

i. **Suicide** or self inflicted injury, whether the Insured Person is medically sane or insane.
ii. War (whether declared or not), invasion, act of foreign enemy, hostilities, civil war, martial law, rebellion, revolution, insurrection, military or usurper power, riot or civil commotion.
iii. Service in the armed forces, or any police organization, of any country at war or at peace or service in any force of an international body or participation in any of the naval, military, paramilitary or air force operation during peace time.
iv. Any change of nature of job after inception of the Policy which results in the enhancement of Our risk, if not accepted and endorsed by Us on the Schedule of Insurance Certificate.
v. Committing an assault, a criminal offence or any breach of law with criminal intent.
vi. Taking or absorbing, accidentally or otherwise, any intoxicating liquor, drug, narcotic, medicine, sedative or poison, except as prescribed by a licensed doctor.
vii. Inhaling any gas or fumes, accidentally or otherwise, except in the course of duty.
viii. Participation in aviation other than as a fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.

ix. Engaging in or taking part in professional or adventure sports or any hazardous pursuits, such as diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping; skiing, sky diving, gliding and winter sports.

x. Any disability arising out of Pre-Existing Disease if not accepted and endorsed by Us on the Schedule of Insurance Certificate.

xi. Body or mental infirmity or any disease except where such condition arises directly due to an Accident occurring during the Policy Period.

xii. Accidental death or disability due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

xiii. Caused by or contributed to or arising from any nuclear weapon materials.

xiv. Caused by or contribution to or arising from any ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.

xv. Any loss, damage, cost or expenses of whatsoever nature caused by, resulting from or in connection with any act of terrorism.

xvi. Death or disablement resulting from, caused by, contributed to or aggravated or prolonged by child birth or from pregnancy.

xvii. Any costs or expenses specified in the List of Expenses Generally Excluded in Annexure II. The Annexure II is only applicable to Accidental Medical Reimbursement benefit.

6. General Terms and Conditions

6.1 Standard General Terms and Conditions

6.1.1 **Free look period**

The Free Look Period shall be applicable on individual health insurance policies and not on renewals.

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.. If he/she is not satisfied with any of the terms and conditions , he/she has the option to cancel his/her policy. In the event the policyholder disagrees to any of the policy terms or conditions, or otherwise and has not made any claim, he/she shall have the option to retun the policy to the insurer for cancellation, stating the reasons for the same.

Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

6.1.2 **Cancellation**

The policy holder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The insurer shall:

a. Refund proportionate premium for unexpired policy period, if the term of the policy upto one year and there is no claim(s) made during the policy period.
b. Refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years are not commenced.

In case of death of an Insured, pro-rate refund of the premium for the deceased insured will be refunded, provided there is no history of claim.

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

A. **Automatic Cancellation** –

The Certificate of Insurance coverage shall automatically terminate in the event of death of the Insured Person.

B. **Cancellation in case of Credit Linked Cases:**

i. In cases the Policy is linked to the credit/ loan tenure, the coverage will continue till the end of loan tenure subject to maximum tenure of 5 years, closure of the loan or Policy Period/ Coverage Period Term whichever is earlier. The Insured Person shall inform Us of such closure of the loan immediately in order to cancel the cover under the Policy.

6.1.3 **Renewal of Policy**

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured.

An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.

a. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
b. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days (annual installment) to maintain continuity of benefits without break in policy.
c. Coverage is available during the grace period.
d. No loading shall apply on renewals based on individual claims experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience.
e. Insurer shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc at renewal stage where there is no change in sum insured offered. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured

6.1.4 **Nomination**

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

6.1.5 **Fraud**

If any claim made by the Insured Person, 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 Person 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.

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.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, 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 Person does not believe to be true;
b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person / 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.

6.1.6 **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.

6.1.7 **Moratorium Period**

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on the grounds of non-disclosure, misrepresentation, except on grounds of established fraud. The period of sixty continuous months is called as moratorium period. The moratorium will be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would applicable from the date of enhancement of sums insured only on the enhanced limits.

The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

Note: the accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium Period.

6.1.8 **Portability**

A Policyholder has the choice to port his/ her policies from one Insurer to another irrespective of individual or group policy subject to the Board approved underwriting policy of the insurers.

The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease , Moratorium period etc. from the Existing Insurer to the Acquiring Insurer in the previous policy.

6.1.9 **Migration**

In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy.

The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

6.1.10 **Withdrawal of Policy**

a. 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.
b. Insured Person will have the option to either renew (up to 90 days from renewal date) same product or 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.

6.1.11 **Redressal of Grievance**:

In case of any grievance the Insured Person may contact the company through:

Website: www.nivabupa.com

Toll free: 1860-500-8888

E-mail: Email us through our service platform https://rules.nivabupa.com/customer-service/ (Senior citizens may write to us at: seniorcitizensupport@nivabupa.com)
Fax: 011-4174-3397
Courier: Customer Services Department
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida,
Uttar Pradesh, 201301

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at:

Head – Customer Services
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida,
Uttar Pradesh, 201301

Contact No: 1860-500-8888
Fax No: 011-4174-3397
Email ID: Email our Grievance officer through our Grievance Redressal platform
https://transactions.nivabupa.com/pages/grievance-redressal.aspx
For updated details of grievance officer, kindly refer the link https://www.nivabupa.com/customer-care/health-services/grievance-redressal.aspx

If the Insured person is not satisfied with the above, they can escalate to GRO@nivabupa.com.

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 (at the addresses given in Annexure III).

Grievance may also be lodged at IRDAI integrated Grievance Management System – www.bimabharosa.irdai.gov.in

6.1.12 **Claim settlement (Provision for Penal interest)**

a. The Company shall settle or reject a claim, as the case may be, within 15 days from the claim submission date.
b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of claim document till the date of payment of claim at a rate of 2% above the bank rate.

6.1.13 **Multiple Policies**

a. Indemnity Based Policies:

a. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his / her claim in terms of any of his / her policies. In all such cases the insurer chosen by the Policyholder shall be considered as the Primary Insurer and will be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.
b. If the amount to be claimed exceeds the available coverage of the said policy, then the primary insurer shall seek the details of other available policies of the policyholder and shall coordinate with other insurers to ensure settlement pf the balance amount as per the policy conditions, without causing any hassles to the policy holder.

b. Benefit Based Policies:

a. On occurrence of the insured event, the policy holder can claim from all Insurers under all policies.

6.1.14 **Disclosure to 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)

6.1.15 **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.

6.1.16 **Complete Discharge**

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

6.2 Specific Terms and Conditions

6.2.1 **Additional premium (Risk Loading)**

a. We may ask for additional premium after due risk evaluation (it's what referred to as Underwriting) based on all information provided by you. We will issue policy to you only after you pay us the additional premium and provide us consent.
b. We will never ask for more than 100% for any particular health condition and never more than 150% for any individual.
c. Once applied, Risk loading continues even for all renewals

6.2.2 **Other Renewal Conditions:**

a. Renewal Premium:

Renewal premium can alter based on Age.

b. Addition of Insured Persons on Renewal:

If a new member is added in the Policy, either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions, loading (if any) and Waiting Periods will be applicable afresh for that member.

c. Changes to Sum Insured on Renewal:

You may opt for enhancement of Sum Insured at the time of Renewal, subject to underwriting.

6.2.3 **Policy Disputes**

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

6.2.4 **Notices**

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

a. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which We must receive written notice.
b. Us at the following address:

Niva Bupa Health Insurance Company Limited
D-5, 2nd Floor, Logix Infotech Park
opp. Metro Station, Sector 59, Noida,
Uttar Pradesh, 201301
Fax No: 011-4174-3397

c. No insurance agents, brokers or other person/entity is authorized to receive any notice on Our behalf.
d. In addition, we may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

6.2.5 **Alteration to the Policy**

This Policy constitutes the complete contract of insurance. Any change in the Policy will only be evidenced by a written endorsement signed and stamped by Us. No one except Us can within the permission of the IRDAI change or vary this Policy.

6.2.6 **Assignment**

The Policy can be assigned subject to applicable laws.

6.2.7 **Premium Payment in Installments**

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

a. Grace Period of 30 days in all types of policies, and a period of 15 days in case of monthly installments
b. For policies where premium is paid in instalments only, the coverage will be given during grace period.
c. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
d. No interest will be charged If the instalment premium is not paid on due date
e. In case of instalment premium due not received within the grace period, the policy will get cancelled.
f. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

6.2.8 **Claims**

a. Cashless claim facility is available at our network hospitals ONLY. As list of network hospitals is dynamic, for the latest list, refer to our website www.nivabupa.com.

b. Once the final authorization request is received for discharge, the same will be processed within three hours from the final documents received. In case of delay from our end, any additional amount charged by the hospital will be borne by us. This amount will be paid over and above the policy limits.
Note: We offer Cashless Everywhere, even in hospitals which are not part of our network. For More details and process please visit our website: https://transactions.nivabupa.com/cashlessclaims/pages/intimation-claim.aspx

c. We shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense at the earliest possible time.

Documents required

Accidental Death	1. Duly filled and signed claim form 2. Original Death Certificate (issued by the office of Registrar of Births and Deaths) 3. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station 4. Copy of Medico Legal Certificate duly attested by the concerned hospital. 5. Copy of Post Mortem report wherever applicable (provided Post Mortem was conducted) 6. Newspaper cuttings / news articles covering the accident (if available)
Accidental Permanent Total Disability and Accidental Permanent Partial Disability	1. Duly filled and signed claim form 2. Hospital Discharge Summary (in original) / self attested copies if the originals are submitted with another insurer 3. Medical consultations and investigations done from outside the hospital. 4. Original certificate of Disability issued by a Medical Board duly constituted by the Central and the State Government. 5. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station 6. Copy of Medico Legal Certificate duly attested by the concerned hospital. 7. Newspaper cuttings / news articles covering the accident (if available)
Accidental Temporary Total Disability	1. Duly filled and signed claim form 2. Hospital Discharge Summary (in original) / self attested copies if the originals are submitted with another insurer. 3. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station 4. Copy of Medico Legal Certificate duly attested by the concerned hospital.

	5. Attendance record of employer / Certificate of employer confirming period of absence 6. Latest salary certificate with grade and designation 7. Newspaper cuttings / news articles covering the accident (if available)
Fixed Medical Expenses (not linked to basic benefits)	1. Duly filled and signed claim form 2. Hospital Discharge Summary (in original) / self attested copies if the originals are submitted with another insurer. 3. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station 4. Copy of Medico Legal Certificate duly attested by the concerned hospital. 5. Final Hospital bill with receipt 6. Bills with supporting prescriptions and reports for investigations done outside the hospital 7. Bills with supporting prescriptions for medicines purchased from outside the hospital 8. Newspaper cuttings / news articles covering the accident (if available)
Variable Medical Expenses (linked to basic benefits)	In addition to the documents required for the Accidental Death, Accidental Permanent Total Disability, Accidental Permanent Partial Disability or Temporary Total Disability: 1. Final Hospital bill with receipt /copies attested by other insurer if the originals are submitted with them. 2. Original bills with supporting prescriptions and reports for investigations done outside the hospital/ copies attested by other insurer if the originals are submitted with them. 3. Original bills with supporting prescriptions for medicines purchased from outside the hospital / copies attested by other insurer if the originals are submitted with them.
Residential Accommodation and Vehicle Modification Allowance	1. Duly filled and signed claim form 2. Documents required for Accidental Permanent Total Disability (if not already submitted) 3. Bills for Residential Accommodation or Vehicle Modification. 4. Narration from architect / civil engineer / affidavit from the customer detailing the modifications done to the house.

	5. Narration from vehicle workshop detailing the modifications done.
Family Transportation	1. Duly filled and signed claim form 2. Documents required for Accidental Death or Accidental Permanent Total Disability (if not already submitted) 3. Copy of ticket and invoice 4. Copy of boarding pass (if journey performed by air)
Last Rites	1. Duly filled and signed claim form 2. Documents required for Accidental Death (if not already submitted)
Broken bones cover	1. Duly filled and signed claim form 2. Hospital Discharge Summary (in original) / self attested copies if the originals are submitted with another insurer / Consultation notes (if hospitalization has not occurred) 3. X-Ray and MRI films along with reports 4. Copy of First Information Report (FIR) / Panchnama / Inquest report duly attested by the concerned police station 5. Copy of Medico Legal Certificate (MLC) duly attested by the concerned hospital. 6. Narration of events of accident if no FIR / MLC available 7. Newspaper cuttings / news articles covering the accident (if available)
Education Allowance for Children	1. Duly filled and signed claim form 2. Documents required for Accidental Death or Accidental Permanent Total Disability (if not already submitted) 3. Letter from employer or group administrator confirming the number of children of Insured Person.

IMPORTANT:

- For any delay in submission, You **MUST** provide the reasons in writing. We will condone such delay on merits (i.e. reasons beyond your control).
- We reserve the right to ask for additional documents/reports from case to case basis.
- We reserve the right to check and investigate the hospital / medical records from any doctor, Hospital, clinic, individual or institution.

- For any hospitalization, We will pay for items included in the bill by the Hospital during the duration of hospitalization. Items not included in the bill will not be paid.

Annexure 1 - The expenses that are not covered or subsumed into room charges / procedure charges / costs of treatment

List I – Expenses not covered

S. No.	Item	S. No.	Item	S. No.	Item
1	BABY FOOD	24	ATTENDANT CHARGES	47	LUMBO SACRAL BELT
2	BABY UTILITIES CHARGES	25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	48	NIMBUS BED OR WATER OR AIR BED CHARGES
3	BEAUTY SERVICES	26	BIRTH CERTIFICATE	49	AMBULANCE COLLAR
4	BELTS/ BRACES	27	CERTIFICATE CHARGES	50	AMBULANCE EQUIPMENT
5	BUDS	28	COURIER CHARGES	51	ABDOMINAL BINDER
6	COLD PACK/HOT PACK	29	CONVEYANCE CHARGES	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
7	CARRY BAGS	30	MEDICAL CERTIFICATE	53	SUGAR FREE Tablets
8	EMAIL / INTERNET CHARGES	31	MEDICAL RECORDS	54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	32	PHOTOCOPIES CHARGES	55	ECG ELECTRODES
10	LEGGINGS	33	MORTUARY CHARGES	56	GLOVES
11	LAUNDRY CHARGES	34	WALKING AIDS CHARGES	57	NEBULISATION KIT
12	MINERAL WATER	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
13	SANITARY PAD	36	SPACER	59	KIDNEY TRAY
14	TELEPHONE CHARGES	37	SPIROMETRE	60	MASK
15	GUEST SERVICES	38	NEBULIZER KIT	61	OUNCE GLASS
16	CREPE BANDAGE	39	STEAM INHALER	62	OXYGEN MASK
17	DIAPER OF ANY TYPE	40	ARMSLING	63	PELVIC TRACTION BELT
18	EYELET COLLAR	41	THERMOMETER	64	PAN CAN

19	SLINGS	42	CERVICAL COLLAR	65	TROLLY COVER
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	43	SPLINT	66	UROMETER, URINE JUG
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	44	DIABETIC FOOT WEAR	67	AMBULANCE
22	TELEVISION CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)	68	VASOFIX SAFETY
23	SURCHARGES	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER		

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

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

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

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

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

S. No.	Item	S. No.	Item	S. No.	Item
1	ADMISSION/REGISTRATION CHARGES	7	INFUSION PUMP– COST	13	MOUTH PAINT
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC	14	VACCINATION CHARGES
3	URINE CONTAINER	9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	15	ALCOHOL SWABES
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	10	HIV KIT	16	SCRUB SOLUTION⁄STERILLIUM
5	BIPAP MACHINE	11	ANTISEPTIC MOUTHWASH	17	GLUCOMETER & STRIPS
6	CPAP/ CAPD EQUIPMENTS	12	LOZENGES	18	URINE BAG

Annexure 2 - List of Insurance Ombudsmen

Office Details	Jurisdiction of Office Union Territory,District)
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu.
BENGALURU - Smt. Neerja Shah 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@ecoi.co.in	Karnataka.
BHOPAL - Shri Guru Saran Shrivastava Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Dr. Dinesh Kumar Verma Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh.
CHENNAI - Shri M. Vasantha Krishna Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).

Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI - Shri Kiriti .B. Saha 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@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD - Shri I. Suresh Babu 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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, UT of Yanam and part of UT of Pondicherry.
JAIPUR - Smt. Sandhya Baliga Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, UT of (a)Lakshadweep,(b) Mahe-a part of UT of Pondicherry.
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, UT of Andaman & Nicobar Islands.

LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Shri Milind A. Kharat Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan SevaAnnexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.

Tel.: 022 - 26106889 / 671 / 980
Fax: 022 - 26106949

Email:inscoun@ecoi.co.in
Shri. M.M.L. Verma, Secretary General
Smt. Moushumi Mukherji, Secretary

Ombudsmen details are subject to change. Please refer this link for the updated details: CIO (cioins.co.in)"