Arogya Sanjeevani Policy, Niva Bupa Health Insurance Co. Ltd. – Prospectus cum Sales Literature

'Arogya Sanjeevani' - Start a healthy relationship

'Arogya Sanjeevani' provides a basic health insurance coverage for you and your family. It is a health insurance policy with all vital benefits tailor made for you. Apart from offering you this health insurance cover, we are also committed to provide you with quality services when you need it the most.

Why Niva Bupa is the healthier health insurance for you and your family:

- You talk to us directly, not through any third parties. We will be there for you when you need us. Because you should concentrate on getting healthier, not chasing your claims.
- You can access our cashless facility at the hospitals of your city which are part of our partner network.
- To build a relationship that lasts a lifetime, we make all efforts to understand your health profile during enrollment, so that when you need us, we can provide speedy and efficient support.
- We cover families across life stages - self, spouse, dependent children and parents and/ or parents-in-law.
- We assure you renewability of your policy for lifetime, if you pay renewal premium within the grace period of 30 days of expiry of your previous policy (15 days in case of premium payment mode other than yearly payment). You should renew on or before the renewal date of the policy to ensure you have continued medical insurance cover even during the grace period.
- As with all health insurance policies, you may save tax under Section 80D of the Income Tax Act when you buy a Niva Bupa health insurance policy. (Tax benefits are subject to changes in the tax laws, so please consult your tax advisor for more details)

1. **Policy Design**
   - 'Arogya Sanjeevani' policy can be issued to an individual customer or to a family with dependent children and / or parents/ parents in law.
   - The sum insured chosen can be on individual basis (i.e. separate equal sum insured for all members) or floater basis (i.e. same sum insured shared among all members).
   - The family includes spouse, dependent children, parents and parents in law.
   - The range of entry ages for principal insured under the policy is from 18 years (last birthday) to 65 years (last birthday). The range of entry ages for dependent children is from 3 months to 25 years. *Please note if any Insured Person who is a child and has completed 26 years at the time of Renewal, then such Insured Person will have to take a separate policy based on Our underwriting guidelines, as he/she will no longer be eligible to be covered under a Policy as a dependent child. In such cases, the credit of the Waiting Periods served under the Policy will be passed on to the separate policy taken by such Insured Person.*
   - The default policy term for all plans is one year.
   - Fixed co-payment of 5% is applicable for all claims under this product.
   - The premium payment modes allowed under the policy are Yearly, Half-Yearly, Quarterly or Monthly.
     - The installment factors for calculating premium are as follows:

Payment mode	Monthly	Quarterly	Half Yearly	Yearly
Installment Factor	8.6%	25.5%	50.7%	100%

     - The premium payment mode once opted, can be changed only at the end of the policy term of one year.
     - For monthly mode, the premium for the second policy month is required to be paid along with first month's premium installment. Thereafter, regular monthly premium is required to be paid from third policy month.

- **No-Claim Discount:** In case a consumer is receiving Cumulative Bonus at the time of renewal, as specified in the policy wordings, we will offer a flat discount of INR 49 to the policy. This discount is applicable only at Renewals on the renewal premium and will not be offered if Cumulative Bonus is not offered in a particular policy period. The discount will be offered for each policy period where there is Cumulative Bonus including the policy that has reached its maximum limit of Booster Benefit.
  - ACH / SI is mandatory for all premium payment modes other than Yearly mode.
  - In case of a claim, if monthly or quarterly or half yearly premium payment mode is opted, then the remaining premium payable for the policy year will be deducted from the admissible claim amount.
  - In case of cancellation of the policy (other than free-look) where monthly premium payment mode is opted, there will be no refund of the premium.
- The premium rates for the plans offered are annexed hereto with the prospectus as Annexure C.

2. Coverage Options

Sum insured range from Rs. 50,000 to Rs. 10 lacs (in multiple of Rs. 50,000). For the Policy, Sum Insured plus Cumulative Bonus, is Our maximum, total and cumulative liability for any and all claims during the Policy Year in respect of the Insured Person.

3. Product Features and Benefits- Key highlights

The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy .

3.1. Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year , up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital/ Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/- per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day.
iii. Surgeon, Anesthetist , Medical Practitioner , Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

3.1.1. Other expenses:

i. Expenses incurred on treatment of cataract subject to the sub limits
ii. Dental treatment, necessitated due to disease or injury
iii. Plastic surgery necessitated due to disease or injury
iv. All the day care treatments
v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.

Note:

I. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.

II. If the Insured Person is admitted in a room / ICU / ICCU at rates exceeding the aforesaid limits, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula:

(eligible Room limit / Room Rent actually incurred) * total Associated Medical Expenses

Associated Medical Expenses shall include Room Rent, nursing charges, Medical Practitioners' fees and operation theatre charges.

3.2. AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

3.3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per each eye in one policy year.

3.4. Pre Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring in patient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

3.5. Post Hospitalisation

The company shall indemnify post-hospitalization medical expenses incurred, related to an admissible hospitalization requiring in patient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

3.6. The following procedures will be covered (wherever medically indicated) either as inpatient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)
B. Balloon Sinuplasty
C. Deep Brain Stimulation
D. Oral Chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra Vitreal Injections
G. Robotic Surgeries
H. Stereotactic Radio Surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the Prostrate (Green Laser treatment or Holmium Laser Treatment)
K. IONM-(Intra Operative Neuro Monitoring)
L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

3.7. The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II ,List-III and List-IV of Annexure-A respectively.

4. CUMULATIVE BONUS (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

Notes:

I. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.
II. In case where the policy is on floater basis , the CB shall be added and available to the family on floater basis , provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons.
III. CB shall be available only if the Policy is renewed / premium paid within the Grace Period.
IV. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons.
V. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/ individual policies or in cases where the policy is split due to the child attaining the age of 26 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
VI. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.
VII. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.
VIII. If a claim is made in the expiring Policy Year , and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

5. WAITING PERIOD

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

5.1. Pre-Existing Diseases (Code- Excl 01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations 2024, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

5.2. First Thirty Days Waiting Period (Code- Excl 03)

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

5.3. Specific Waiting Period (Code- Excl 02)

a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of

inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/ procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i) 24 Months waiting period
   A) Benign ENT disorders
   B) Tonsillectomy
   C) Adenoidectomy
   D) Mastoidectomy
   E) Tympanoplasty
   F) Hysterectomy
   G) All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
   H) Benign prostate hypertrophy
   I) Cataract and age related eye ailments
   J) Gastric/ Duodenal Ulcer
   K) Gout and Rheumatism
   L) Hernia of all types
   M) Hydrocele
   N) Non Infective Arthritis
   O) Piles, Fissures and Fistula in anus
   P) Pilonidal sinus, Sinusitis and related disorders
   Q) Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
   R) Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
   S) Varicose Veins and Varicose Ulcers
   T) Internal Congenital Anomalies

ii) 36 Months waiting period
   A) Treatment for joint replacement unless arising from accident
   B) Age-related Osteoarthritis & Osteoporosis

6. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

6.1. Investigation & Evaluation (Code- Excl04)

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

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

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

i) 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.

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

6.3. Obesity/ Weight Control (Code- Excl06)

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

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

6.4. 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.

6.5. 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.

6.6. 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.

6.7. 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.

6.8. Excluded Providers (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its 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.

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

6.10. 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)

6.11. 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)

6.12. Refractive Error (Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

6.13. 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.

6.14. Sterility and Infertility (Code- Excl17)

Expenses related to sterility and infertility. This includes:

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

6.15. Maternity Expenses (Code- Excl18)

i. Medical treatment expenses traceable to child birth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

6.16. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

6.17. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

6.18. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

6.19. Treatment taken outside the geographical limits of India.

6.20. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

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.

8. CLAIM PROCEDURE

8.1. Procedure for Cashless claims:

(i) Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA.
(ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
(iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.
(iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
(v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
(vi) In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

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

8.2. Procedure for reimbursement of claims:

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

8.3. Notification of Claim

Notice with full particulars shall be sent to the Company/ TPA (if applicable) as under:

i. Within 24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

8.4. Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Details of past medical history record, first and subsequent consultation
vi. Payment receipts
vii. Discharge summary (original) including complete medical history of the patient along with other details.
viii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner.
ix. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
x. Sticker/ Invoice of the Implants (original), wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines.
xiii. Legal heir/succession certificate, wherever applicable.
xiv. Any other relevant document required by Company/ TPA for assessment of the claim.
xv. Age / Identity proof document of Insured Person in case of claim approved under Cashless Facility (not required if submitted at the time of pre-authorization request) and Policyholder in case of Reimbursement claim
    a. Self attested copy of valid age proof (passport / driving license / PAN card / class X certificate / birth certificate)
    b. Self attested copy of identity proof (passport / driving license / PAN card / voter identity card)
    c. Recent passport size photograph
xvi. For Medico-legal cases (MLC) or in case of Accident:
    a. MLC/ Panchnama / First Information Report (FIR) copy attested by the concerned Hospital / police station (if applicable).
    b. Original self-narration of incident in absence of MLC / FIR.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.

3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

8.5. Co-payment

Each and every claim under the Policy shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the copayment.

8.6. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the claim submission date..

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of claim initimation till the date of payment of claim at a rate of 2% above the bank rate.

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

8.7. Payment of Claim

All claims under the policy shall be paid in Indian currency only.

Note: In case of a claim, if monthly or quarterly or half yearly premium payment mode is opted, then the remaining premium payable for the policy year will be deducted from the admissible claim amount.

9. GENERAL TERMS AND CONDITIONS

9.1. 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).

9.2. 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..

9.3. Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and /or premium, if necessary, accordingly.

9.4. Records to be Maintained

The Insured person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

9.5. Complete Discharge

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

9.6. Notice and Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

9.7. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

9.8. 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.

9.9. 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..

9.10. Cancellation

I.

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.

9.11. Automatic change in Coverage under the policy

The coverage for the Insured person(s) shall automatically terminate:

1. In the case of his/her (Insured Person's) demise:
   However the cover shall continue for the remaining Insured Persons till the end of the Policy Period. The other Insured Persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.
2. Upon exhaustion of sum insured and cumulative bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

9.12. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian Court and according to Indian law.

9.13. Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/ arbitrators of the amount of expenses shall be first obtained.

9.14. Migration

(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.

9.15. 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.

9.16. 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

9.17. Premium Payment in Instalments

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

i. Grace Period of 30 days in all types of policies, , and a period of 15 days in case of monthly instalments.
ii. For policies where premium is paid in instalments only, the coverage will be given during grace period.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specified Waiting Periods" in the event of payment of premium within the stipulated grace period.
iv. No interest will be charged if the instalment premium is not paid on due date
v. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

9.18. 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 affected.

9.19. 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.

9.20. Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.
iii. The policyholder may be changed only at the time of the renewal. The new policyholder must be the legal heir/ immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without a break.

The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.

9.21. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

9.22. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

9.23. Nomination

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

9.24. Withdrawal of Policy

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

10. REDRESSAL OF GRIEVANCE

a. 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 : +91 11 41743397
Courier: Customer Services Department
Niva Bupa Health Insurance Company Limited
2nd Floor, Plot No D-5 , Sec-59, Noida , Gautam Buddh Nagar, 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
Niva Bupa Health Insurance Company Limited
2nd Floor, Plot No D-5 , Sec-59, Noida , Gautam Buddh Nagar, Uttar Pradesh – 201301

Contact No: 1860-500-8888
Fax No.: +91 11 41743397
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 B).

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

11. TABLE OF BENEFITS

Name	Arogya Sanjeevani Policy, Niva Bupa Health Insurance Co. Ltd.
Product Type	Individual/Floater
Category of Cover	Indemnity
Sum Insured	INR 50,000 to 10 Lac (in multiples of INR 50,000) On Individual basis- SI shall apply to each individual family member On Floater basis- SI shall apply to the entire family
Policy Period	1 year
Eligibility	Policy can be availed by persons between the age of 18 years to 65 years, as Proposer. Proposer with higher age can obtain policy for family, without covering self. Policy can be availed for Self and the following family members i. Legally wedded spouse ii. Parents and Parents-in-law iii. Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
Grace Period	For Yearly payment of mode, a fixed period of 30 days is to be allowed as Grace Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
Hospitalisation Expenses	Expenses of hospitalisation for a minimum period of 24 consecutive hours only shall be admissible. Time limit of 24 hours shall not apply when the treatment is undergone in a Day Care Centre.
Pre Hospitalisation	For 30 days prior to the date of hospitalisation
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for room/ doctors' fees	I. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital/ Nursing Home up to 2% of the sum insured subject to a maximum of Rs.5,000/- per day. II. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the hospital/Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/- per day
Cataract Treatment	Up to 25% of Sum Insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.
AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to sum insured,

	during each Policy year as specified in the policy schedule.
Pre Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after a waiting period of 4 years.
Cumulative Bonus	Increase in the sum insured by 5% in respect of each claim free year subject to a maximum of 50% of SI. In the event of claim the cumulative bonus shall be reduced at the same rate.
Co pay	5% co pay on all claims

12. Pre-Insurance Medical Check-up

The underwriting grid, as given below, shall guide the proposals that are referred for medical assessment and underwriting.

Underwriting Grid			
Age in years	**SI**	**Up to10L**	
	Plan Type	**Individual**	**Family Floater**
0-45		Nil	
46 & above		Level 2	
* Questionnaire shall be for all Age groups ** Disclosure based Tele UW / PPMC shall be triggered on the discretion of the UW in the age bands as per the grid • Ported policies will be referred for underwriting and necessary risk assessment.			

The medical checkups are spread in levels depending on the age and type of plan chosen.

Standard Tests under PPMC may include tests such as (but not limited to) MER, CBC, RUA, T Chol, TG, HbA1c, ECG, SGPT, SGOT, S Creat, GGT.

The underwriter may seek additional medical tests or past medical records if required for making an informed underwriting assessment and decision.

The underwriter may seek additional medical tests or past medical records if required for making an informed underwriting assessment and decision. The validity of medical tests will be;

i. For medical test reports with test results within normal range, the validity is for 6 months from the date of tests conducted.
ii. For medical test reports with test result outside of the normal range, validity is for 3 months from the date of tests conducted.

The following grid of cost of tests sharing will be applicable on costs incurred towards PPMC:

Accepted Proposal	Decline Proposal
100 % to be borne by Niva Bupa	100 % to be borne by customer

In case any medical tests conducted beyond the defined level of medical tests and policy gets accepted, we will bear as per the above grid for the additional cost of such medical tests.

For all the plans under this product in case customer requests for cancellation of an accepted proposal, customer will bear 100% of the cost incurred towards PPMC.

During the underwriting process, each individual's medical history will be evaluated for risk and upon full assessment of facts, based on the severity and prognosis of the condition(s), it will be ascertained whether the proposed insured's declared condition presents a future medical risk.

Three potential options will be determined as per the underwriting guidelines.

1. Standard risk- accept application with no loading or condition /exclusion(s)
2. Sub-standard risk- such proposals are accepted by applying pertinent waiting periods with/without charging extra loading premium to the proposed insured(s), as applicable.
3. Risk outside of Niva Bupa's risk appetite- decline the proposal. We may decline policy cover where potential risk cannot be quantified through the use of best knowledge and expertise. We will consider past medical history, pathological conditions, acquired disease conditions, deformity or disability, terminal conditions, and/or a combination thereof to determine if a risk is uninsurable.

Annexure-A

List I- Items for which coverage is not available in the policy

Sl. No.	**Item**
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE

17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER

42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG

67	AMBULANCE
68	VASOFIX SAFETY

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

Sl. No.	**Item**
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS

20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl. No.	**Item**
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD

4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sl. No.	**Item**
1	ADMISSION/REGISTRATION CHARGES

2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION⁄STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure B

The contact details of the **Insurance Ombudsman** offices are as below:

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, 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@cioins.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@cioins.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@cioins.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@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, UT of Jammu & Kashmir, Ladakh and 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 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu,UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - 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@cioins.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 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.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@cioins.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of Lakshadweep, 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@cioins.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@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - 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@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.

PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

EXECUTIVE COUNCIL OF INSURERS,
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.
Tel.: 022 - 69038801/03/04/05/06/07/08/09
Email: inscoun@cioins.co.in
Shri B. C. Patnaik, Secretary General
Smt Poornima Gaitonde, Secretary

Annexure C

<<Final approved Premium chart will be appended>>

Benefit Illustration

Benefit Illustration (5 Lac Sum Insured, Policy Term 1 year)										
Age of the members insured	**Coverage opted on individual basis covering each member of the family separately (at a single point in time)**		**Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)**				**Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)**			
	Premium (Rs.)	**Sum Insured (Rs.)**	**Premium (Rs.)**	**Discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**	**Premium or Consolidated premium for all members of family (Rs.)**	**Floater discount, if any**	**Premium after discount (Rs.)**	**Sum Insured (Rs.)**
Illustration 1										
18	4,002.00	5,00,000	4,002.00	400.20	3,601.80	5,00,000	4,002.00	5,741.40	13,396.60	5,00,000
21	4,002.00	5,00,000	4,002.00	400.20	3,601.80	5,00,000	4,002.00			
39	5,157.00	5,00,000	5,157.00	515.70	4,641.30	5,00,000	5,157.00			
45	5,977.00	5,00,000	5,977.00	597.70	5,379.30	5,00,000	5,977.00			
Total premium for all members of the family is **Rs.19,138**, when each member is covered separately. Sum Insured available for each individual is **Rs.500,000.**			Total premium for all members of the family is **Rs.17,224.20**, when they are covered under a single policy. Sum Insured available for each family member is **Rs.500,000.**				Total premium when the policy is opted on floater basis is **Rs.13,996.60.** Sum Insured of **Rs.500,000** is available for the entire family.			
Illustration 2										
55	9,937.00	5,00,000	9,937.00	993.70	8,943.30	5,00,000	9,937.00	6,952.25	20,856.75	5,00,000
63	17,872.00	5,00,000	17,872.00	1,787.20	16,084.80	5,00,000	17,872.00			
Total premium for all members of the family is **Rs.27,809**, when each member is covered separately. Sum Insured available for each individual is **Rs.500,000**.			Total premium for all members of the family is **Rs.25,028.10**, when they are covered under a single policy. Sum Insured available for each family member is **Rs.500,000.**				Total premium when the policy is opted on floater basis is **Rs.20,856.75**. Sum Insured of **Rs.500,000** is available for the entire family.			
Illustration 3										
65	17,872.00	5,00,000	17,872.00	1,787.20	16,084.80	5,00,000	17,872.00	10,383.75	31,151.25	5,00,000
70	23,663.00	5,00,000	23,663.00	2,366.30	21,296.70	5,00,000	23,663.00			
Total premium for all members of the family is **Rs.41,535**, when each member is covered separately. Sum Insured available for each individual is **Rs.500,000.**			Total premium for all members of the family is **Rs.37,381.50**, when they are covered under a single policy. Sum Insured available for each family member is **Rs.500,000.**				Total premium when the policy is opted on floater basis is **Rs.31,151.25.** Sum Insured of **Rs.500,000** is available for the entire family.			

Note: Premium rates specified in the above illustration are standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.

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