



SurTech



DR. SUDHIR CHANDRA SUR INSTITUTE OF TECHNOLOGY AND SPORTS COMPLEX

540, Dum Dum Road, Suremath, Kolkata- 700074, West Bengal



Policy of General Insurance (W.e.f 2021-22)

Revised and Approved by BOG

Dated on 03/07/2021

Under Agenda No. 3

Ref.No:	Compiled By:	Checked By:	Approved By:
DSCSITSC/POLY/ 2021-22/11	<i>Amrita Chakrabarti</i>	<i>[Signature]</i>	<i>[Signature]</i>
Issue No- <u>4</u>	(HR, Admin)	(IQAC Convener)	(Principal)

Dr. Sudhir Chandra Sur Institute
of Technology and Sports Complex
540, Dum Dum Road, Kolkata-700074

Policy of General Insurance

I. Preamble & Operating Clause

This is a legal contract between the Policyholder and Us to provide the insurance cover detailed in the Policy to the Insured Persons up to the Sum Insured subject to the receipt of full premium, disclosure to information norm including the information provided in the Proposal Form or the Request for Quote (RFQ) by the Proposer or by his/ her authorized Intermediary on behalf of him/her-self and all persons to be insured which is incorporated in the policy and is the basis of it; and the terms, conditions, and exclusions of this Policy.

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the medically necessary and Reasonable and Customary expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured opted as specified in the Schedule.

II. Covers under the Policy

In the event of any claim arising as a result of treatment taken for an Injury or Illness during the Policy period which becomes payable under any applicable Base Cover and/or Optional Covers, then We shall indemnify the Reasonable and Customary Medical Expenses incurred or pay for the listed Benefits, in accordance with the terms, conditions and exclusions of the Policy subject to availability of the Sum Insured for the cover/benefit applicable and subject to the limit, if any, specified in the Policy Schedule/ Certificate of Insurance. All limits mentioned in the Policy Schedule/ Certificate of Insurance are applicable for each Policy period of coverage.

Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner and are incurred on Medically Necessary Treatment of the Insured Person.

1. In-patient Hospitalization Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment taken during Hospitalization provided that the admission date of the Hospitalization due to Illness or Injury is within the Policy period:

- A. Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less, including nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.
- B. Charges for accommodation in ICU/CCU/HDU up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less,



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- C. Operation theatre cost, Anesthetics, Blood, Oxygen, Surgical Appliances and/ or Medical Appliances, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents, and other medical expenses related to the treatment.
- D. The fees charged by the Medical Practitioner, Surgeon, Specialists and Anesthetists treating the Insured Person;
- E. Medicines, drugs, and other allowable consumables prescribed by the treating Medical Practitioner;
- F. Cost of Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalized such as but not limited to Radiology, Pathology tests, X-rays, MRI and CT Scans, Physiotherapy.

Note 1:

Proportionate Clause: In case of admission to a room at rates exceeding the limits mentioned in the Policy Schedule/Certificate of Insurance (for Clause II.1.A), the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.

Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.

Note 2:

Mental Illness Cover Limit:

In case of following mental illnesses, the Inpatient Hospitalization benefit will be covered up to the limit as mentioned in the schedule.

1. Schizophrenia (ICD - F20; F21; F25)
2. Bipolar Affective Disorders (ICD - F31; F34)
3. Depression (ICD - F32; F33)
4. Obsessive Compulsive Disorders (ICD - F42; F60.5)
5. Psychosis (ICD - F 22; F23; F28; F29)

All claims under this Benefit can be made as per the process defined under Section V. C and D

2. Day Care Treatment Cover

We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment (as defined in Section VII.19) during the Policy Period following an Illness or Injury that occurs during the Policy Period provided the Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice.

The benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance, whichever is less. All claims under this Benefit can be made as per the process defined under Section V. C and D

3. Pre-hospitalization Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred due to an Illness or Injury that occurs during the Policy Period up to the number of days and up to the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:



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- (i) We have accepted a claim for In-patient Hospitalization under Section II.1 or II.2 above;
- (ii) The Pre-hospitalisation Medical Expenses are related to the same Illness or Injury.
- (iii) The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.
- (iv) All claims under this Benefit can be made as per the process defined under Section V. D

4. Post-hospitalisation Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period upto the number of days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance, provided that:

- (i) We have accepted a claim for In-patient Hospitalization under Section II.1 or II.2 above;
- (ii) The Pre-hospitalisation Medical Expenses are related to the same Illness or Injury.
- (iii) The date of discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to the same Any One Illness for which We have accepted an In-patient Hospitalization claim under Section II.1 or II.2 above.

All claims under this Benefit can be made as per the process defined under Section V. D

5. Road Ambulance Cover

We will cover the costs incurred up to the limit as specified in the Policy Schedule or Certificate of Insurance on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. It becomes payable if a claim has been admitted under Section II.1 or II.2 and the expenses are related to the same Illness or Injury.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified in the Policy Schedule or Certificate of Insurance:

- (i) it is medically required to transfer the Insured Person to another Hospital or diagnostic Centre during Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
- (ii) it is medically required to transfer the Insured Person to another Hospital during Hospitalization due to lack of specialty treatment in the existing Hospital.

All claims under this Benefit can be made as per the process defined under Section V. D

6. Domiciliary Hospitalisation Cover

We will cover Medical Expenses, up to the limit specified in the Policy Schedule/ Certificate of Insurance, incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

- i. The Domiciliary Hospitalisation continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalisation;
- ii. The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically required and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital or the Insured Person satisfies Us that a Hospital bed was unavailable;
- iii. We shall not be liable to pay for any claim in connection with:
 - a. Asthma, bronchitis, tonsillitis, and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
 - b. Arthritis, gout and rheumatism;
 - c. Chronic nephritis and nephritic syndrome;
 - d. Diarrhoea and all type of dysenteries, including gastroenteritis;
 - e. Diabetes mellitus and insipidus;



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- f. Epilepsy;
- g. Hypertension;
- h. Psychiatric or psychosomatic disorders of all kinds;
- i. Pyrexia of unknown origin.

All claims under this Benefit can be made as per the process defined under Section V. D

7. Donor Expenses Cover

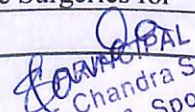
We will cover the In-patient Hospitalization Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated up to the limit as specified in the Policy Schedule or Certificate of Insurance provided that:

- i. The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
 - ii. We have admitted a claim towards In-patient Hospitalisation under the Base Cover and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;
 - iii. We will not cover:
 - a. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor;
 - b. Screening expenses of the organ donor;
 - c. Costs associated with the acquisition of the donor's organ;
 - d. Transplant of any organ/tissue where the transplant is experimental or investigational;
 - e. Expenses related to organ transportation or preservation;
 - f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.
- All claims under this Benefit can be made as per the process defined under Section V. C and D

8. Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claim under section 4.1, expenses incurred on the following procedures (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital, shall be covered. The claim shall be subject to additional sub- limits indicated against them in the table below:

Sr. No.	Modern Treatment Methods & Advancement in Technology	Additional Limit
1.	Uterine Artery Embolization & High Intensity Focussed Ultrasound (HIFU)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Uterine Artery Embolization & HIFU
2.	Balloon Sinuplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Balloon Sinuplasty
3.	Deep Brain Stimulation	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Deep Brain Stimulation
4.	Oral Chemotherapy	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Oral Chemotherapy
5.	Immunotherapy- Monoclonal Antibody to be given as injection	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period
6.	Intra vitreal Injections	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period
7.	Robotic Surgeries (including Robotic Assisted Surgeries)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for


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		(i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies (ii) •up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for other diseases
8.	Stereotactic Radio Surgeries	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Stereotactic Radio Surgeries
9.	Bronchial Thermoplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Bronchial Thermoplasty.
10.	Vaporisation of the Prostate (Green laser treatment or holmium laser treatment)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period.
11.	Intra Operative Neuro Monitoring (IONM)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Intra Operative Neuro Monitoring
12.	Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered only	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period

All claims under this Benefit can be made as per the process defined under Section V. C and D
There are Optional covers available with the Policy. Refer Section VIII-Optional Covers: Policy Terms and Conditions for Optional Covers for further details on these.

III. COVER TYPE

The Policy provides cover on an Individual or Family Floater basis. A separate Sum Insured for each Insured Person, as specified in the Policy Schedule/Certificate of Insurance, is provided under Individual basis while under Family Floater basis, the Sum Insured limit is shared by the whole family of the group member as specified in the Policy Schedule/ Certificate of Insurance and Our total liability for the family cannot exceed the Sum Insured in a Policy period. The cover type basis shall be as specified in the Policy Schedule/ Certificate of Insurance. The basis of cover chosen for the Base Cover is applicable for the Optional Covers as well.

Relationships covered under the Policy are as specified in the Policy Schedule/ Certificate of Insurance.

IV. PERMANENT EXCLUSIONS & WAITING PERIODS

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

A. Permanent Exclusions

We shall not be liable to make any payment under this Policy caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

1. All expenses, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
2. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion



of nuclear fuel nuclear, chemical or biological attack.

3. a) Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells except as provided for in clause II.8 (12) above; b) growth hormone therapy.
4. External Congenital Anomaly or defects.
5. Sterility and Infertility (**Code-Excl17**): Expenses related to Sterility and Infertility. This includes:
 - i. Any type of contraception, sterilization
 - ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - iii. Gestational Surrogacy
 - iv. Reversal of sterilization
6. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
7. Conditions for which treatment could have been done on an out-patient basis without any Hospitalization.
8. Investigation & Evaluation (**Code-Excl04**):
 - i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
 - ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
9. Any treatment or part of a treatment that is not of a reasonable charge, is not a Medically Necessary Treatment; drugs or treatments which are not supported by a prescription.
10. Costs of donor screening or costs incurred in an organ transplant Surgery involving organs not harvested from a human body.
11. 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.
12. Any form of Alternative Treatment:
 - i. AYUSH Treatment;
 - ii. Hydrotherapy, Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.
13. Dental Treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalisation. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way.
14. Routine eye examinations, cost of spectacles, multifocal lens, contact lenses.
15. Refractive Error (**Code-Excl15**): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptries.
16. a) Cost of hearing aids; including optometric therapy; b) cochlear implants unless necessitated by an Accident or required intra- operatively.
17. Vaccinations including inoculation and immunizations except in case of post-bite treatment.
18. Any Treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall Treatment and products,
19. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.
20. Any stay in Hospital without undertaking any Treatment or any other purpose other than for receiving eligible Treatment of a type that normally requires a stay in the Hospital.
21. 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 hospitalisation claim or day care procedure. (**Code-Excl14**)



22. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.
23. 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:
 - 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.
24. Treatments received in health 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**)
25. 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.
26. Certification / diagnosis / Treatment by a family member, or a person who stays with the Insured Person, save for the proven material costs which are eligible for reimbursement as per the applicable cover, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for.
27. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (**Code-Excl12**)
28. Prostheses, corrective devices and and/or Medical Appliances, which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalized.
29. 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.
30. 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.
31. Obesity/ Weight Control (**Code-Excl06**): Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
 - i. Surgery to be conducted is upon the advice of the Doctor
 - ii. The surgery/Procedure conducted should be supported by clinical protocols
 - iii. The member has to be 18 years of age or older and
 - iv. 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:
 - a. Obesity-related cardiomyopathy
 - b. Coronary heart disease
 - c. Severe Sleep Apnoea
 - d. Uncontrolled Type2 Diabetes
32. Treatment received outside India.
33. a) Instrument used in Treatment of Sleep Apnea Syndrome (C.P.A.P.); b) Oxygen Concentrator for Bronchial Asthmatic condition; c) Infusion pump or any other external devices used during or after Treatment.
34. 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.
35. Injury caused whilst flying or taking part in aerial activities (including cabin) except as a

fare-paying passenger in a regular scheduled airline or air charter company.

36. **Maternity (Code-Excl18):**

- i. Medical treatment expenses traceable to child birth (Including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
 - ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
37. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalised, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses. For complete list of non-medical expenses, please refer to the Annexure I 'Non-Medical Expenses' and also on Our website.
38. Any opted Deductible (Per claim/ Aggregate/ Corporate) amount or percentage of admissible claim under Co-Payment, Sub Limit if applicable and as specified in the Policy Schedule/ Certificate of Insurance to this Policy.
39. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
40. Any physical, medical or mental condition or Treatment or service that is specifically excluded in the Policy Schedule/ Certificate of Insurance under Special Conditions.

B. **Pre-Existing Disease Waiting Period (Code-Excl01)**

- i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, of continuous coverage after the date of inception of the first policy with us.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- iv. Coverage under the policy after the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

C. **Initial Waiting Period for Hospitalization (Code-Excl03)**

- i. Expenses related to the treatment of any illness within the number of days, as mentioned in the Policy schedule or Certificate of Insurance, from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

D. **Specific Waiting Period (Code-Excl02)**

- i. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, 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.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.



- iii. 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.
- iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- v. 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.
- vi. List of specific diseases/procedures:
 - a) Cataract
 - b) Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids
 - c) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal Diseases
 - d) Varicose Veins and Varicose Ulcers
 - e) Stones in the urinary, uro-genital and biliary systems including calculus diseases
 - f) Benign Prostate Hypertrophy, all types of Hydrocele
 - g) Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids and any abscess related to the anal region
 - h) Chronic Supportive Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery
 - i) Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps (unless malignant), Polycystic Ovarian Diseases
 - j) Any Surgery of the genito-urinary system unless necessitated by malignancy
 - k) Age-related Macular Degeneration (ARMD)
 - l) All Neurodegenerative disorders
 - m) Waiting Period for Named Mental Illnesses

S.No.	Organ / Organ Systems	Illness / Surgeries
1.	Mental Disorders	1) Schizophrenia (ICD - F20; F21; F25) 2) Bipolar Affective Disorders (ICD - F31; F34) 3) Depression (ICD - F32; F33) 4) Obsessive Compulsive Disorders (ICD - F42; F60.5) 5) Psychosis (ICD - F22; F23; F28; F29)

V. Claims Procedure

A. Claims Administration & Process

It shall be the condition precedent to admission of Our liability under this Policy that the terms and conditions of making the payment of premium in full and on time, insofar as they relate to anything to be done or complied with by You or any Insured Person, are fulfilled including complying with the following in relation to claims:

[Signature]
 PRINCIPAL
 Dr. Sudhir Chandra Sur Institute
 of Technology & Sports Complex
 540, Dum Dum Rd. Kolkata-74



1. On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
2. The treatment should be taken as per the directions, advice and guidance of the treating Medical Practitioner. Any failure to follow such directions, Medical advice or guidance will prejudice the claim.
3. The Insured Person must submit to medical examination by Our Medical Practitioner or our authorized representative in case requested by Us and at Our cost, as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
4. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

B. Notification of claim

Upon the happening of any event which may give rise to a claim under this Policy, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

- i. Within 24 hours 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.

C. Procedure for Cashless claims

1. Cashless facility for treatment in network hospitals only shall be available to insured if opted for claim processing by TPA.
2. Treatment may be taken in a network provider/PPN hospital and is subject to pre- authorization by the TPA. Booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company (<https://uijc.co.in/en/tpa-ppn-network-hospitals>) and the TPA mentioned in the schedule.
3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.
4. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Insurance-desk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for pre- authorization.
5. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
6. Once the request for pre-authorization has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where Cashless Facility is pre- authorised by Us or the associated TPA, We will make the payment of the amounts assessed directly to the Network Provider.
7. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under V.4 above.
8. At the time of discharge, the insured person shall verify and sign the discharge papers and final bill and pay for non-medical and inadmissible expenses.

Note: (Applicable to V.C): Cashless facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider/ PPN hospital for Illness or Injury / Accident/ Critical Illness as the case may be which are covered under the Policy. For all cashless authorisations, the Insured Person will, in any event, be required to settle all non- admissible expenses, expenses above specified Sub Limits (if

applicable), Co-Payments and / or opted Deductible (Per claim/ Aggregate/ Corporate) (if applicable), directly with the Hospital.

9. The TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medical details. Denial of a Pre-authorisation request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.
10. In case of admission in PPN hospitals, duly filled and signed PPN declaration format available with the hospital must be submitted.
11. Claims for Pre and Post-Hospitalisation will be settled on a reimbursement basis on production of cash receipts alongwith supporting documents.

D. Procedure for reimbursement of claims

In non-network hospitals payment must be made up-front and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/company (if claim is processed by the company) within the prescribed time limit.

E. Documents

1. The claim is to be supported with the following original documents and submitted within the prescribed time limit.
 - i.i. Duly completed claim form;
 - i.ii. Photo ID and Age proof;
 - i.iii. Health Card, policy copy, photo ID, KYC documents;
 - i.iv. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed, along with date of diagnosis, investigation test reports etc. supported by the prescription from attending medical practitioner.
 - i.v. Original discharge card / day care summary / transfer summary;
 - i.vi. Original final Hospital bill with detailed break-up with all original deposit and final payment receipt;
 - i.vii. Original invoice with payment receipt and implant stickers for all implants used during Surgeries i.e. lens sticker and Invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery;
 - i.viii. All previous consultation papers indicating history and treatment details for current ailment;
 - i.ix. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center;
 - i.x. All original medicine / pharmacy bills along with the Medical Practitioner's prescription;
 - i.xi. MLC / FIR copy-in Accidental cases only;
 - i.xii. Copy of death summary and copy of death certificate (in death claims only);
 - i.xiii. Pre and post-operative imaging reports;
 - i.xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person, treatment details and the Insured Person's progress;
 - i.xv. KYC documents
 - i.xvi. Cheque copy with name of proposer printed on the cheque leaf or copy of the first page of the bank passbook or the bank statement not later than 3 months.

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.6.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

2. Time limit for submission of documents

Type of claim	Time limit for submission of documents to company/TPA
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Where Cashless Facility has been authorised	Immediately after discharge.
Reimbursement of hospitalisation and pre hospitalisation expenses (limited to 30 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 60 days)	Within 15 (fifteen) days from completion of post hospitalisation treatment

Note: Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

3. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
4. All the documents submitted to TPA shall be electronically collected by Us for settlement and denial of the claims by the appropriate authority.

F. Scrutiny of Claim Documents

- a. TPA/ We shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/ Network Provider as the case may be. If the deficiency in the necessary claim documents is not met or is partially met in 10 working days of the first intimation. We will send a maximum of 3 (three) reminders. We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
- b. In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.
- c. The Pre-Hospitalisation Medical Expenses Cover claim and Post- Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

G. Claim Assessment

We will pay the fixed or indemnity amount as specified in the applicable Base or Optional cover in accordance with the terms of this Policy.

We will assess all admissible claims under the Policy in the following progressive order:

1. Application Proportionate clause as per Note 1.clause II.1.
2. Co-pay as applicable.
3. Limit/ Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/ Certificate of Insurance
4. Opted Deductible (Per claim/ Aggregate) Claim Assessment for Benefit Plans:

We will pay fixed benefit amounts as specified in the Policy Schedule/ Certificate of Insurance in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts not specified in the Policy.

H. Claim Settlement (provision for Penal Interest)

1. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
2. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Insured Person from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the

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Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

4. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Insured Person at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(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).

i. **Claim Rejection/ Repudiation**

If the company, for any reasons, decides to reject a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be. Where a rejection is communicated by Us, the Insured Person may, if so desired, within 15 days from the date of receipt of the claims decision represent to Us for reconsideration of the decision.

j. **Claim Payment Terms**

- i. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.

All claims will be payable in India and in Indian rupees.

- ii. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.

- iii. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.

- iv. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for 'Any one illness' under this Policy shall be applied as if they were under a single claim.

- v. **For Cashless claims**, the payment shall be made to the Network Provider whose discharge would be complete and final.

- vi. **For Reimbursement claims**, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

k. **Services offered by TPA (To be stated where TPA is involved)**

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorisation of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include:

- i. Claim settlement and rejection;
- ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

l. **Payment of Claim**

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

VI. Terms and conditions

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, misdescription or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

2. **Condition Precedent to Admission of Liability**

The terms and conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

3. **Parties to the Policy**

The only parties to this Policy are the Policyholder and Us.

4. **No Constructive Notice**

Any knowledge or information of any circumstance or condition in relation to You/Insured Person in Our possession or in the possession of any of Our officials shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve You/Insured Person from your/her duty of disclosure, notwithstanding subsequent acceptance of any premium.

5. **Eligibility**

To be eligible for coverage under the Policy, the Insured Person must be -

a. Either an employee of the policyholder where there is an employer/employee relationship OR a member of the group as defined in extant IRDAI guidelines on Group Health Insurance in case of Non-Employer-Employee policies

b. The relationships which may be covered under the Policy are-

i. Self

ii. Employee/member's legal Spouse, Life Partner (including live-in partner)

For the purpose of this section, Life Partner (including live-in partner) shall be taken as declared at the time of inception of Policy and no change would be accepted during the Policy Period. However, the Insured may request for change at the time of Renewal of the cover.

iii. The Employee/member's children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Children above 18 years will continue to be covered along with parents up to the age of 26 years, provided they are unmarried/unemployed and dependent.

iv. Parents/Parents-in-law

v. The Employee/member's siblings shall be covered up to the age of 26 years, provided they are unmarried/unemployed and dependent.

vi. Any other relationship as specified in the Policy Schedule/Certificate of Insurance

c. **Minimum Group size:** The Policyholder shall ensure that the minimum number of Employees/members who will form a group to avail the Benefits under this Policy shall be 7 (Seven).

d. New Born Babies will be accepted for cover (subject to the limitations of the New Born Baby Benefit Cover) from birth if mother is covered and maternity cover is opted. Acceptance of New Born Babies as Insured Persons is subject to written notification on or before the last day of the month following the birth of the child and receipt of the agreed premium.

6. **Reasonable Care**

The Insured Person understands and agrees to take all reasonable steps in order to safeguard against any Illnesses, Accident or Injury that may give rise to any claim under this Policy.

7. **Premium**

The premium for each Policy will be determined based on the available data of each group, coverage sought by the insured and applicable discounts and loadings. Payment of premiums will be available in Single mode. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a Condition Precedent to Our liability to make any payment under this Policy.

Premium will be subject to revision at the time of renewal of the Policy. Further, premium shall be paid in Indian Rupees and in favour of United India Insurance Company Ltd.

NOTE: Where Instalment facility is granted by Us for the payment of premium, it is to be in accordance with the schedule of payments agreed between the Policyholder and Us in writing. Where premium is payable on an instalment basis, the revival period shall be 15 days. Wherever premiums are not received within the revival period, the Policy will be terminated effective from instalment due date and all claims that fall beyond such instalment due date shall not be paid. However, we will be liable to pay in respect of all claims where the Treatment/Admission/Accident has commenced/ occurred before the date of termination of such Policy.

For installment premium, in the event of cancellation of policy, we will refund premium on pro rata basis after deducting Our expenses.

Premium shall be refunded for all lives which have not registered a claim with Us under the Policy up to the date of cancellation.

8. Role of Group Administrator/Policyholder

- i. The Policyholder should provide all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy including the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.
- ii. Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the RFQ/ proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, or endorsement of the Policy.
- iii. The Policy holder i.e. the Employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.
- iv. The claims of the individual employees may be processed through the employer.

9. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us. All endorsement requests will be made by the Policyholder only.


10. Material Information for administration

The Insured Person and/ or the Policyholder must give Us all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy. You must give Us written notification specifying the details of the Insured Persons to be deleted and the details of the eligible persons proposed to be added to the Policy as Insured Persons.

Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the proposal form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation or endorsement of the Policy.

11. Material Change

It is Condition Precedent to Our liability under the Policy that You shall at Your own expense immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business of any Insured Person. We may, in Our discretion, adjust


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the scope of cover and / or the premium paid or payable, accordingly.

12. 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:

- i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- iii. any other act fitted to deceive; and
- iv. 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.

13. Geographical Area

The geographical scope of this Policy applies to events limited to India unless specified under this Policy in a particular Benefit or definition. However, all admitted or payable claims shall be settled in India in Indian rupees.

14. Addition and Deletion of a Member

We shall include/exclude a group member/Employee of the Policyholder and/or his/her Dependent(s) as an Insured Person under the Policy in accordance with the following procedure:

A. Additions

a. Employer-Employee Group:

- i) Newly appointed employee and his/her dependents
- ii) Newly wedded spouse of the employee,
- iii) New born child of the employee

may be added to the Policy as an Insured Person during the Policy period provided that the application for cover has been accepted by Us, additional premium on pro-rata basis applied on the risk coverage duration for the Insured Person has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Person

b. Non-Employer-Employee Group: As specified in the Policy Schedule

B. Deletions:

a. Employer-Employee Group

- i) Employee leaving the company/organization on account of resignation/retirement/termination and his/her dependents shall be deleted from the policy effective from the date of resignation/retirement/termination or till the last day of the month of resignation/retirement/termination at the option of the insured
- ii) In the event of death of an employee, his/her dependents may continue to be covered until the expiry of the policy period at the option of the insured

b. Non-Employer-Employee Group: As specified in the Policy Schedule

Refund of premium shall be made on a pro-rata basis, provided that no claim is paid/outstanding in respect of that Insured Person or his/her Dependents.

Throughout the Policy period, the Policyholder will notify Us of all and any changes in the membership of the Policy occurring in a month on or before the last day of the succeeding month.

15. Nomination

The Insured Person 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.

16. Endorsements

The Policy will allow the following endorsements during the Policy period. Any request for endorsement must be made only in writing by the Policyholder. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later.

Rectification in name of the proposer / Insured Person. Rectification in gender of the proposer/ Insured Person. Rectification in relationship of the Insured Person with the proposer.

Rectification of age/ date of birth of the Insured Person

Change in the correspondence address of the proposer.

Change/updating in the contact details viz., phone number, E-mail ID, etc. Updating of alternate contact address of the proposer.

Change in Nominee details.

Deletion of Insured Person on death or upon leaving the group provided no claims are paid / outstanding.

Addition of member (New Born Baby or newly wedded Spouse).

All endorsement requests shall be assessed by the underwriter and where required additional information/documents/ premium may be requested.

17. Multiple Policies

- i. In case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
- ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and condition of this policy.
- iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.
- iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

18. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation, non-disclosure of material facts by the Insured Person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience.

19. Renewal Terms

Alterations like increase/ decrease in Sum Insured or change in optional covers can be requested at the time of Renewal of the Policy. We reserve Our right to carry out assessment of the group and provide the Renewal quote in respect of the revised Policy. We may in Our sole discretion, revise the premiums payable under the Policy or the terms of the cover, provided that all such changes are in accordance with the IRDAI rules and regulations as applicable from time to time.

20. Cancellation

- i. The policyholder may request for cancellation of the policy at any time by giving 15 days' notice in writing. In such case We shall refund the percentage of premium for the unexpired Policy Period on short period scale as per the table below:
The grid is applicable for single premium Policy

Cancellation Grid	
Period* for which risk is retained	Refund
Upto 1 Month	75%
>1 Month- less than 3 Month	50%
>3 Months - less than 6 months	25%
>6 Months - less than 9 months	15%
>9 Months	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the policy.

- ii. The Company may cancel the policy at any time on grounds of mis-representation, 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 mis- representation, non-disclosure of material facts or fraud.

21. Our Right of Termination

A. Termination of Policy:

Prior to the expiry of the Policy as shown in the Policy Schedule/ Certificate of Insurance, cover will end immediately for all Insured Persons, if:

- i. there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- ii. there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis for all lives which have not registered a claim with Us, after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- iii. the Policyholder does not pay the premiums owed under the Policy within the Grace Period. Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If Treatment has been

authorized or an approval for Cashless facility has been issued, we will not be held responsible for any Treatment costs if the Policy ends. However, we will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.

B. Termination for Insured Person's cover

Cover will end for a Member or dependent:

- i. If the Policyholder stops paying premiums for the Insured Person(s) and their Dependents (if any);
- ii. When this Policy terminates at the expiry of the period shown in the Policy Schedule/ Certificate of Insurance.
- iii. If he or she dies;
- iv. When a dependent insured person ceases to be a Dependent; unless otherwise agreed specifically for continuation till end of policy period;
- v. If the Insured Person ceases to be a member of the group.

22. Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

23. Migration

The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. For Detailed Guidelines on Migration, kindly refer the link: https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

24. Operation of Policy & Certificate of Insurance

The Policy shall be issued for the duration as specified in the Policy Schedule/ Certificate of Insurance. The Policy takes effect on the Inception Date stated in the Policy Schedule and/or the Certificate of Insurance and ends on the date of expiry of the Policy. For specific groups, upon request, all additions thereto by way of Certificate/s of Insurance shall be valid up to the Policy Period commencing from the actual date of addition to the Policy, it being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on Renewal of the Policy or until expiry of the Certificate of Insurance, whichever is later.

25. Electronic Transactions

The Policyholder/ Insured Person agrees to comply with all the terms and conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other services, shall constitute legally binding when done in compliance with Our terms for such facilities.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder/ Insured Person. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by the Policyholder/ Insured Person.

26. Communications & Notices

- iii. Any notice, direction or instruction or any other communication related to the Policy should be made in writing.
- iv. Such communication shall be sent to the address of the Company or through any other electronic modes at contact address as specified in the Policy Schedule.
- v. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us.
- vi. The Company shall communicate to The Policyholder/ Insured Person in writing, at the address as specified in the Policy Schedule/ Certificate of Insurance or through any other electronic mode at the contact address as specified in the policy schedule

27. 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.

28. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholders about the same 90 days prior to date of withdrawal of the product.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

29. Moratorium Period

After completion of eight continuous years under the policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

30. Redressal of Grievances

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

Website: www.uiic.co.in

Toll free: 1800 425 333 33

E-mail: customercare@uiic.co.in

Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 19, IV Lane, Nungambakkam High Road, Chennai, Tamil Nadu- 600034

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 customercare@uiic.co.in

For updated details of grievance officer, kindly refer the link <https://uiic.co.in/en/customercare/grievance>

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. The contact details of the Insurance Ombudsman offices have been provided as Annexure-C

Grievance may also be lodged at IRDAI Integrated Grievance Management System: <https://igms.irda.gov.in/>

31. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions,

validity, construct, limitations and/or exclusions contained in the policy shall be determined by the Indian court and according to Indian law.

VII. Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age or Aged** means age of the Insured Person on last birthday as on date of commencement of the Policy.
3. **Alternative Treatments** are forms of Treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.
4. **Annexure** means a document attached and marked as Annexure to this Policy.
5. **Ambulance** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical Treatment of the person requiring medical attention.
6. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
7. **Associated Medical Expenses** means hospitalisation related expenses on Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital; Anesthesia, blood, oxygen, operation theatre charges, surgical appliances and such other similar expenses with the exception of:
 - a. cost of pharmacy and consumables medicines
 - b. cost of implants/medical devices
 - c. cost of diagnostics

The scope of this definition is limited to admissible claims where a proportionate deduction is applicable, as per Note 1 of Clause II.1.

8. **AYUSH Treatment** refers to the medical and /or Hospitalization Treatments given under Ayurveda, Unani, Siddha and Homeopathy Systems.
9. **Benefit** means any benefit shown in the Policy Schedule and/or Certificate of Insurance.
10. **Base Sum Insured** means the Sum Insured for the Base Cover as specified in the Policy Schedule and/or Certificate of Insurance.
11. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
12. **Cashless facility** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured Person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorisation is approved.
13. **Certificate of Insurance** means the certificate We issue to the Insured Person outlining the Insured Person's cover under the Policy.
14. **Co-Morbidity** is the presence of one or more additional conditions co-occurring with a primary condition; in the countable sense of the term, a comorbidity is each additional condition
15. **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
16. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
 - a) **Internal Congenital Anomaly**-Congenital anomaly which is not in the visible and accessible parts of the body.
 - b) **External Congenital Anomaly**-Congenital anomaly which is in the visible and accessible

parts of the body.

16. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

17. **Cosmetic Surgery** means Surgery or medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.

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

19. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

ii. which would have otherwise required a hospitalization of more than 24 hours.

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

20. **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-

i) has qualified nursing staff under its employment;

ii) has qualified medical practitioner/s in charge;

iii) has fully equipped operation theatre of its own where surgical procedures are carried out;

iv) Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

21. **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.

22. **Dentist** means a dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided.

23. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

24. **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

25. **Effective Date** means the date shown on the Certificate of Insurance on which the Insured Person was first included under the Policy.

26. **Eligibility** means the provisions of the Policy that state the requirements to be complied with.

27. **Employee** means any member of Your staff who is proposed and sponsored by You and who becomes an Insured Person under this Policy.

28. **Emergency Care** 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.

29. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an emergency anymore.

30. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract.

31. **Grace Period** means the specified period of time immediately following the premium due

date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

32. **Home nursing** is arranged by the Hospital for a Qualified Nurse to visit the patient's home to give expert nursing services immediately after Hospital Treatment for as long as is required by medical necessity, visits for as long as is required by medical necessity for Treatment which would normally be provided in a Hospital.

In either case, the Specialist who treated the patient must have recommended these services.

33. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act or complies with all minimum criteria as under:

- i) has qualified nursing staff under its employment round the clock;
- ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- iii) has qualified medical practitioner(s) in charge round the clock;
- iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

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

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

1. **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

2. **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 on going or long-term monitoring through consultations, examinations, check-ups, and/ or tests
- ii. it needs on going 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

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

37. **Inception Date** means the inception date of this Policy as specified in the Policy Schedule or Certificate of Insurance when the coverage under the Policy commences.

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

39. **In-patient** means an Employee/ Member or Dependent who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving Treatment.

40. **Insured Person** means the Employee/ Member and/or Dependents named in the Policy Schedule/ Certificate of Insurance, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium is paid.

41. **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



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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.

42. **ICU 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.
43. **IRDAI** means the Insurance Regulatory and Development Authority of India.

44. **Maternity expenses means:**

- a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- b) expenses towards lawful medical termination of pregnancy during the Policy period.

45. **Medical Assistance Service** is a service which provides Medical Advice, evacuation, assistance and repatriation. This service can be multi-lingual and is available 24 hours a day.

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

47. **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.

48. **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 its scope and jurisdiction of license.

49. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

- i. is required for the medical management of the illness or injury suffered by the insured;
- ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- iii. must have been prescribed by a medical practitioner;
- iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

50. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same Insurer.

51. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a cashless facility.

52. **Nominee** means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.

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

54. **New Born Baby** means baby born during the Policy period and is aged upto 90 days.

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

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56. **Out-Patient** means a patient who undergoes OPD treatment.
57. **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.
58. **Policy** is sent to You comprising of Policy wordings, Certificates of Insurance issued to the Insured Persons, group proposal form/RFQ and Policy Schedule/ Certificate Of Insurance which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.
59. **Policy Period** means the period between the Inception Date and the expiry date of the Policy as specified in the Policy Schedule/ Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.
60. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
61. **Pre-Existing Disease (PED)** means any condition, ailment, injury, or disease:
- That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement or
 - For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement.
62. **Pre-hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:
- Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
 - The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
63. **Post-hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
- Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
 - The inpatient hospitalisation claim for such hospitalisation is admissible by the insurance company.
64. **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.
65. **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.
66. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
67. **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.
68. **Spouse** means the Employee's legal husband or wife proposed to be covered under the Policy.
69. **Specialist** is a Medical Practitioner who:



- Has received advanced specialist training;
- Practices a particular branch of medicine or Surgery;
- Is or has been appointed as a consultant in a Hospital or is or has been appointed to a position in a Hospital Which We accept as being of equivalent status.

It is clarified that a physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided is only a Specialist for the purpose of physiotherapy as described in the list of Benefits.

70. **Sum Insured** means, subject to the terms, conditions and exclusions of this Policy, the amount representing Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person and is as specified in the Policy Schedule and/or Certificate of Insurance against the particular Benefit(s).

71. **Surgical Appliance and/or Medical Appliance** means:

- An artificial limb, prosthesis or device which is required for the purpose of or in connection with a Surgery;
- An artificial device or prosthesis which is a necessary part of the Treatment immediately following Surgery for as long as such device or prosthesis is required by medical necessity.
- A prosthesis or appliance which is medically necessary and is part of the recuperation process on a Short-Term basis.

72. **Service Partner** is an assistance company utilized by Us to support You for facilitation of access to Network Providers and for providing Medical Assistance Services. In India such services will be provided by a TPA.

73. **Sub Limit** defines limitation on the amount of coverage available to cover a specific type of claim. A sublimit is part of, rather than in addition to, the limit that would otherwise apply to the admissible claim amount.

74. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

75. **Third Party Administrator (TPA)** means a Company who is licensed under the IRDAI (Third Party Administrators-Health Services) Regulations 2016, as amended from time to time, by the IRDAI and is engaged for a fee or remuneration by Us for the purposes of providing health services.

76. **Treatment** means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve Illness within the scope of the Policy.

77. **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.

78. **Waiting Period** means a time bound exclusion period related to condition(s) specified in the Policy Schedule or Certificate of Insurance or Policy which shall be served before a claim related to such condition(s) becomes admissible.

79. **We/Our/Us** means the United India Insurance Company Limited.

80. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

VIII. Optional Covers: Policy Terms and Conditions for Optional Covers (In conjunction with Policy Terms and Conditions)

This Policy may also provide Options to the Base Covers if these are specified to be applicable in the Policy Schedule and/or the Certificate of Insurance subject to (I) the terms, conditions, exclusions and limitations of the Options set out herein along with Optional Benefits (if any), (II) receipt of premium, statements in the proposal and information disclosed to Us by You or on Your behalf and on behalf of all persons to be insured which is incorporated into the Policy and is the basis of it.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base

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Cover (Section II of the Policy) shall apply.

Maternity Expenses Cover

We will cover Medical Expenses incurred in respect of a female Insured Person above 18 years during the Policy Period for the delivery of a child in a Hospital (including but not limited to caesarean section, vacuum birthing, water birthing, hypnobirthing, midwife birthing) or for medically required and lawful medical termination of pregnancy.

This Benefit will be available subject to the following:

- (i) Up to the limits as specified in the Policy Schedule or Certificate of Insurance;
- (ii) After the waiting period as specified in the Policy Schedule or Certificate of Insurance from the Start Date;
- (iii) Up to a maximum number of deliveries/ terminations as specified in the Policy Schedule or Certificate of Insurance,
 - (iv) Those insured persons who are already having number of living children as specified in the schedule will not be eligible for this benefit.
 - (v) Pre and post-natal Medical Expenses incurred only under hospitalisation shall be covered within the Maternity Expenses Cover limit. In such a case, We will pay the Pre and post-natal Medical expenses incurred from the date of conception up to a period of 6 weeks from delivery.
 - (vi) Payment under this cover will be limited to per event and will be a part of the Base Sum Insured specified in the Policy Schedule and/or Certificate of Insurance.

We will not be liable to make any payment in respect of the following:

- a. Medical Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future illnesses.
- b. Medical Expenses for ectopic pregnancy, which will be covered under Section II.1 of the Base Cover Terms and Conditions.
- c. Complications arising as a result of infertility Treatment (assisted conception).

Pre or post-natal Care Expenses shall not be considered for payment under any Pre-hospitalisation Medical Expenses or Postâ

€hospitalisation Medical Expenses paid under the Base Cover.

If Maternity Expenses Cover is in force in respect of the Insured Person, then the part of Exclusion IV.A.36 pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

All claims under this Benefit can be made as per the process defined under Section V of the Base Cover Terms and Conditions.

Corporate Buffer

We will provide for a Corporate Buffer as per limits specified in the Policy Schedule/Certificate of Insurance during the Policy period, provided that:

- i. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.
- ii. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule.
- iii. This Benefit will be restricted to Individual/ family/amount specified in the Policy Schedule in respect of each and every Insured Person/ family.
- iv. If the Policy is issued on a Family Floater basis, the enhanced Sum Insured on account of the Corporate Buffer applicable will also be available on a Family Floater basis.
- v. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy period. The Benefit payable will be over and above the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Sections V. under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

Waiver of Proportionate Clause

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Note 1 (Proportionate Clause) under Clause II.1 (Base Covers) stands deleted for the members covered in the Policy as stated in the Schedule.

You/Insured Person shall continue to bear the differential between actual and eligible Room Rent.

Claim Process for Optional Covers

1. Claim Intimation:

In addition to the claim intimation process set out in the Base Cover, the following conditions apply in relation to the respective Options. Upon the discovery or occurrence of an Accident/ Critical Illness or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee, as the case may be, must notify Us/ Our TPA either at the call centre or in writing and shall undertake the following:

In the case of Accidental Death Benefit/ PTD/ PPD/ Critical Illness (if applicable) -The Insured Person or the Nominee shall notify Us either at the call centre or in writing, within 10 days from the date of occurrence of such Accident/diagnosis of a Critical Illness.

2. Reimbursement Process

In addition to the documents mentioned in the Base Cover claim reimbursement process, the following additional documents will be required for reimbursement claim for the respective Options.

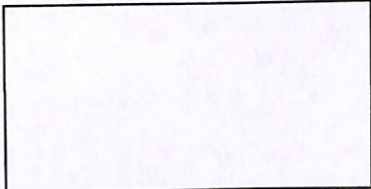
Optional Cover	Additional Documents Required
Critical Illness - Benefit Cover	<p>The Insured Person may submit the following documents for reimbursement of the claim to our policy issuing office at his/her own expense ninety (90) days from the date of first diagnosis of the Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be</p> <p>Medical certificate confirming the diagnosis of Critical Illness. Discharge certificate/ card from the Hospital, if any.</p> <p>Investigation test reports confirming the diagnosis. First consultation letter and subsequent prescriptions. Indoor case papers, if applicable.</p> <p>Specific documents listed under the respective Critical Illness. Any other documents as may be required by Us.</p> <p>In those cases, where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.</p>
Out- Patient Cover	<p>The Insured Person shall avail these benefits as defined in Policy T&C if opted for.</p> <p>Submission of claim</p> <p>Invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to the TPA Head Office</p> <p>Assessment of claim documents</p> <p>We shall assess the claim documents and ascertain the admissibility of claim.</p> <p>Settlement & Repudiation of a claim</p> <p>We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document.</p>



Dental Expenses Cover & Vision Expenses Cover	<p>The Insured Person shall avail these Benefits as defined below, if opted for. Submission of claim Insured Person can send the claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by the Insured Person as the case may be, to Our branch office or head office.</p> <p>Assessment of claim documents We shall assess the claim documents and ascertain the admissibility of claim.</p> <p>Settlement & Repudiation of a claim We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document.</p> <p>In respect of Orthodontic Treatment claims for Dependent Children below 18 years, pre- authorisation is a must.</p> <p>For claims in respect of Orthodontic Treatment towards Dependent Children below 18 years, the Employee/ Member or Dependent must send the following information prepared by the Dentist who is to carry out the proposed Treatment to Us before Treatment starts, so that We can confirm the Benefit that will be payable:</p> <p>Full description of the proposed Treatment;</p> <ul style="list-style-type: none">•X-rays and study models;•An estimate of the cost of the Treatment. <p>Any Benefit will be payable only if We have authorised the cover before Treatment starts.</p>
Refractive Error Correction Expenses Cover	Prescription from Specialist Medical Practitioner specifying the refractive error and medical necessity of the Treatment.
Home Nursing Charges Cover	Bills from registered nursing service provider.
Air Ambulance Cover	Air ambulance ticket for registered service provider.
Emergency Evacuation Cover	<p>In the event of an Insured Person requiring Emergency evacuation and repatriation, the Insured Person must notify Us immediately either at Our call centre or in writing.</p> <p>Emergency medical evacuations shall be pre-authorized by Us.</p> <p>Our team of Specialists in association with the Emergency assistance service provider shall determine the medical necessity of such Emergency evacuation or repatriation post which the same will be approved.</p>
Medical Equipment Cover	Prescriptions of treating Specialist for support items and original invoice of actual Medical Expenses incurred.
Ultra-modern Treatment Cover	Certificate by qualified medical surgeons indicating the medical necessity of the procedure.
Birth Control Procedure Cover	All medical records and treating Medical Practitioner's certificate on the indication.
Infertility Treatment Cover	Certificate from Specialist Medical Practitioner detailing the cause of infertility, Treatment, procedure.
Deductible (Aggregate/ Per-Claim)	<p>Any claim towards Hospitalisation during the Policy period must be submitted to Us for assessment in accordance with the claim process laid down under Section V of the Policy towards Cashless facility or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the Deductible, We will assess and pay such claim in accordance with Section V.F and G of the Policy.</p> <p>Wherever such Hospitalisation claims as stated under Section V above is being covered under another policy held by the Insured Person, We will</p>



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assess the claim on available photocopies duly attested by the Insured Person's insurer / TPA as the case may be.

We may call for any additional document/information as required based on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarity.

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30 of 40

Annexure-I

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

Item	Payable / Not Payable
BABY FOOD	Not Payable
BABY UTILITIES CHARGES	Not Payable
BEAUTY SERVICES	Not Payable
BELTS/ BRACES	Payable for cases who have undergone surgery of thoracic or lumbar spine.
BUDS	Not Payable
COLD PACK/HOT PACK	Not Payable
CARRY BAGS	Not Payable
EMAIL / INTERNET CHARGES	Not Payable
FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
LEGGINGS	Payable in case of varicose vein surgery
LAUNDRY CHARGES	Not Payable
MINERAL WATER	Not Payable
SANITARY PAD	Not Payable
TELEPHONE CHARGES	Not Payable
GUEST SERVICES	Not Payable
CREPE BANDAGE	Not Payable
DIAPER OF ANY TYPE	Not Payable
EYELET COLLAR	Not Payable
SLINGS	Reasonable costs for one sling in

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		case of upper arm fractures is payable
	BLOOD GROUPING AND CROSS MATCHING OF DONORSSAMPLES	Part of Cost of Blood, not payable
	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
	Television Charges	Payable under room charges not if separately levied
	SURCHARGES	Part of Room Charge, Not payable separately
	ATTENDANT CHARGES	Not Payable - Part of Room Charges
	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
	BIRTH CERTIFICATE	Not Payable
	CERTIFICATE CHARGES	Not Payable
	COURIER CHARGES	Not Payable
	CONVEYANCE CHARGES	Not Payable
	MEDICAL CERTIFICATE	Not Payable
	MEDICAL RECORDS	Not Payable
	PHOTOCOPIES CHARGES	Not Payable
	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable
	WALKING AIDS CHARGES	Not Payable
	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSPITAL)	Not Payable
	SPACER	Not Payable
	SPIROMETRE	Device not payable
	NEBULIZER KIT	Not Payable

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STEAM INHALER	Not Payable
ARMSLING	Not Payable
THERMOMETER	Not Payable
CERVICAL COLLAR	Not Payable
SPLINT	Not Payable
DIABETIC FOOT WEAR	Not Payable
KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
KNEE IMMOBILIZER/SHOULD ER IMMOBILIZER	Not Payable
LUMBO SACRAL BELT	Payable for cases who have undergone surgery of lumbar spine
NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadruplegia for any reason and at reasonable cost of approximately Rs 200/ day
AMBULANCE COLLAR	Not Payable
AMBULANCE EQUIPMENT	Not Payable
ABDOMINAL BINDER	Payable for cases who have undergone surgery of lumbar spine.
PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Payable in post hospitalisation
SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. Forlonger stay in ICU, may

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		require a change and at least one set every second day is payable.
	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
	NEBULISATION KIT	Payable reasonably if used during hospitalisation
	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
	KIDNEY TRAY	Not Payable
	MASK	Not Payable
	OUNCE GLASS	Not Payable
	OXYGEN MASK	Not Payable
	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
	PAN CAN	Not Payable
	TROLLEY COVER	Not Payable
	UROMETER, URINE JUG	Not Payable
	AMBULANCE	Payable
	VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs

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

Sr. 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 / VISTOR'S 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	PULSE OXIMETER CHARGES

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

Sr. No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHIELD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUZE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, 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
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sr. 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 SWABS
16	SCRUB SOLUTIONS / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure-II

Details of Insurance Ombudsmen

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel No: 079 - 25501201/02/05/06. Email: bimalokpal.ahmedabad@ecoi.co.in



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Karnataka	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
Madhya Pradesh and Chhattisgarh	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
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar - 751 009.Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	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
Tamil Nadu, UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	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@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23232481/2321350 4. Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	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



Andhra Pradesh, Telangana and UT of Yanam - a part of the UT of Pondicherry	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
Rajasthan	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
Kerala , UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry	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
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	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
Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich,	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



Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	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
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar	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



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r, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kasganj, Sambhal, Amroha, Hathras, Kanshiramna gar, Saharanpur	
Bihar, Jharkhand.	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
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	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

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ENGINEERING COLLEGE**

540, Dum Dum Road, Surermath, Kolkata- 700074, West Bengal



**Policy of
General Insurance
(W.e.f 2018-19)**

Approved by BOG
Dated on 03/07/2018
Under Agenda No. 3

Ref.No: DSDEC/ POLY/ 2018-19/11 Issue No- <u>3</u>	Compiled & Checked By <i>Sudhir Chandra Sur</i> (HR , Admin)	Approved By: <i>(Signature)</i> Principal Dr. Sudhir Chandra Sur Degree Engineering College (Principal) 540, Dum Dum Road, Surermath Kolkata - 74
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Policy of General Insurance

I. Preamble & Operating Clause

This is a legal contract between the Policyholder and Us to provide the insurance cover detailed in the Policy to the Insured Persons up to the Sum Insured subject to the receipt of full premium, disclosure to information norm including the information provided in the Proposal Form or the Request for Quote (RFQ) by the Proposer or by his/ her authorized Intermediary on behalf of him/her-self and all persons to be insured which is incorporated in the policy and is the basis of it; and the terms, conditions, and exclusions of this Policy.

If during the policy period one or more Insured Person (s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify the medically necessary and Reasonable and Customary expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured opted as specified in the Schedule.

II. Covers under the Policy

In the event of any claim arising as a result of treatment taken for an Injury or Illness during the Policy period which becomes payable under any applicable Base Cover and/or Optional Covers, then We shall indemnify the Reasonable and Customary Medical Expenses incurred or pay for the listed Benefits, in accordance with the terms, conditions and exclusions of the Policy subject to availability of the Sum Insured for the cover/benefit applicable and subject to the limit, if any, specified in the Policy Schedule/ Certificate of Insurance. All limits mentioned in the Policy Schedule/ Certificate of Insurance are applicable for each Policy period of coverage.

Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner and are incurred on Medically Necessary Treatment of the Insured Person.

1. In-patient Hospitalization Expenses Cover

We will pay the Reasonable and Customary Charges for the following Medical Expenses of an Insured Person in case of Medically Necessary Treatment taken during Hospitalization provided that the admission date of the Hospitalization due to Illness or Injury is within the Policy period:

- A. Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less, including nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.
- B. Charges for accommodation in ICU/CCU/HDU up to the category/limit specified in the Policy Schedule/ Certificate of Insurance or actual expenses incurred, whichever is less,
- C. Operation theatre cost, Anesthetics, Blood, Oxygen, Surgical Appliances and/ or Medical

1 of 40

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Appliances, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents, and other medical expenses related to the treatment.

- d. The fees charged by the Medical Practitioner, Surgeon, Specialists and Anesthetists treating the Insured Person;
- e. Medicines, drugs, and other allowable consumables prescribed by the treating Medical Practitioner;
- f. Cost of Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is hospitalized such as but not limited to Radiology, Pathology tests, X-rays, MRI and CT Scans, Physiotherapy.

Note 1:

Proportionate Clause: In case of admission to a room at rates exceeding the limits mentioned in the Policy Schedule/Certificate of Insurance (for Clause II.1.A), the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.

Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.

Note 2:

Mental Illness Cover Limit:

In case of following mental illnesses, the Inpatient Hospitalization benefit will be covered up to the limit as mentioned in the schedule.

1. Schizophrenia (ICD - F20; F21; F25)
2. Bipolar Affective Disorders (ICD - F31; F34)
3. Depression (ICD - F32; F33)
4. Obsessive Compulsive Disorders (ICD - F42; F60.5)
5. Psychosis (ICD - F 22; F23; F28; F29)

All claims under this Benefit can be made as per the process defined under Section V. C and D

2. Day Care Treatment Cover

We will cover the Medical Expenses incurred on the Insured Person's Day Care Treatment (as defined in Section VII.19) during the Policy Period following an Illness or Injury that occurs during the Policy Period provided the Day Care Treatment is for Medically Necessary Treatment and follows the written Medical Advice.

The benefit under the policy will be limited to the amount specified in the Policy Schedule/ Certificate of Insurance, whichever is less. All claims under this Benefit can be made as per the process defined under Section V. C and D

3. Pre-hospitalization Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Pre-hospitalization Medical Expenses incurred due to an Illness or Injury that occurs during the Policy Period up to the number of days and up to the amount limit as specified in the Policy Schedule or Certificate of Insurance Or actual expenses incurred, whichever is less, provided that:



- (i) We have accepted a claim for In-patient Hospitalization under Section II.1 or II.2 above;
- (ii) The Pre-hospitalization Medical Expenses are related to the same Illness or Injury.
- (iii) The date of admission to the Hospital for the purpose of this Benefit shall be the date of the Insured Person's first admission to the Hospital in relation to the same Any One Illness.
- (iv) All claims under this Benefit can be made as per the process defined under Section V. D

4. Post-hospitalization Medical Expenses Cover

We will cover, on a reimbursement basis, the Insured Person's Post-hospitalization Medical Expenses incurred following an Illness or Injury that occurs during the Policy Period upto the number of days and upto the amount limit as specified in the Policy Schedule or Certificate of Insurance, provided that:

- (i) We have accepted a claim for In-patient Hospitalization under Section II.1 or II.2 above;
- (ii) The Pre-hospitalization Medical Expenses are related to the same Illness or Injury.
- (iii) The date of discharge from the Hospital for the purpose of this Benefit shall be the date of the Insured Person's last discharge from the Hospital in relation to the same Any One Illness for which We have accepted an In-patient Hospitalization claim under Section II.1 or II.2 above.

All claims under this Benefit can be made as per the process defined under Section V. D

5. Road Ambulance Cover

We will cover the costs incurred up to the limit as specified in the Policy Schedule or Certificate of Insurance on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. It becomes payable if a claim has been admitted under Section II.1 or II.2 and the expenses are related to the same Illness or Injury.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified in the Policy Schedule or Certificate of Insurance:

- (i) it is medically required to transfer the Insured Person to another Hospital or diagnostic Centre during Hospitalization for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
- (ii) it is medically required to transfer the Insured Person to another Hospital during Hospitalization due to lack of specialty treatment in the existing Hospital.

All claims under this Benefit can be made as per the process defined under Section V. D

6. Domiciliary Hospitalization Cover

We will cover Medical Expenses, up to the limit specified in the Policy Schedule/ Certificate of Insurance, incurred for the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

- i. The Domiciliary Hospitalization continues for at least 3 consecutive days in which case We will make payment under this Benefit in respect of Medical Expenses incurred from the first day of Domiciliary Hospitalization;
- ii. The treating Medical Practitioner confirms in writing that Domiciliary Hospitalization was medically required and the Insured Person's condition was such that the Insured Person could not be transferred to a Hospital or the Insured Person satisfies Us that a Hospital bed was unavailable;
- iii. We shall not be liable to pay for any claim in connection with:
 - a. Asthma, bronchitis, tonsillitis, and upper respiratory tract infection including laryngitis and pharyngitis, cough and cold, influenza;
 - b. Arthritis, gout and rheumatism;
 - c. Chronic nephritis and nephritic syndrome;
 - d. Diarrhea and all type of dysenteries, including gastroenteritis;

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- e. Diabetes mellitus and insipidus;
- f. Epilepsy;
- g. Hypertension;
- h. Psychiatric or psychosomatic disorders of all kinds;
- i. Pyrexia of unknown origin.

All claims under this Benefit can be made as per the process defined under Section V. D

7. Donor Expenses Cover

We will cover the In-patient Hospitalization Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated up to the limit as specified in the Policy Schedule or Certificate of Insurance provided that:

- i. The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
 - ii. We have admitted a claim towards In-patient Hospitalization under the Base Cover, and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;
 - iii. We will not cover:
 - a. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor;
 - b. Screening expenses of the organ donor;
 - c. Costs associated with the acquisition of the donor's organ.
 - d. Transplant of any organ/tissue where the transplant is experimental or investigational;
 - e. Expenses related to organ transportation or preservation.
 - f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.
- All claims under this Benefit can be made as per the process defined under Section V. C and D

8. Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claim under section 4.1, expenses incurred on the following procedures (wherever medically indicated) either as in-patient or as part of day care treatment in a hospital, shall be covered. The claim shall be subject to additional sub-limits indicated against them in the table below:

Sr. No.	Modern Treatment Methods & Advancement in Technology	Additional Limit
1.	Uterine Artery Embolization & High Intensity Focused Ultrasound (HIFU)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Uterine Artery Embolization & HIFU
2.	Balloon Sinuplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Balloon Sinuplasty
3.	Deep Brain Stimulation	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Deep Brain Stimulation
4.	Oral Chemotherapy	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Oral Chemotherapy
5.	Immunotherapy- Monoclonal Antibody to be given as injection	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period
6.	Intra vitreal Injections	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period



7.	Robotic Surgeries (including Robotic Assisted Surgeries)	•up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for (i) the treatment of any disease involving Central Nervous System irrespective of aetiology; (ii) Malignancies (ii) •up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Robotic Surgeries for other diseases
8.	Stereotactic Radio Surgeries	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Stereotactic Radio Surgeries
9.	Bronchial Thermoplasty	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Bronchial Thermoplasty.
10.	Vaporization of the Prostate (Green laser treatment or holmium laser treatment)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period.
11.	Intra Operative Neuro Monitoring (IONM)	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period for claims involving Intra Operative Neuro Monitoring
12.	Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered only	up to the limit as specified in the Policy Schedule or Certificate of Insurance per policy period

All claims under this Benefit can be made as per the process defined under Section V. C and D
There are Optional covers available with the Policy. Refer Section VIII-Optional Covers: Policy Terms and Conditions for Optional Covers for further details on these.

III. COVER TYPE

The Policy provides cover on an Individual or Family Floater basis. A separate Sum Insured for each Insured Person, as specified in the Policy Schedule/Certificate of Insurance, is provided under Individual basis while under Family Floater basis, the Sum Insured limit is shared by the whole family of the group member as specified in the Policy Schedule/ Certificate of Insurance and Our total liability for the family cannot exceed the Sum Insured in a Policy period. The cover type basis shall be as specified in the Policy Schedule/ Certificate of Insurance. The basis of cover chosen for the Base Cover is applicable for the Optional Covers as well.

Relationships covered under the Policy are as specified in the Policy Schedule/ Certificate of Insurance.

IV. PERMANENT EXCLUSIONS & WAITING PERIODS

All the Waiting Periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

A. Permanent Exclusions

We shall not be liable to make any payment under this Policy caused by, based on, arising out of, relating to or howsoever attributable to any of the following:

1. All expenses, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing



- duties in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
2. All Illness/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel nuclear, chemical or biological attack.
 3. a) Stem cell implantation/Surgery, harvesting, storage or any kind of Treatment using stem cells except as provided for in clause II.8 (12) above; b) growth hormone therapy.
 4. External Congenital Anomaly or defects.
 5. Sterility and Infertility (**Code-Excl17**): Expenses related to Sterility and Infertility. This includes:
 - i. Any type of contraception, sterilization
 - ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - iii. Gestational Surrogacy
 - iv. Reversal of sterilization
 6. Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
 7. Conditions for which treatment could have been done on an out-patient basis without any Hospitalization.
 8. Investigation & Evaluation (**Code-Excl04**):
 - i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
 - ii. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
 9. Any treatment or part of a treatment that is not of a reasonable charge, is not a Medically Necessary Treatment; drugs or treatments which are not supported by a prescription.
 10. Costs of donor screening or costs incurred in an organ transplant Surgery involving organs not harvested from a human body.
 11. 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.
 12. Any form of Alternative Treatment:
 - i. AYUSH Treatment;
 - ii. Hydrotherapy, Acupuncture, Reflexology, Chiropractic Treatment or any other form of indigenous system of medicine.
 13. Dental Treatment, dentures or Surgery of any kind unless necessitated due to an Accident and requiring minimum 24 hours Hospitalization. Treatment related to gum disease or tooth disease or damage unless related to irreversible bone disease involving the jaw which cannot be treated in any other way.
 14. Routine eye examinations, cost of spectacles, multifocal lens, contact lenses.
 15. Refractive Error (**Code-Excl15**): Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptries.
 16. a) Cost of hearing aids; including optometric therapy; b) cochlear implants unless necessitated by an Accident or required intra- operatively.
 17. Vaccinations including inoculation and immunizations except in case of post-bite treatment.
 18. Any Treatment and associated expenses for alopecia, baldness, wigs, or toupees and hair fall Treatment and products,
 19. Cost incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose.



20. Any stay in Hospital without undertaking any Treatment or any other purpose other than for receiving eligible Treatment of a type that normally requires a stay in the Hospital.
21. 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)**
22. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.
23. 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:
 - 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.
24. Treatments received in health 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)**
25. 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.
26. Certification / diagnosis / Treatment by a family member, or a person who stays with the Insured Person, save for the proven material costs which are eligible for reimbursement as per the applicable cover, or from persons not registered as Medical Practitioners under the respective Medical Councils, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for.
27. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**
28. Prostheses, corrective devices and and/or Medical Appliances, which are not required intra-operatively for the Illness/ Injury for which the Insured Person was Hospitalized.
29. 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.
30. 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.
31. Obesity/ Weight Control **(Code-Excl06)**: Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
 - i. Surgery to be conducted is upon the advice of the Doctor
 - ii. The surgery/Procedure conducted should be supported by clinical protocols
 - iii. The member has to be 18 years of age or older and
 - iv. 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:
 - a. Obesity-related cardiomyopathy
 - b. Coronary heart disease
 - c. Severe Sleep Apnoea
 - d. Uncontrolled Type2 Diabetes
32. Treatment received outside India.
33. a) Instrument used in Treatment of Sleep Apnea Syndrome (C.P.A.P.); b) Oxygen Concentrator for Bronchial Asthmatic condition; c) Infusion pump or any other external devices used during



or after Treatment.

34. 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.
35. Injury caused whilst flying or taking part in aerial activities (including cabin) except as a fare-paying passenger in a regular scheduled airline or air charter company.
36. Maternity (Code-Excl18):
 - i. Medical treatment expenses traceable to childbirth (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.
37. All non-medical expenses including but not limited to convenience items for personal comfort not consistent with or incidental to the diagnosis and Treatment of the Illness/Injury for which the Insured Person was Hospitalized, such as, ambulatory devices, walker, crutches, belts, collars, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer/thermometer and any medical equipment that is subsequently used at home except when they form part of room expenses. For complete list of non-medical expenses, please refer to the Annexure I 'Non-Medical Expenses' and on Our website.
38. Any opted Deductible (Per claim/ Aggregate/ Corporate) amount or percentage of admissible claim under Co-Payment, Sub Limit if applicable and as specified in the Policy Schedule/ Certificate of Insurance to this Policy.
39. Charges related to a hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing, including MRD charges (medical records department charges).
40. Any physical, medical or mental condition or Treatment or service that is specifically excluded in the Policy Schedule/ Certificate of Insurance under Special Conditions.

B. Pre-Existing Disease Waiting Period (Code-Excl01)

- i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, of continuous coverage after the date of inception of the first policy with us.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- iv. Coverage under the policy after the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

c. Initial Waiting Period for Hospitalization (Code-Excl03)

- i. Expenses related to the treatment of any illness within the number of days, as mentioned in the Policy schedule or Certificate of Insurance, from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.



D. Specific Waiting Period (Code-Excl02)

- i. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of the number of months, as mentioned in the Policy schedule or Certificate of Insurance, 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.
- ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- iii. 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.
- iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- v. 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.
- vi. List of specific diseases/procedures:
 - a) Cataract
 - b) Hysterectomy for Menorrhagia or Fibromyoma or prolapse of Uterus unless necessitated by malignancy myomectomy for fibroids
 - c) Knee Replacement Surgery (other than caused by an Accident), Non-infectious Arthritis, Gout, Rheumatism, Osteoarthritis and Osteoporosis, Joint Replacement Surgery (other than caused by Accident), Prolapse of Intervertebral discs (other than caused by Accident), all Vertebrae Disorders, including but not limited to Spondylitis, Spondylosis, Spondylolisthesis, Congenital Internal Diseases
 - d) Varicose Veins and Varicose Ulcers
 - e) Stones in the urinary, uro-genital and biliary systems including calculus diseases.
 - f) Benign Prostate Hypertrophy, all types of Hydroceles
 - g) Fissure, Fistula in anus, Piles, all types of Hernia, Pilonidal sinus, Hemorrhoids, and any abscess related to the anal region.
 - h) Chronic Supportive Otitis Media (CSOM), Deviated Nasal Septum, Sinusitis and related disorders, Surgery on tonsils/Adenoids, Tympanoplasty and any other benign ear, nose and throat disorder or surgery
 - i) Gastric and duodenal ulcer, any type of Cysts/Nodules/Polyps/internal tumors/skin tumors, and any type of Breast lumps (unless malignant), Polycystic Ovarian Diseases
 - j) Any Surgery of the genito-urinary system unless necessitated by malignancy
 - k) Age-related Macular Degeneration (ARMD)
 - l) All Neurodegenerative disorders
 - m) Waiting Period for Named Mental Illnesses

S. No.	Organ / Organ Systems	Illness / Surgeries
1.	Mental Disorders	1) Schizophrenia (ICD - F20; F21; F25) 2) Bipolar Affective Disorders (ICD - F31; F34) 3) Depression (ICD - F32; F33) 4) Obsessive Compulsive Disorders (ICD - F42; F60.5) 5) Psychosis (ICD - F



V. Claims Procedure

A. Claims Administration & Process

It shall be the condition precedent to admission of Our liability under this Policy that the terms and conditions of making the payment of premium in full and on time, insofar as they relate to anything to be done or complied with by You or any Insured Person, are fulfilled including complying with the following in relation to claims:

1. On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.
2. The treatment should be taken as per the directions, advice and guidance of the treating Medical Practitioner. Any failure to follow such directions, Medical advice or guidance will prejudice the claim.
3. The Insured Person must submit to medical examination by Our Medical Practitioner or our authorized representative in case requested by Us and at Our cost, as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.
4. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

B. Notification of claim

Upon the happening of any event which may give rise to a claim under this Policy, the insured person/insured person's representative shall notify the TPA (if claim is processed by TPA)/company (if claim is processed by the company) in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

- i. Within 24 hours 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.

C. Procedure for Cashless claims

1. Cashless facility for treatment in network hospitals only shall be available to insured if opted for claim processing by TPA.
2. Treatment may be taken in a network provider/PPN hospital and is subject to pre- authorization by the TPA. Booklet containing list of networks provider/PPN hospitals shall be provided by the TPA. Updated list of networks provider/PPN is available on website of the company (<https://uiic.co.in/en/tpa-ppn-network-hospitals>) and the TPA mentioned in the schedule.
3. Call the TPA's toll free phone number provided on the health ID card for intimation of claim and related assistance. Inform the ID number for easy reference.
4. On admission in the network provider/PPN hospital, produce the ID card issued by the TPA at the Hospital Insurance-desk. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for pre- authorization.
5. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
6. Once the request for pre-authorization has been granted, the treatment must take place within 15 days of the pre-authorization date at a Network Provider and pre-authorization shall be valid only if all the details of the authorized treatment, including dates, Hospital and locations, match with the details of the actual treatment received. For Hospitalization where



Cashless Facility is pre- authorized by Us or the associated TPA, we will make the payment of the amounts assessed directly to the Network Provider.

7. In the event of any change in the diagnosis, plan of Treatment, cost of Treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under V.4 above.
8. At the time of discharge, the insured person shall verify and sign the discharge papers and final bill and pay for non-medical and inadmissible expenses.
Note: (Applicable to V.C): Cashless facility for Hospitalization expenses shall be limited exclusively to Medical Expenses incurred for Treatment undertaken in a Network Provider/ PPN hospital for Illness or Injury / Accident/ Critical Illness as the case may be which are covered under the Policy. For all cashless authorizations, the Insured Person will, in any event, be required to settle all non- admissible expenses, expenses above specified Sub Limits (if applicable), Co-Payments and / or opted Deductible (Per claim/ Aggregate/ Corporate) (if applicable), directly with the Hospital.
9. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.
10. In case of admission in PPN hospitals, duly filled and signed PPN declaration format available with the hospital must be submitted.
11. Claims for Pre and Post-Hospitalization will be settled on a reimbursement basis on production of cash receipts along with supporting documents.

D. Procedure for reimbursement of claims

In non-network hospitals payment must be made up-front and for reimbursement of claims the insured person may submit the necessary documents to TPA (if claim is processed by TPA)/company (if claim is processed by the company) within the prescribed time limit.

E. Documents

1. The claim is to be supported with the following original documents and submitted within the prescribed time limit.
 - i.i. Duly completed claim form.
 - i.ii. Photo ID and Age proof;
 - i.iii. Health Card, policy copy, photo ID, KYC documents;
 - i.iv. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed, along with date of diagnosis, investigation test reports etc. supported by the prescription from attending medical practitioner.
 - i.v. Original discharge card / day care summary / transfer summary;
 - i.vi. Original final Hospital bill with detailed break-up with all original deposit and final payment receipt;
 - i.vii. Original invoice with payment receipt and implant stickers for all implants used during Surgeries i.e. lens sticker and Invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery;
 - i.viii. All previous consultation papers indicating history and treatment details for current ailment;
 - i.ix. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription and invoice / bill with receipt from diagnostic center;
 - i.x. All original medicine / pharmacy bills along with the Medical Practitioner's prescription;
 - i.xi. MLC / FIR copy-in Accidental cases only;
 - i.xii. Copy of death summary and copy of death certificate (in death claims only) ;
 - i.xiii. Pre- and post-operative imaging reports;
 - i.xiv. Copy of indoor case papers with nursing sheet detailing medical history of the Insured Person,



treatment details and the Insured Person's progress;

i.xv. KYC documents

i.xvi. Cheque copy with name of proposer printed on the cheque leaf or copy of the first page of the bank passbook or the bank statement not later than 3 months.

Note

In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other insurer, the company may accept the duly certified documents listed under condition 5.6.4 and claim settlement advice duly certified by the other insurer subject to satisfaction of the company.

2. Time limit for submission of documents

Type of claim	Time limit for submission of documents to company/TPA
Where Cashless Facility has been authorized	Immediately after discharge.
Reimbursement of hospitalization and pre hospitalization expenses (limited to 30 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalization expenses (limited to 60 days)	Within 15 (fifteen) days from completion of post hospitalization treatment

Note: Waiver of this Condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.

- 3. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorization to obtain Medical and other records from the hospital, lab, etc.
- 4. All the documents submitted to TPA shall be electronically collected by Us for settlement and denial of the claims by the appropriate authority.

F. Scrutiny of Claim Documents

- a. TPA/ We shall scrutinize the claim form and the accompanying documents. Any deficiency in the documents shall be intimated to the Insured Person/ Network Provider as the case may be. If the deficiency in the necessary, claim documents is not met or is partially met in 10 working days of the first intimation. We will send a maximum of 3 (three) reminders. We may, at Our sole discretion, decide to deduct the amount of claim for which deficiency is intimated to the Insured Person and settle the claim if we observe that such a claim is otherwise valid under the Policy.
- b. In case a reimbursement claim is received when a pre-authorization letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorization has been utilized as well as whether the Insured Person has settled all the dues with the Network Provider. Once such a check and declaration is received from the Network Provider, the case will be processed.
- c. The Pre-Hospitalization Medical Expenses Cover claim and Post- Hospitalization Medical Expenses Cover claim shall be processed only after decision of the main Hospitalization claim.

G. Claim Assessment

We will pay the fixed or indemnity amount as specified in the applicable Base or Optional cover in accordance with the terms of this Policy.

We will assess all admissible claims under the Policy in the following progressive order:

- 1. Application Proportionate clause as per Note 1. clause II.1.



2. Co-pay as applicable.
3. Limit/ Sub Limit on Medical Expenses are applicable as specified in the Policy Schedule/ Certificate of Insurance
4. Opted Deductible (Per claim/ Aggregate) Claim Assessment for Benefit Plans:
We will pay fixed benefit amounts as specified in the Policy Schedule/ Certificate of Insurance in accordance with the terms of this Policy. We are not liable to make any reimbursements of Medical Expenses or pay any other amounts not specified in the Policy.

H. Claim Settlement (provision for Penal Interest)

1. The Company shall settle or reject a claim within 30 days of the date of receipt of last necessary document.
2. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Insured Person from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Insured Person at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
(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).

I. Claim Rejection/ Repudiation

If the company, for any reasons, decides to reject a claim under the policy, we shall communicate to the insured person in writing explicitly mentioning the grounds for rejection/repudiation and within a period of 30 (thirty) days from the receipt of the final document(s) or investigation report (if any), as the case may be. Where a rejection is communicated by Us, the Insured Person may, if so desired, within 15 days from the date of receipt of the claim's decision represent to Us for reconsideration of the decision.

J. Claim Payment Terms

- i. We shall have no liability to make payment of a claim under the Policy in respect of an Insured Person once the Sum Insured for that Insured Person is exhausted.
All claims will be payable in India and in Indian rupees.
- ii. We are not obliged to make payment for any claim or that part of any claim that could have been avoided or reduced if the Insured Person could have reasonably minimized the costs incurred, or that is brought about or contributed to by the Insured Person by failing to follow the directions, Medical Advice or guidance provided by a Medical Practitioner.
- iii. The Sum Insured opted under the Policy shall be reduced by the amount payable / paid under the Policy terms and conditions and any optional covers applicable under the Policy and only the balance shall be available as the Sum Insured for the unexpired Policy Period.
- iv. If the Insured Person suffers a relapse within 45 days from the date of discharge from the Hospital for which a claim has been made, then such relapse shall be deemed to be part of the same claim and all the limits for 'Any one illness' under this Policy shall be applied as if they were under a single claim.
- v. **For Cashless claims**, the payment shall be made to the Network Provider whose discharge would be complete and final.
- vi. **For Reimbursement claims**, the payment shall be made to the Insured Person. In the unfortunate event of the Insured Person's death, we will pay the Nominee (as named in the Policy Schedule/ Certificate of Insurance) and in case of no Nominee, to the legal heir who



holds a succession certificate or indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

k. **Services offered by TPA (To be stated where TPA is involved)**

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include:

- i. Claim settlement and rejection;
- ii. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered with the Company.

l. **Payment of Claim**

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

VI. Terms and conditions

1. Disclosure of Information

The policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the policy.

3. Parties to the Policy

The only parties to this Policy are the Policyholder and Us.

4. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to You/Insured Person in Our possession or in the possession of any of Our officials shall not be deemed to be notice or be held to bind or prejudicially affect Us or absolve You/Insured Person from your/her duty of disclosure, notwithstanding subsequent acceptance of any premium.

5. Eligibility

To be eligible for coverage under the Policy, the Insured Person must be -

- a. Either an employee of the policyholder where there is an employer/employee relationship OR a member of the group as defined in extant IRDAI guidelines on Group Health Insurance in case of Non-Employer-Employee policies
- b. The relationships which may be covered under the Policy are-
 - i. Self
 - ii. Employee/member's legal Spouse, Life Partner (including live-in partner)
To this section, Life Partner (including live-in partner) shall be taken as declared at the time of inception of Policy and no change would be accepted during the Policy Period. However, the Insured may request for change at the time of Renewal of the cover.
 - iii. The Employee/member's children between the age of 91 days and 18 years shall be covered provided either or both parents are covered concurrently. Children above 18 years will continue to be covered along with parents up to the age of 26 years, provided they are unmarried/unemployed and dependent.



- iv. Parents/Parents-in-law
- v. The Employee/member's siblings shall be covered up to the age of 26 years, provided they are unmarried/unemployed and dependent.
- vi. Any other relationship as specified in the Policy Schedule/Certificate of Insurance
- c. Minimum Group size: The Policyholder shall ensure that the minimum number of Employees/members who will form a group to avail the Benefits under this Policy shall be 7 (Seven).
- d. Newborn Babies will be accepted for cover (subject to the limitations of the Newborn Baby Benefit Cover) from birth if mother is covered and maternity cover is opted for. Acceptance of Newborn Babies as Insured Persons is subject to written notification on or before the last day of the month following the birth of the child and receipt of the agreed premium.

6. Reasonable Care

The Insured Person understands and agrees to take all reasonable steps in order to safeguard against any Illnesses, Accident or Injury that may give rise to any claim under this Policy.

7. Premium

The premium for each Policy will be determined based on the available data of each group, coverage sought by the insured and applicable discounts and loadings. Payment of premiums will be available in Single mode. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions, and endorsements of this Policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a Condition Precedent to Our liability to make any payment under this Policy.

Premium will be subject to revision at the time of renewal of the Policy. Further, premium shall be paid in Indian Rupees and in favor of United India Insurance Company Ltd.

NOTE: Where Instalment facility is granted by Us for the payment of premium, it is to be in accordance with the schedule of payments agreed between the Policyholder and Us in writing. Where premium is payable on an instalment basis, the revival period shall be 15 days. Wherever premiums are not received within the revival period, the Policy will be terminated effective from instalment due date and all claims that fall beyond such instalment due date shall not be paid. However, we will be liable to pay in respect of all claims where the Treatment/Admission/Accident has commenced/ occurred before the date of termination of such Policy.

For installment premium, in the event of cancellation of policy, we will refund premium on pro rata basis after deducting Our expenses.

Premium shall be refunded for all lives which have not registered a claim with Us under the Policy up to the date of cancellation.

8. Role of Group Administrator/Policyholder

- i. The Policyholder should provide all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy including the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.
- ii. Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the RFQ/ proposal form, and which is relevant to Us in order to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, or endorsement of the Policy.
- iii. The Policy holder i.e. the Employer may issue confirmation of insurance protection to the



individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.

iv. The claims of the individual employees may be processed through the employer.

9. **Alterations in the Policy**

This Policy constitutes the complete contract of insurance. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us. All endorsement requests will be made by the Policyholder only.

10. **Material Information for administration**

The Insured Person and/ or the Policyholder must give Us all the written information that is reasonably required to work out the premium and pay any claim/ Benefit provided under the Policy. You must give Us written notification specifying the details of the Insured Persons to be deleted and the details of the eligible persons proposed to be added to the Policy as Insured Persons.

Material information to be disclosed includes every matter that the Insured Person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the proposal form, and which is relevant to Us to accept the risk of insurance and if so on what terms. The Insured Person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, or endorsement of the Policy.

11. **Material Change**

It is Condition Precedent to Our liability under the Policy that You shall at Your own expense immediately notify Us in writing of any material change in the risk on account of change in nature of occupation or business of any Insured Person. We may, in Our discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

12. **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 claim, who shall be jointly and severally liable for such repayment to the Insurer.

To 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:

- i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
- ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
- iii. any other act fitted to deceive; and
- iv. 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.

13. **Geographical Area**

The geographical scope of this Policy applies to events limited to India unless specified under this Policy in a particular Benefit or definition. However, all admitted or payable claims shall be settled in India in Indian rupees.

14. **Addition and Deletion of a Member**

We shall include/exclude a group member/Employee of the Policyholder and/or his/her



Dependent(s) as an Insured Person under the Policy in accordance with the following procedure:

A. Additions

a. Employer-Employee Group:

- i) Newly appointed employee and his/her dependents
- ii) Newly wedded spouse of the employee,
- iii) Newborn child of the employee

may be added to the Policy as an Insured Person during the Policy period provided that the application for cover has been accepted by Us, additional premium on pro-rata basis applied on the risk coverage duration for the Insured Person has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Person

b. Non-Employer-Employee Group: As specified in the Policy Schedule

B. Deletions:

a. Employer-Employee Group

- i) Employee leaving the company/organization on account of resignation/retirement/termination and his/her dependents shall be deleted from the policy effective from the date of resignation/retirement/termination or till the last day of the month of resignation/retirement/termination at the option of the insured.
- ii) In the event of death of an employee, his/her dependents may continue to be covered until the expiry of the policy period at the option of the insured.

b. Non-Employer-Employee Group: As specified in the Policy Schedule

Refund of premium shall be made on a pro-rata basis, provided that no claim is paid/outstanding in respect of that Insured Person or his/her Dependents.

Throughout the Policy period, the Policyholder will notify Us of all and any changes in the membership of the Policy occurring in a month on or before the last day of the succeeding month.

15. Nomination

The Insured Person 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.

16. Endorsements

The Policy will allow the following endorsements during the Policy period. Any request for endorsement must be made only in writing by the Policyholder. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later.

Rectification in name of the proposer / Insured Person. Rectification in gender of the proposer/ Insured Person. Rectification in relationship of the Insured Person with the proposer. Rectification of age/ date of birth of the Insured Person

Change in the correspondence address of the proposer.

Change/updating in the contact details viz., phone number, E-mail ID, etc. Updating of alternate contact address of the proposer.

Change in Nominee details.

Deletion of Insured Person on death or upon leaving the group provided no claims are paid / outstanding.

Addition of member (Newborn Baby or newly wedded Spouse).

All endorsement requests shall be assessed by the underwriter and where required additional



information/documents/ premium may be requested.

17. Multiple Policies

- i. In case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim if the claim is within the limits of and according to the terms of the chosen policy.
- ii. Insured Person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies, even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and condition of this policy.
- iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.
- iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

18. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation, non-disclosure of material facts by the Insured Person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience.

19. Renewal Terms

Alterations like increase/ decrease in Sum Insured or change in optional covers can be requested at the time of Renewal of the Policy. We reserve Our right to carry out assessment of the group and provide the Renewal quote in respect of the revised Policy.

We may in Our sole discretion, revise the premiums payable under the Policy or the terms of the cover, provided that all such changes are in accordance with the IRDAI rules and regulations as applicable from time to time.

20. Cancellation

- i. The policyholder may request for cancellation of the policy at any time by giving 15 days' notice in writing. In such case We shall refund the percentage of premium for the unexpired Policy Period on short period scale as per the table below:

The grid is applicable for single premium Policy

Cancellation Grid	
Period* for which risk is retained	Refund
Upto 1 Month	75%
>1 Month- less than 3 Month	50%
>3 Months - less than 6 months	25%



>6 Months - less than 9 months	15%
>9 Months	Nil

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the policy.

- ii. 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 mis- representation, non-disclosure of material facts or fraud.

21. Our Right of Termination

A. Termination of Policy:

Prior to the expiry of the Policy as shown in the Policy Schedule/ Certificate of Insurance, cover will end immediately for all Insured Persons, if:

- i. there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- ii. there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis for all lives which have not registered a claim with Us, after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- iii. the Policyholder does not pay the premiums owed under the Policy within the Grace Period. Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If Treatment has been authorized or an approval for Cashless facility has been issued, we will not be held responsible for any Treatment costs if the Policy ends. However, we will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.

B. Termination for Insured Person's cover

Cover will end for a Member or dependent:

- i. If the Policyholder stops paying premiums for the Insured Person(s) and their Dependents (if any);
- ii. When this Policy terminates at the expiry of the period shown in the Policy Schedule/ Certificate of Insurance.
- iii. If he or she dies;
- iv. When a dependent insured person ceases to be a Dependent; unless otherwise agreed specifically for continuation till end of policy period;
- v. If the Insured Person ceases to be a member of the group.

22. Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

23. Migration

The Insured Person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health



insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. For Detailed Guidelines on Migration, kindly refer the link: https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

24. Operation of Policy & Certificate of Insurance

The Policy shall be issued for the duration as specified in the Policy Schedule/ Certificate of Insurance. The Policy takes effect on the Inception Date stated in the Policy Schedule and/or the Certificate of Insurance and ends on the date of expiry of the Policy. For specific groups, upon request, all additions thereto by way of Certificate/s of Insurance shall be valid up to the Policy Period commencing from the actual date of addition to the Policy, it being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on Renewal of the Policy or until expiry of the Certificate of Insurance, whichever is later.

25. Electronic Transactions

The Policyholder/ Insured Person agrees to comply with all the terms and conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy, or Our other services, shall constitute legally binding when done in compliance with Our terms for such facilities.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder/ Insured Person. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by the Policyholder/ Insured Person.

26. Communications & Notices

- iii. Any notice, direction or instruction or any other communication related to the Policy should be made in writing.
- iv. Such communication shall be sent to the address of the Company or through any other electronic modes at contact address as specified in the Policy Schedule.
- v. No insurance agents, brokers, other person or entity is authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us.
- vi. The Company shall communicate to The Policyholder/ Insured Person in writing, at the address as specified in the Policy Schedule/ Certificate of Insurance or through any other electronic mode at the contact address as specified in the policy schedule

27. Complete Discharge

Any payment to the Policyholder, Insured Person or his/her nominees or his/her legal representative or Assignee or to the Hospital 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.

28. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholders about the same 90 days prior to date of withdrawal of the product.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

29. Moratorium Period

After completion of eight continuous years under the policy no look back would be applied. This



period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments as per the policy.

30. Redressal of Grievances

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

Website: www.uiic.co.in

Toll free: 1800 425 333 33

E-mail: customercare@uiic.co.in

Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 19, IV Lane, Nungambakkam High Road, Chennai, Tamil Nadu- 600034

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 customercare@uiic.co.in

For updated details of grievance officer, kindly refer the link <https://uiic.co.in/en/customercare/grievance>

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. The contact details of the Insurance Ombudsman offices have been provided as Annexure-C

Grievance may also be lodged at IRDAI Integrated Grievance Management System: <https://igms.irda.gov.in/>

31. Territorial Jurisdiction

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

VII. Definitions

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

1. **Accident** means a sudden, unforeseen, and involuntary event caused by external, visible and violent means.
2. **Age or Aged** means age of the Insured Person on last birthday as on date of commencement of the Policy.
3. **Alternative Treatments** are forms of Treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha, and Homeopathy in the Indian context.
4. **Annexure** means a document attached and marked as Annexure to this Policy.
5. **Ambulance** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical Treatment of the person requiring medical attention.
6. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
7. **Associated Medical Expenses** means hospitalization related expenses on Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital; Anesthesia, blood, oxygen, operation theatre



charges, surgical appliances and such other similar expenses with the exception of:

- a. cost of pharmacy and consumables medicines
- b. cost of implants/medical devices
- c. cost of diagnostics

The scope of this definition is limited to admissible claims where a proportionate deduction is applicable, as per Note 1 of Clause II.1.

8. **AYUSH Treatment** refers to the medical and /or Hospitalization Treatments given under Ayurveda, Unani, Siddha, and Homeopathy Systems.
9. **Benefit** means any benefit shown in the Policy Schedule and/or Certificate of Insurance.
10. **Base Sum Insured** means the Sum Insured for the Base Cover as specified in the Policy Schedule and/or Certificate of Insurance.
11. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
12. **Cashless facility** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured Person 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.
13. **Certificate of Insurance** means the certificate We issue to the Insured Person outlining the Insured Person's cover under the Policy.
14. **Co-Morbidity** is the presence of one or more additional conditions co-occurring with a primary condition; in the countable sense of the term, a comorbidity is each additional condition
15. **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
16. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
 - a) **Internal Congenital Anomaly**-Congenital anomaly which is not in the visible and accessible parts of the body.
 - b) **External Congenital Anomaly**-Congenital anomaly which is in the visible and accessible parts of the body.
16. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
17. **Cosmetic Surgery** means Surgery or medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect.
18. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
19. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
 - i. undertaken under General or Local Anesthesia in a hospital/day care Centre in less than 24 hours because of technological advancement, and
 - ii. which would have otherwise required a hospitalization of more than 24 hours.Treatment normally taken on an out-patient basis is not included in the scope of this definition.
20. **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-
 - i) has qualified nursing staff under its employment;
 - ii) has qualified medical practitioner/s in charge;
 - iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
 - iv) Maintains daily records of patients and will make these accessible to the insurance company's



authorized personnel.

21. **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.

22. **Dentist** means a dentist, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state, or other regulated area in which the Treatment is provided.

23. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions, and surgery.

24. **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 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

25. **Effective Date** means the date shown on the Certificate of Insurance on which the Insured Person was first included under the Policy.

26. **Eligibility** means the provisions of the Policy that state the requirements to be complied with.

27. **Employee** means any member of Your staff who is proposed and sponsored by You and who becomes an Insured Person under this Policy.

28. **Emergency Care** 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.

29. **Emergency** shall mean a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an emergency anymore.

30. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract.

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

32. **Home nursing** is arranged by the Hospital for a Qualified Nurse to visit the patient's home to give expert nursing services immediately after Hospital Treatment for as long as is required by medical necessity, visits for as long as is required by medical necessity for Treatment which would normally be provided in a Hospital.

In either case, the Specialist who treated the patient must have recommended these services.

33. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act or complies with all minimum criteria as under:

- i) has qualified nursing staff under its employment round the clock;
- ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- iii) has qualified medical practitioner(s) in charge round the clock;
- iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
- v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

34. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive



'In- patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

1. **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

2. **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 on going or long-term monitoring through consultations, examinations, check-ups, and/ or tests
- ii. it needs on going 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

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

37. **Inception Date** means the inception date of this Policy as specified in the Policy Schedule or Certificate of Insurance when the coverage under the Policy commences.

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

39. **In-patient** means an Employee/ Member or Dependent who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving Treatment.

40. **Insured Person** means the Employee/ Member and/or Dependents named in the Policy Schedule/ Certificate of Insurance, who is / are covered under this Policy, for whom the insurance is proposed and the appropriate premium is paid.

41. **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.

42. **ICU 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.

43. **IRDAI** means the Insurance Regulatory and Development Authority of India.

44. **Maternity expenses means:**

- a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
- b) expenses towards lawful medical termination of pregnancy during the Policy period.

45. **Medical Assistance Service** is a service which provides Medical Advice, evacuation, assistance and repatriation. This service can be multi-lingual and is available 24 hours a day.

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

47. **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.



48. **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 its scope and jurisdiction of license.
49. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
- is required for the medical management of the illness or injury suffered by the insured;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a medical practitioner;
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
50. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same Insurer.
51. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by a cashless facility.
52. **Nominee** means the person named in the Policy Schedule or Certificate of Insurance (as applicable) who is nominated to receive the Benefits in respect of an Insured Person or Dependent covered under the Policy in accordance with the terms and conditions of the Policy, if such person is deceased when the Benefit becomes payable.
53. **Non-Network Provider** means any hospital, day care centre or other provider that is not part of the network.
54. **New Born Baby** means baby born during the Policy period and is aged upto 90 days.
55. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
56. **Out-Patient** means a patient who undergoes OPD treatment.
57. **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.
58. **Policy** is sent to You comprising of Policy wordings, Certificates of Insurance issued to the Insured Persons, group proposal form/RFQ and Policy Schedule/ Certificate Of Insurance which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy contract and shall be read together.
59. **Policy Period** means the period between the Inception Date and the expiry date of the Policy as specified in the Policy Schedule/ Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.
60. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
61. **Pre-Existing Disease (PED)** means any condition, ailment, injury, or disease:
- That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement or
 - For which medical advice or treatment was recommended by, or received from, a physician



within 48 months prior to the effective date of the policy issued by the Insurer or its reinstatement.

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

- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
- ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

63. **Post-hospitalisation Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

- i. Such Medical Expenses are for the same condition for which the insured person's hospitalisation was required, and
- ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the insurance company.

64. **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.

65. **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.

66. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

67. **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.

68. **Spouse** means the Employee's legal husband or wife proposed to be covered under the Policy.

69. **Specialist** is a Medical Practitioner who:

- Has received advanced specialist training;
- Practices a particular branch of medicine or Surgery;
- Is or has been appointed as a consultant in a Hospital or is or has been appointed to a position in a Hospital Which We accept as being of equivalent status.

It is clarified that a physiotherapist who is registered or licensed as such under the laws of the country, state or other regulated area in which the Treatment is provided is only a Specialist for the purpose of physiotherapy as described in the list of Benefits.

70. **Sum Insured** means, subject to the terms, conditions and exclusions of this Policy, the amount representing Our maximum, total liability for any or all claims arising under this Policy for the respective Benefit(s) in respect of an Insured Person and is as specified in the Policy Schedule and/or Certificate of Insurance against the particular Benefit(s).

71. **Surgical Appliance and/or Medical Appliance** means:

- An artificial limb, prosthesis or device which is required for the purpose of or in connection with a Surgery;
- An artificial device or prosthesis which is a necessary part of the Treatment immediately following Surgery for as long as such device or prosthesis is required by medical necessity.
- A prosthesis or appliance which is medically necessary and is part of the recuperation process on a Short-Term basis.



72. **Service Partner** is an assistance company utilized by Us to support You for facilitation of access to Network Providers and for providing Medical Assistance Services. In India such services will be provided by a TPA.

73. **Sub Limit** defines limitation on the amount of coverage available to cover a specific type of claim. A sublimit is part of, rather than in addition to, the limit that would otherwise apply to the admissible claim amount.

74. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

75. **Third Party Administrator (TPA)** means a Company who is licensed under the IRDAI (Third Party Administrators-Health Services) Regulations 2016, as amended from time to time, by the IRDAI and is engaged for a fee or remuneration by Us for the purposes of providing health services.

76. **Treatment** means any relevant treatment controlled or administered by a Medical Practitioner to cure or substantially relieve Illness within the scope of the Policy.

77. **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.

78. **Waiting Period** means a time bound exclusion period related to condition(s) specified in the Policy Schedule or Certificate of Insurance or Policy which shall be served before a claim related to such condition(s) becomes admissible.

79. **We/Our/Us** means the United India Insurance Company Limited.

80. **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

VIII. **Optional Covers: Policy Terms and Conditions for Optional Covers** (In conjunction with Policy Terms and Conditions)

This Policy may also provide Options to the Base Covers if these are specified to be applicable in the Policy Schedule and/or the Certificate of Insurance subject to (I) the terms, conditions, exclusions and limitations of the Options set out herein along with Optional Benefits (if any), (II) receipt of premium, statements in the proposal and information disclosed to Us by You or on Your behalf and on behalf of all persons to be insured which is incorporated into the Policy and is the basis of it.

All other clauses, terms and conditions, Waiting Periods and exclusions applicable to the Base Cover (Section II of the Policy) shall apply.

Maternity Expenses Cover

We will cover Medical Expenses incurred in respect of a female Insured Person above 18 years during the Policy Period for the delivery of a child in a Hospital (including but not limited to caesarean section, vacuum birthing, water birthing, hypnobirthing, midwife birthing) or for medically required and lawful medical termination of pregnancy.

This Benefit will be available subject to the following:

- (i) Up to the limits as specified in the Policy Schedule or Certificate of Insurance;
- (ii) After the waiting period as specified in the Policy Schedule or Certificate of Insurance from the Start Date;
- (iii) Up to a maximum number of deliveries/ terminations as specified in the Policy Schedule or Certificate of Insurance,
 - (iv) Those insured persons who are already having number of living children as specified in the schedule will not be eligible for this benefit.
 - (v) Pre and post-natal Medical Expenses incurred only under hospitalisation shall be covered



within the Maternity Expenses Coverlimit. In such a case, We will pay the Pre and post-natal Medical expenses incurred from the date of conception up to a period of 6 weeks from delivery.

(vi) Payment under this cover will be limited to per event and will be a part of the Base Sum Insured specified in the Policy Schedule and/or Certificate of Insurance.

We will not be liable to make any payment in respect of the following:

- a. Medical Expenses incurred in respect of the harvesting and storage of stem cells when carried out as a preventive measure against possible future Illnesses.
- b. Medical Expenses for ectopic pregnancy, which will be covered under Section II.1 of the Base Cover Terms and Conditions.
- c. Complications arising as a result of infertility Treatment (assisted conception).

Pre or post-natal Care Expenses shall not be considered for payment under any Pre-hospitalisation Medical Expenses or Postâ

€hospitalisation Medical Expenses paid under the Base Cover.

If Maternity Expenses Cover is in force in respect of the Insured Person, then the part of Exclusion IV.A.36 pertaining to the Optional cover will be deemed to be inoperative for the purpose of this Option in respect of that Insured Person.

All claims under this Benefit can be made as per the process defined under Section V of the Base Cover Terms and Conditions.

Corporate Buffer

We will provide for a Corporate Buffer as per limits specified in the Policy Schedule/Certificate of Insurance during the Policy period, provided that:

- i. All other terms, exclusions and conditions contained in the Policy or endorsed thereon remain unchanged.
- ii. This Benefit will be available for those Insured Persons who have already exhausted their Sum Insured limit subject to per Insured Person/ family limit as mentioned in the Policy Schedule.
- iii. This Benefit will be restricted to Individual/ family/amount specified in the Policy Schedule in respect of each and every Insured Person/ family.
- iv. If the Policy is issued on a Family Floater basis, the enhanced Sum Insured on account of the Corporate Buffer applicable will also be available on a Family Floater basis.
- v. Any Benefit accrued under this cover cannot be carried forward to the subsequent Policy period. The Benefit payable will be over and above the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Sections V. under the Base Cover Terms and Conditions and Section III under the Optional Cover Terms and Conditions, as applicable.

Waiver of Proportionate Clause

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Note 1 (Proportionate Clause) under Clause II.1 (Base Covers) stands deleted for the members covered in the Policy as stated in the Schedule.

You/Insured Person shall continue to bear the differential between actual and eligible Room Rent.

Claim Process for Optional Covers

1. Claim Intimation:

In addition to the claim intimation process set out in the Base Cover, the following conditions apply in relation to the respective Options. Upon the discovery or occurrence of an Accident/ Critical Illness or any other contingency that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy, the Insured Person or the Nominee, as the case may be, must notify Us/ Our TPA either at the call centre or in writing and shall



undertake the following:

In the case of Accidental Death Benefit/ PTD/ PPD/ Critical Illness (if applicable) -The Insured Person or the Nominee shall notify Us either at the call centre or in writing, within 10 days from the date of occurrence of such Accident/diagnosis of a Critical Illness.

2. **Reimbursement Process**

In addition to the documents mentioned in the Base Cover claim reimbursement process, the following additional documents will be required for reimbursement claim for the respective Options.

Optional Cover	Additional Documents Required
Critical Illness - Benefit Cover	<p>The Insured Person may submit the following documents for reimbursement of the claim to our policy issuing office at his/her own expense ninety (90) days from the date of first diagnosis of the Illness/ date of Surgical Procedure or date of occurrence of the medical event, as the case may be</p> <p>Medical certificate confirming the diagnosis of Critical Illness. Discharge certificate/ card from the Hospital, if any.</p> <p>Investigation test reports confirming the diagnosis. First consultation letter and subsequent prescriptions. Indoor case papers, if applicable.</p> <p>Specific documents listed under the respective Critical Illness. Any other documents as may be required by Us.</p> <p>In those cases, where Critical Illness arises due to an Accident, a copy of the FIR or medico legal certificate will be required, wherever conducted.</p>
Out- Patient Cover	<p>The Insured Person shall avail these benefits as defined in Policy T&C if opted for.</p> <p>Submission of claim</p> <p>Invoices, treating Medical Practitioner's prescription, reports, duly signed by Insured Person as the case may be, to the TPA Head Office</p> <p>Assessment of claim documents</p> <p>We shall assess the claim documents and ascertain the admissibility of claim.</p> <p>Settlement & Repudiation of a claim</p> <p>We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document.</p>
Dental Expenses Cover & Vision Expenses Cover	<p>The Insured Person shall avail these Benefits as defined below, if opted for.</p> <p>Submission of claim Insured Person can send the claim form provided along with the invoices, treating Medical Practitioner's prescription, reports, duly signed by the Insured Person as the case may be, to Our branch office or head office.</p> <p>Assessment of claim documents</p> <p>We shall assess the claim documents and ascertain the admissibility of claim.</p> <p>Settlement & Repudiation of a claim</p> <p>We shall settle claims, including its rejection, within 30 days of the receipt of the last 'necessary' document.</p> <p>In respect of Orthodontic Treatment claims for Dependent Children below 18 years, pre- authorisation is a must.</p> <p>For claims in respect of Orthodontic Treatment towards Dependent Children below 18 years, the Employee/ Member or Dependent must send the following information prepared by the Dentist who is to carry out the proposed Treatment to Us before Treatment starts, so that We can confirm the Benefit that will be payable:</p>

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540, Dum Dum Road, Suremath
Kolkata - 74



	Full description of the proposed Treatment; •X-rays and study models; •An estimate of the cost of the Treatment. Any Benefit will be payable only if We have authorised the cover before Treatment starts.
Refractive Error Correction Expenses Cover	Prescription from Specialist Medical Practitioner specifying the refractive error and medical necessity of the Treatment.
Home Nursing Charges Cover	Bills from registered nursing service provider.
Air Ambulance Cover	Air ambulance ticket for registered service provider.
Emergency Evacuation Cover	In the event of an Insured Person requiring Emergency evacuation and repatriation, the Insured Person must notify Us immediately either at Our call centre or in writing. Emergency medical evacuations shall be pre-authorised by Us. Our team of Specialists in association with the Emergency assistance service provider shall determine the medical necessity of such Emergency evacuation or repatriation post which the same will be approved.
Medical Equipment Cover	Prescriptions of treating Specialist for support items and original invoice of actual Medical Expenses incurred.
Ultra-modern Treatment Cover	Certificate by qualified medical surgeons indicating the medical necessity of the procedure.
Birth Control Procedure Cover	All medical records and treating Medical Practitioner's certificate on the indication.
Infertility Treatment Cover	Certificate from Specialist Medical Practitioner detailing the cause of infertility, Treatment, procedure.
Deductible (Aggregate/ Per-Claim)	Any claim towards Hospitalisation during the Policy period must be submitted to Us for assessment in accordance with the claim process laid down under Section V of the Policy towards Cashless facility or reimbursement respectively in order to assess and determine the applicability of the Deductible on such claim. Once the claim has been assessed, if any amount becomes payable after applying the Deductible, We will assess and pay such claim in accordance with Section V.F and G of the Policy. Wherever such Hospitalisation claims as stated under Section V above is being covered under another policy held by the Insured Person, We will assess the claim on available photocopies duly attested by the Insured Person's insurer / TPA as the case may be.

We may call for any additional document/information as required based on the circumstances of the claim wherever the claim is under further investigation or available documents do not provide clarity.



Annexure-I

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

Item	Payable / Not Payable
BABY FOOD	Not Payable
BABY UTILITIES CHARGES	Not Payable
BEAUTY SERVICES	Not Payable
BELTS/ BRACES	Payable for cases who have undergone surgery of thoracic or lumbar spine.
BUDS	Not Payable
COLD PACK/HOT PACK	Not Payable
CARRY BAGS	Not Payable
EMAIL / INTERNET CHARGES	Not Payable
FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	Not Payable
LEGGINGS	Payable in case of varicose vein surgery
LAUNDRY CHARGES	Not Payable
MINERAL WATER	Not Payable
SANITARY PAD	Not Payable
TELEPHONE CHARGES	Not Payable
GUEST SERVICES	Not Payable
CREPE BANDAGE	Not Payable
DIAPER OF ANY TYPE	Not Payable
EYELET COLLAR	Not Payable
SLINGS	Reasonable costs for one sling in

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Engineering College
540, Dum Dum Road, Suremath
Kolkata - 74
Page 7 of 40



		case of upper arm fractures is payable
	BLOOD GROUPING AND CROSS MATCHING OF DONORSSAMPLES	Part of Cost of Blood, not payable
	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
	Television Charges	Payable under room charges not if separately levied
	SURCHARGES	Part of Room Charge, Not payable separately
	ATTENDANT CHARGES	Not Payable - Part of Room Charges
	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
	BIRTH CERTIFICATE	Not Payable
	CERTIFICATE CHARGES	Not Payable
	COURIER CHARGES	Not Payable
	CONVEYANCE CHARGES	Not Payable
	MEDICAL CERTIFICATE	Not Payable
	MEDICAL RECORDS	Not Payable
	PHOTOCOPIES CHARGES	Not Payable
	MORTUARY CHARGES	Payable up to 24 hrs, shifting charges not payable
	WALKING AIDS CHARGES	Not Payable
	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE HOSPITAL)	Not Payable
	SPACER	Not Payable
	SPIROMETRE	Device not payable
	NEBULIZER KIT	Not Payable



	STEAM INHALER	Not Payable
	ARMSLING	Not Payable
	THERMOMETER	Not Payable
	CERVICAL COLLAR	Not Payable
	SPLINT	Not Payable
	DIABETIC FOOT WEAR	Not Payable
	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
	KNEE IMMOBILIZER/SHOULD ER IMMOBILIZER	Not Payable
	LUMBO SACRAL BELT	Payable for cases who have undergone surgery of lumbar spine
	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadruplegia for any reason and at reasonable cost of approximately Rs 200/ day
	AMBULANCE COLLAR	Not Payable
	AMBULANCE EQUIPMENT	Not Payable
	ABDOMINAL BINDER	Payable for cases who have undergone surgery of lumbar spine.
	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Payable in post hospitalisation
	SUGAR FREE Tablets	Payable -Sugar free variants of admissible medicines are not excluded
	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Payable when prescribed
	ECG ELECTRODES	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may



		require a change and at least one set everysecond day is payable.
	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
	NEBULISATION KIT	Payable reasonably if used during hospitalisation
	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
	KIDNEY TRAY	Not Payable
	MASK	Not Payable
	OUNCE GLASS	Not Payable
	OXYGEN MASK	Not Payable
	PELVIC TRACTION BELT	Payable in case of PIVD requiring traction
	PAN CAN	Not Payable
	TROLLEY COVER	Not Payable
	UROMETER, URINE JUG	Not Payable
	AMBULANCE	Payable
	VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs

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

Sr. 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

Principal
Dr. Sudhir Chandra Sur Degree
Engineering College
540, Dum Dum Road, Surernath
Kolkata
34 of 76



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 / VISTOR'S 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	PULSE OXIMETER CHARGES

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

Sr. No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHIELD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUZE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONIC SCALPEL, SHAVER
13	SURGICAL DRILL

Principal
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540, Dum Dum Road, Suremath
Kolkata
35 of 40



14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sr. 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 SWABS
16	SCRUB SOLUTIONS / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure-II

Details of Insurance Ombudsmen

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel No: 079 - 25501201/02/05/06. Email: bimalokpal.ahmedabad@ecoi.co.in

Principal
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Kolkata - 706 of 40



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Karnataka	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
Madhya Pradesh and Chhattisgarh	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
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar - 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab , Haryana, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	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
Tamil Nadu, UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry)	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@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23232481/2321350 4. Email: bimalokpal.delhi@ecoi.co.in
Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	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



Andhra Pradesh, Telangana and UT of Yanam - a part of the UT of Pondicherry	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
Rajasthan	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
Kerala , UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry	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
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	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
Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich,	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

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Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	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
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar	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

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39 of 40



r, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kasganj, Sambhal, Amroha, Hathras, Kanshiramna gar, Saharanpur	
Bihar, Jharkhand.	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
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	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