HDFC ERGO GENERAL INSURANCE COMPANY LIMITED

Policy Wordings

Individual Personal Accident Policy- Standard

HDFC ERGO General Insurance Company Limited will cover all Insured Person/s under this Policy upto the Sum Insured. The insurance cover at all times shall be governed by and shall be subject to the terms, conditions and exclusions under this Policy.

SECTION A. DEFINITIONS

The terms defined below have the meanings ascribed to them wherever they appear in this Policy Document and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

I. Standard Definitions

Def 1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Def 2. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

- **a.** Central or State Government AYUSH Hospital; or
- **b.** Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or
- **c.** AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
  - **i.** Having at least 5 in-patient beds;
  - **ii.** Having qualified AYUSH Medical Practitioner in charge round the clock;
  - **iii.** Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
  - **iv.** Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative

Def 3. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

- **a.** Having qualified registered AYUSH Medical Practitioner (s) in charge;
- **b.** Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- **c.** Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def 4. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

Def 5. **Cumulative Bonus** means any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Def 6. **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 the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

- has qualified nursing staff under its employment;

- has qualified medical practitioner/s in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;

Def 7. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel **Day Care Procedures** means those medical treatment, and/or surgical procedure which is undertaken under General or Local Anaesthesia in a Hospital/day care centre in less than 24 hours because of technological advancement, which would have otherwise required a Hospitalisation of more than 24 hours. Treatment normally taken on an Out-patient basis is not included in the scope of this definition

Def 8. **Deductible** means a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

Def 9. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def 10. **Grace Period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

Def 11. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def 12. **Hospitalisation or Hospitalised** means admission in a Hospital for a minimum of 24 consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than 24 consecutive hours.

Def 13. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

Def 14. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

Def 15. **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.

a) Pre-Hospitalisation Medical Expenses means the Medical expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible

b) Post- Hospitalisation Medical Expenses means Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and

ii. iv.The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

Def 16. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

- Is required for the medical management of the Illness or injury suffered by the Insured Person;
- 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.

Def 17. **Medical Practitioner** means a person who holds a valid registration from the medical council of any state or medical council of India or council for Indian medicine or for homeopathy set up by the government of India or a state government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. Medical Practitioner who is sharing the same residence with the Insured Person's and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Def 18. **Network Provider** means Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility

Def 19. **Non Network** means any Hospital, day care centre or other provider that is not part of the Network

Def 20. **Notification of Claim** means the process of notifying a claim to the insurer or TPA through any of the recognized modes of communication.

Def 21. **OPD treatment** means the treatment 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

Def 22. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def 23. **Pre-existing Condition** means any condition, ailment, injury or disease

Def 24. a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

Def 25. b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

Def 26. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def 27. **Reasonable & Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved.

Def 28. **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.

II. Specific Definitions

Def 1. **Acts of God perils** means and include lightening, storm, tempest, flood inundation, subsidence, landslide, earthquake, tsunami, cyclone, volcano, and other similar calamities

Def 2. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his Profession whether he / she is trained or not. Age or Aged means completed years as at the Commencement Date.

Def 3. **AYUSH Treatment** refers to the medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

Def 4. **Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def 5. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.

Def 6. **Carrier** means a civilian or commercial land, air or water conveyance operating under a valid licence from transportation of passengers by air, sea, road or rail for a fee.

Def 7. **Carrier (For Taxi and Bus)** means a registered radio taxi, two wheeler taxi, auto services or private intercity bus service booked through a transportation aggregator Like Ola, Uber, Meru, Red Bus etc. which can be booked through an App or other means and provides services for a fee.

Def 8. **Dependents** means only the family members listed below:

- **i.** Your legally married spouse as long as she continues to be married to You;
- **ii.** Your children Aged between 91 days and 25 years if they are unmarried
- **iii.** Your natural parents or parents that have legally adopted You, provided that the parent was below 65 years at his

iv. initial participation in the Policy.

v. Your Parent -in-law as long as Your spouse continues to be married to You and were below 65 years at his initial

vi. participation in the Policy.

All Dependent parents must be financially dependent on You.

Def 9. **Insured Person** means You and the persons named in the Schedule.

Def 10. **Known Carrier/ Host** means an insect or an animal that carries or hosts disease causing organism and spreads disease by transferring these organisms.

Def 11. **Material Facts** means 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.

Def 12. **Dependent Child** means a child (natural or legally adopted), who is unmarried, aged between 91 days and 25 years, financially dependent on the primary Insured or Proposer and does not have his / her independent sources of income.

Def 13. **Policyholder** means the person named in the Policy Schedule as the policyholder

Def 14. **Policy Schedule** means schedule attached to and forming part of the Policy

Def 15. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer. Pre-existing Disease means any condition, ailment, injury or disease

Def 16. **Nominee** means the person named in the Policy Schedule who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Policyholder is deceased.

Def 17. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any) and the policy schedule (as the same may be amended from time to time).

Def 18. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Schedule.

Def 19. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def 20. **Professional Sport** means a sport , which would remunerate a player in excess of 50% of his or her annual income as a means of their livelihood

Def 21. **Serious Injury** means a personal injury which results in death, dismemberment, significant disfigurement, a fracture, loss of a foetus, permanent loss of use of a body organ, member, function or system, permanent consequential limitation of use of a body organ or member, significant limitation of use of a body function or system, or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities

Def 22. **Spouse** means Your legally married spouse as long as she continues to be married to You.

Def 23. **Sum Insured** means, in respect of each Benefit, the sum shown in the Schedule against that Benefit and such sum represents Our maximum liability for each Insured Person for any and all claims made during the Policy Period under that Benefit, provided that Our maximum liability for each Insured Person for any and all claims made during the Policy Period for any and all

Benefits shall be limited to the Accidental Death Sum Insured unless expressly stated to the contrary.

Def 24. **Terrorism' shall** mean an act, including, but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or Government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear."

Def 25. **We/Our/Us** means the HDFC ERGO General Insurance Company Limited.

Def 26. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

SECTION B. BENEFITS

We will provide the Benefits as detailed below for an event or occurrence described in any of the Benefits that occurs during the Policy Period. Each Benefit is subject to its Sum Insured, but Our liability to make payment in respect of any and all Benefits (including optional Benefits) shall be limited to the Accidental Death Sum Insured unless expressly stated to the contrary.

Benefit 1. Accidental Death

1) Accidental Death

If an Insured Person suffers an Accidental bodily injury during the Policy Period which is the sole and direct cause of his death within 365 days from the date of the Accident, then We will pay the Sum Insured as specified in Policy schedule against this benefit to the assignee or the nominee or the legal representative, as the case may be, subject to terms & conditions of this policy.

On payment of claim under this benefit the policy shall terminate for that Insured Person for whom the claim has been paid.

2) Transportation of Mortal Remains

If We have accepted a claim under benefit 1) of this policy, then We will in addition reimburse the lower of 2% of the Sum Insured under Accidental death OR the actual amount incurred in transporting the mortal remains of the Insured Person from the place of the Accident or the Hospital to his residence or to a cremation /burial ground, provided the insured person has died outside his city of residence.

Benefit 2. Permanent Total Disablement

1) If an Insured Person suffers an Accidental bodily injury during the Policy Period and this is the sole and direct cause of his permanent total disablement within 365 days from the date of the Accident in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

	% of Sum Insured
Loss of 2 Limbs (both Hands or both Feet or one Hand and one Foot)	100%
Loss of a Limb and an Eye	100%
Complete and irrecoverable loss of sight of both Eyes	100%
Complete and irrecoverable loss of speech & hearing of both Ears	100%
Loss of a Limb	50%
Complete and irrecoverable loss of sight of an Eye	50%

2) In this Benefit:

a) Limb means a hand at or above the wrist or a foot above the ankle.

b) Loss of Limb means:

i. the physical separation of a Limb above the wrist or ankle respectively, or

ii. the total loss of functional use of a Limb for at least 365 days from the date of onset of such disability provided that We must be satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

c) Includes cover for Paralysis Including Paraplegia, Quadriplegia with loss of functional use of limbs.

d) Any claim made under this benefit will not terminate the policy.

Benefit 3. Permanent Partial Disablement

1) If an Insured Person suffers an Accidental bodily injury during the Policy Period and this is the sole and direct cause of his permanent partial disablement within 365 days from the date of the Accident in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

Loss of:	**% of Sum Insured**
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	50%
Each hand at the wrist	50%
Each thumb	20%
Each Index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg upto a point below the femur	65%

Each leg to a point below the knee	50%
Each foot at the ankle	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%

2) In this Benefit:

a) Loss means:

i) the physical separation of a body part, or

ii) the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disability provided that We are satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

b) If an Insured Person suffers a Loss not mentioned in the table above, then We will assess the degree of disablement with Our medical advisors and determine the amount of payment to be made.

c) If a claim in respect of a whole member (any organ, organ system or a limb) also encompasses some or all of its parts, Our liability to make payment will be limited to the member only and not any of its parts or constituents.

d) Any claim made under this benefit will not terminate the policy.

Benefit 4. Temporary Total Disablement

If an Insured Person suffers an Accident during the Policy Period which is the sole and direct cause of a temporary disability which completely prevents him from performing each and every duty pertaining to his employment or occupation, then We will pay a weekly benefit, provided that:

1) The temporary total disablement is certified by a Doctor, and

2) Our liability to make payment will be limited to of 1% of the Sum Insured for each week during the period of temporary total disablement for a period not exceeding 100 weeks from the date of the Accident and if the Insured Person is disabled for a part of a week, then only a proportionate part of the weekly benefit will be payable, and

3) We will not pay any amount in excess of the Insured Person's base weekly income (at the time of accident) excluding overtime, bonuses, tips, commissions, or any other special compensation.

Benefit 5. Emergency Road Ambulance Charges

If We have accepted a claim under this Policy and following the Accident it is necessary to immediately transfer the Insured Person to the nearest Hospital by ambulance offered by a healthcare or an ambulance service provider, then We will in addition reimburse the actual expenses of the transfer to the hospital upto the amount as mentioned in schedule of benefits.

Benefit 6. Education Fund

We have accepted a claim under Benefit 1, Benefit 2 or Benefit 3, then We will in addition pay the benefit Sum Insured for Dependent Children upto the maximum limit in the policy provided that:

- such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.
- Age of the child or children as the case may be should not be more than 25 completed years.
- The Sum Insured mentioned in the schedule of benefits is the total amount payable for all Dependent Children collectively
- and not per insured child basis
- This benefit is payable only once per policy year.

Benefit 7. Family Transportation

If We have accepted a claim under Benefit 1 or Benefit 2, then We will in addition reimburse the actual expenses incurred in transporting one Immediate Family Member to the Hospital where the Insured Person is admitted following an Accident.

Note: In this Benefit, Immediate Family Member means the Insured Person's legal spouse, children, parents, parents-in-law, legal guardian, ward, step child or adopted child.

Benefit 8. Accident Medical Expenses

If We have accepted a claim under Benefits 1-4, then We will in addition reimburse the Medical Expenses incurred by the Insured Person at a Hospital, provided that Our maximum liability under this Benefit shall be limited to the lowest of:

a) The actual expenses incurred, or

b) 40% of the admitted claim amount under Benefits 1 to 4, or

c) 10% of the Benefit 1 Sum Insured, or

d) Rs. 200,000.

SECTION. B.2. CUMULATIVE BONUS

Note: This is only applicable for Benefits 1-3.

a) If Policy is renewed with Us without any break, We will apply a cumulative bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 5% of the Sum Insured for this Policy Year irrespective of claims.

b) The maximum cumulative bonus shall not exceed 50% of the Sum Insured in any Policy Year for benefits under Benefits 1-3.

SECTION C. EXCLUSION

We will not make any payment for any claim in respect of any Insured Person, caused by, arising

from or attributable to any of the following unless expressly stated to the contrary in this Policy:

1) Special Exclusions to Benefit 1-4, 12, 13, 15 ,16 & 17

a) Any infections except pyogenic infection developing on or as a result of a wound caused by an accident which occurs through an Accidental cut or wound.

b) Medical or surgical treatment except as necessary solely and directly as a result of an Accident.

2) Special Exclusions to Benefit 13

a) Treatment availed outside India

b) Treatment at a healthcare facility which is NOT a Hospital.

3) Special Exclusions to Benefit 16

a) Sickness or disease.

b) Any pathological fracture.

c) Any hair line fracture.

4) Special Exclusions to Benefit 17

a) Actual or alleged dowry harassment.

b) Actual or attempted self-immolation.

5) Special Exclusions to Benefit 19

Coma resulting directly from alcohol or drug abuse is excluded.

6) Special Exclusions to Benefit 21

a) Any benefits which an Insured Person is eligible to receive under the Workmen's Compensation Act 1923 or any similar enactment.

b) Any expenses incurred in excess of the amount that would have usually been incurred had the Insured Person not been insured under this Policy.

c) Any modifications or alterations not compliant with the applicable law.

7) Specific General Exclusion applicable to all Benefits:

We will not pay for any claim which is caused by, arising from or attributable to:

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

b) Intentional self-inflicted injury, suicide or attempted suicide..

c) Hazardous or Adventure Sports

d) 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 unless otherwise opted by Insured and mentioned.

e) Cosmetic or Plastic Surgery: 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.

f) Sexually transmitted disease or illness (except HIV/ AIDS).

g) The abuse or the consequences of the abuse of intoxicants or hallucinogenic substances including all forms of narcotic drugs and alcohol.

h) War, invasion, act of foreign enemy (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

i) Maternity Expenses, Pregnancy or childbirth or in consequence thereof.

j) External Congenital diseases, defects or anomalies or in consequence thereof.

k) Any non-allopathic treatment except In-patient care AYUSH Treatments.

l) Diseases spread/ caused through an insect bite by transfer of organisms for which the insect is a known carrier or host.

m) Any non-medical expenses mentioned on our website https://www.hdfcergo.com/docs/default-source/downloads/others/ non-medical-expenses.pdf

SECTION D. GENERAL CONDITIONS

I. Standard General Conditions

A. 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.

B. Claims Settlement (Provision for Penal Interest)

i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We have requested to establish the circumstances of the claim, its quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii. If We accept a claim and become liable to make payment under Benefits 2, 3, 4, 16, or 19, (the first claim) and there is a subsequent claim under another of these Benefits or Benefit 1 in respect of the same Insured Person and the same Accident within 365 days of the date of the Accident (the second claim), then We will only be liable to pay the difference between the amount payable for the first claim and the amount payable for the second claim.

iii. We will only make payment to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us of having incurred the expenses, this person will be deemed to be

authorised by You to receive the concerned payment. In the event of the death of an Insured Person, We will make payment to the Nominee (as named in the Schedule) or assignee as the case may be. In absence of nominee or assignee and You are deceased, We will make payment to the Your legal heir, executor or appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.

iv. All payments made shall be subject to an applicable Deductible (if any) for such payment.

v. Payments under this Policy shall only be made in Indian Rupees irrespective of the location of accident which has given rise to the claim.

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

vii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of intimation to the date of payment of claim at a rate 2% above the Bank Rate.

viii. The assignment o of benefits of the policy shall be subject to applicable law.

Applicable for if Loan Secure benefit is opted

i. We shall on admission of a claim make the payment of the principal outstanding amount to the Bank/Financial Institution where the Insured Person has authorized us for the same. Where the Insured Person has opted for a Static Sum Insured; We shall on admission of a claim make the payment of the principal outstanding amount to the Bank/Financial Institution where the Insured Person has authorized Us for the same and any balance Static Sum Insured shall be payable to the Insured Person or Nominee, as applicable. The Insured Person can authorize for payment of principal outstanding amount to the Bank/ Financial Institution at the time of opting for coverage under this Policy or at a later date.

ii. We will only make payment to Insured Person, Nominee or the Bank/Financial Institution, as applicable, under this Policy. Receipt of payment by Insured Person, Nominee or Master Policyholder shall be considered as a complete discharge of Our liability against the respective/any claim under this Policy. In the event of Insured Person's death, We will make payment to the Nominee (as named in the Schedule/Certificate of Insurance). Payment of the admissible claim to the Bank/ Financial Institution shall be as per table below

Sum Insured Type	**Sum Insured settlement basis**	**Claim amount paid to**
Reducing Sum Insured	The Principal Outstanding in the books of Bank/Financial Institution as on the date of occurrence of the event minus all the unpaid/ overdue EMI's (if any) payable to Bank/Financial Institution	Bank/Financial Institution

C. 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 have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

D. Multiple Policies (Applicable to Indemnity Benefits on the Policy)

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 conditions 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.

E. Renewal of Policy

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to conditions stated under Moratorium clause.

i. Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.

ii. The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

iii. No loading shall apply on renewals based on individual claims experience

iv. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.

v. Renewal premium due can be paid prior to the due date as per norms set out by the Company.

vi. We offer lifelong renewal for all the Insured Persons. However, for age 70 and above during renewals the Sum Insured will be restricted to Rs. 20, 00,000 INR if the coverage is beyond 20,00,000 and premium will be charged as per restricted sum insured. Policy does not offer Sum Insured enhancement beyond the completed age of 70 years.

F. Nomination

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

G. Cancellation

i. The Policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period. Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year.

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

iii. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s

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

H. Free Look Period (Applicable for policies with policy duration of 1 year or greater)

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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

This condition shall apply to policies with Policy Period opted is of 1, 2 and 3 years

I. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

J. Disclosure of Information

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

K. 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.

L. Moratorium Period

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

of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

M. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

N. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

O. Redressal of Grievance

In case of any grievance the insured person may contact the company through:

First Point of Contact	Call us at 022 6158 2020 / 022 6234 6234/www.hdfcergo.com
Level 1	For lack of a response or if the response provided does not meet your expectation, you can: 1. Write to The Complaints & Grievance Cell (C&G Cell) HDFC ERGO General Insurance Company Limited, D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai – 400078, Maharashtra 2. You can also write an email to grievance@hdfcergo.com 3. Call on 18002677444 (operational Monday - Saturday 9AM to 6PM)
Level 2	If you're not satisfied with the resolution or if no response was received within 15 days, you can: 1. Write to the Chief Grievance Officer HDFC ERGO General Insurance Company Limited, D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai – 400078, Maharashtra 2. You can also write an email to cgo@hdfcergo.com
Level 3	In case grievance is not resolved at the above escalation levels, you can also lodge an online complaint through the website of Council for Insurance Ombudsmen (CIO) www.cioins.co.in

Dedicated Helpline For	Email ID	Contact Number
Senior Citizen	seniorcitizen@hdfcergo.com	022 6158 2026
Women	-	022 6158 2055

You may also refer the Grievance Redressal Escalation matrix on our website https://www.hdfcergo.com/customer-voice/grievances

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. Grievance may also be lodged at IRDAI Integrated Grievance Management System -https://bimabharosa.irdai.gov.in

II. Specific Definitions

A. Non-Disclosure or Misrepresentation:

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

cancelled ab-initio from the inception date or the renewal date (as the case may be), , upon a 30 day notice by sending an endorsement to Your address shown in the Schedule, or the Policy may be modified by Us with the consent of the Proposer and the claim under such Policy if any, shall be rejected/repudiated forthwith.

B. Dispute Resolution Clause:

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

C. Change of Occupation:

You will give Us notice of any change in the business or occupation of any Insured Person within 30 days of such change and We will issue an endorsement to this effect.

If at the time a claim arises under this Policy the Insured Person has changed his occupation without Us being notified, then Our maximum liability will be limited to the amount that would have been payable for the premium paid and the new occupation.

D. Notices:

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

i. Any Insured Person, it would be sent to You at the address specified in Schedule / endorsement

ii. Us, shall be delivered to Our address specified in the Schedule.

iii. No insurance agents, brokers, other person/ entity is authorised to receive any notice

on Our behalf.

E. Alterations to the Policy:

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or varied by any one (including an insurance agent or broker) except Us, and any change we make will be evidenced by a written endorsement signed and stamped by Us.

F. Per kilometre (km) basis coverage

a. Per km basis coverage will be provided through a mobile app, our own and/or third party. This app will use map based services (e.g Google maps) to identify the location, terrain and distance travelled by insured person. Mountainous terrain will attract higher per km premium due to higher risk of travel in such regions. To identify mountainous terrain, following states are considered as hill states: Jammu & Kashmir, Himachal Pradesh, Uttarakhand, Sikkim, Arunachal Pradesh, Nagaland, Mizoram, Manipur, Meghalaya and Tripura.

b. We will not start the coverage without customer explicitly opting/ starting it.

c. We will not start the coverage without collecting premium in advance.

d. We will use only RBI approved payment channels for premium remittance. e.g credit cards, debit cards, mobile wallets, online banking, UPI.

e. All rules and controls will be built into the app.

Customer can avail per km basis coverage by making a premium payment by either of below mentioned processes

i. Point to point: Customer will choose start point and destination point for his/her trip on the app. App will calculate the distance between the two points and compute the premium accordingly. An additional 25% premium will be collected to ensure continuity of coverage should the distance between the points vary for reasons like change in route. Multiple notifications/ messages will be sent to customers much before his/her premium gets exhausted. This will allow customer to make an informed decision on whether to extend his/her coverage or not. He/she can extend coverage by paying additional premium for fixed number of km's (in multiples of 10 km).

ii. Fixed number of kms: Customer can buy coverage for fixed number of km's (in multiples of 10km) and pay the premium accordingly. Multiple notifications/ messages will be sent to customers much before their premium gets exhausted. This will allow customer to make an informed decision on whether to extend his/her coverage or not. He/she can extend coverage by paying additional premium for fixed number of km's (in multiples of 10 km).

Termination of cover

i. Customer can voluntarily terminate the coverage.

ii. Automatic termination of coverage on complete utilization of premium or km's bought.

iii. Automatic termination at the end of 30 days from coverage inception.

Refund of Premium: Unused balance at the time of coverage termination would be refunded to the customer.

G. Geography

This Policy applies to events or occurrences taking place anywhere in the world unless limited by Us in a through an endorsement.

The benefit in respect of Accidental Medical Expense, Accidental In-patient Hospitalisation, Accidental Out-patient Hospitalisation, Accident Hospital Cash, Loss of Personal effects, Emergency Air Ambulance, Emergency Hotel stay, Cab and Bus Cover shall be paid only for expenses and or mugging, incurred in India, irrespective of the place where the injury was sustained / accident occurred. The benefit towards Modification of Residence/ Vehicle expenses shall be payable only upon modification performed in India.

All payments under this Policy will only be made in Indian Rupees within India.

H. Insured Person

Only those persons named as an Insured Person in the Schedule shall be covered under this Policy. Any person may be added during the Policy Period as an Insured Person after his application has been accepted by Us, additional premium has been paid and We have issued an endorsement confirming the addition of such person as an Insured Person.

If an Insured Person dies, he will cease to be an Insured Person upon Us receiving all relevant particulars in this regard. We will return a rate-able part of the premium received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.

I. Loading & Discounts

Acceptance with Risk Loading: For health hazards with a higher morbidity risk as compared to the general population with similar demography. The maximum loading applied will not exceed 100% for individual health issue/medical condition and 150% on an individual. The loading applied can be a percentage based loading or a flat loading depending on the chances of recurrence of the health issue. For loadings applied the information for the same will be provided by either a recorded voice call or letter and consent for the same (either written, or on the voice call, or from the registered mail ID) needs to be provided with the additional premium for the policy to be issued. The consent would not be mandatory if the loading (additional premium) is paid by self- cheque, credit card, debit card or online payment methods.

We will provide a Family Discount of 10% if 2 or more family members are covered e family members are covered under a single Individual Personal Accident Policy. An additional discount of 7.5% and 10% will be provided if insured person is paying 2 and 3 years premium in advance as a single premium. These discounts shall be applicable at inception and renewal of the policy

J. Notification of Claims

a. We must be informed of any event or occurrence that may give rise to claim under this Policy within 30 days of it happening.

b. If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency, we should be informed within 24 hours of the Insured person admission in Hospital.

c. For all benefits which are contingent on our prior acceptance of a claim under Benefits 1-4, We must be informed within 30 days of the event or occurrence that may give rise to

a contingent benefit claim.

K. Cashless Service (applicable in case of Accidental Inpatient Hospitalisation benefit only)

Treatment, Consultation or Procedure:	Treatment , Consultation or Procedure Taken at:	Cashless Service is Available:	We must be given notice that the Insured Person wishes to take advantage of the cashless service accompanied by full particulars:
If any treatment, consultation or procedure for which a claim may be made to be taken in an Emergency	Network Hospital	We will provide cashless service by making payment to the extent of Our liability directly to the Network Hospital.	Within 24 hours after the treatment or Hospitalisation

L. Supporting Documentation & Examination

We must be provided with any documentation and information We may request to establish the circumstances of the claim, its quantum or Our liability for it including, in English, Our claim form duly completed. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include the following. Please note that in case of a non-disclosure or/and a fraud suspicion we may ask for additional documentation/reports which are not listed below.

- Our claim form, duly completed and signed for on behalf of the Insured Person.
- Death certificate
- Disability certificate
- Medical reports
- Case histories, investigation reports
- Treatment papers and discharge summaries
- Original Bills (including but not limited to pharmacy purchase bill, consultation bill, diagnostic bill) and any attachments thereto like receipts or prescriptions in support of any amount claimed which will then become Our property.
- A precise diagnosis of the treatment for which a claim is made.
- All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
- Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
- Copy of settlement letter from other insurance company
- Stickers and invoice of implants used during surgery
- Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident

- Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
- Legal heir certificate
- Marriage certificate (if applicable)

The Insured Person will have to undergo medical examination by Our authorised Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of processing any claim. We will bear the cost towards performing such medical examination (at the specified location) of the Insured Person.

SECTION E. OTHER TERMS AND CONDITIONS

1. Schedule of Benefits

Benefit	Sum Insured
Benefit 1.1) Accidental Death [AD]	As specified in the Schedule
Benefit 1.2) Transportation of Mortal Remains	2% of AD SI; Max up to 10,000
Benefit 2. Permanent Total Disablement	Up to AD SI
Benefit 3. Permanent Partial Disablement	Up to AD SI
Benefit 4. Temporary Total Disablement	As specified in the Schedule; max up to Rs 5,00,000
Benefit 5. Emergency Ambulance Charges	Rs. 2,000
Benefit 6. Education Fund	10% of AD SI; Max Rs. 20,000
Benefit 7. Family Transportation	Up to 50,000
Benefit 8. Accident Medical Expenses	Up to 50,000

2. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, You can contact HDFC ERGO General Insurance Company Limited through:

Website : www.hdfcergo.com Email : care@hdfcergo.com

Customer care : 022 6234 6234 / 0120 6234 6234

Fax1800 425 4077

Courier : HDFC ERGO General Insurance company Ltd, 5th floor, Tower 1, Stellar IT Park, C-25, Sector-62, Noida, UP, India – 201301.

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

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD **Office of the Insurance Ombudsman,** Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU **Office of the Insurance Ombudsman,** Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL **Office of the Insurance Ombudsman,** 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR **Office of the Insurance Ombudsman,** 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455/2596429/2596003 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
CHANDIGARH **Office Of The Insurance Ombudsman,** Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI **Office of the Insurance Ombudsman,** Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).

Office Details	Jurisdiction of Office Union Territory, District)
DELHI **Office of the Insurance Ombudsman,** 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI **Office of the Insurance Ombudsman,** Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD **Office of the Insurance Ombudsman,** 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR **Office of the Insurance Ombudsman,** Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI **Office of the Insurance Ombudsman,** 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA **Office of the Insurance Ombudsman,** Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.

Office Details	Jurisdiction of Office Union Territory, District)
LUCKNOW **Office of the Insurance Ombudsman,** 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI **Office of the Insurance Ombudsman,** 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N, S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.
NOIDA **Office of the Insurance Ombudsman,** Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA **Office of the Insurance Ombudsman,** 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE **Office of the Insurance Ombudsman,** Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region
THANE **Office of the Insurance Ombudsman,** 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."

Annexure I – List of Non-Medical Expenses

Sr. NO.	ITEM	S. NO.	ITEM
1	BABY FOOD	35	OXYGEN CYLINDER (for usage outside hospital)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (other than patient's diet provided by hospital)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (long/ short/ hinged)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (toiletries are not payable, only prescribed medical pharmaceuticals payable)
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [delivery kit, orthokit, recovery kit, etc.]
25	EXTRA DIET OF PATIENT (other than that which forms part of bed charge)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY