Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerwada, Pune - 411 006. Reg. No.: 113
For more details, log on to: www.bajajallianz.com | E-mail: bagichelp@bajajallianz.co.in or
Call at: Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)
Issuing Office:

EXTRA CARE
Policy Wordings

SECTION A) PREAMBLE

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

SECTION B) DEFINITIONS-STANDARD DEFINITIONS

1. **Accident, Accidental:**
An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **AYUSH Hospital:**
An 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 with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 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.

3. **AYUSH Day Care Centre:**
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:

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

4. **Any one illness:**
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.

5. **Cashless facility:**
Cashless facility means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.

6. **Condition Precedent:**
Condition Precedent means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

7. **Congenital Anomaly:**
Congenital Anomaly means 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

8. **Day care centre:**
A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -up with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

i. Has qualified nursing staff under its employment,
ii. Has qualified medical practitioner(s) in charge,
iii. Has a 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.

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

i. Undertaken under General or Local Anesthesia in a hospital/daycare 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.

10. **Deductible:**
Deductible is 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.

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

12. **Disclosure to information norm:**
The Policy shall be void and all premium paid there on shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

13. **Emergency Care:**
Emergency care means management of 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's health.

14. **Grace Period:**
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.

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

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

17. **Illness:**
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
a. Acute condition -Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
b. Chronic condition – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. It needs ongoing or long-term control for relief of symptoms
iii. It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. It continues indefinitely
v. It recurs or is likely to recur.

18. **Injury:**
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.

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

20. **Intensive Care Unit:**
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.

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

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

23. **Medical expenses:**
Medical Expenses means those expenses that an Insured 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 had not been Insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

24. **Medical Practitioner/Doctor/ Physician:**
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 or Ayurvedic and or such other authorities 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 and acceptable to Us.

25. **Medically Necessary Treatment:**
Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
    i. Is required for the medical management of the illness or injury suffered by the Insured;
    ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii. Must have been prescribed by a medical practitioner,
iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

26. **Migration:**
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.

27. **Network Provider:**
Network Provider means hospitals or healthcare providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

30. **OPD treatment:**
OPD treatment means one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a daycare or in-patient.

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

32. **Pre-Existing Disease:**
Pre- existing disease means any condition, ailment or injury or disease
a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement Or
b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement.

33. **Pre-hospitalization Medical Expenses:**
Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

34. **Post-hospitalization Medical Expenses:**
Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:
a. Such Medical Expenses are for the same condition for which the Insured Person's hospitalization was required, and
b. The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.

35. **Qualified Nurse:**
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.

36. **Reasonable and Customary charges:**
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.

37. **Renewal:**
Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

39. **Surgery or Surgical Procedure:**
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.

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

SECTION B) DEFINITIONS-SPECIFIC DEFINITIONS

1. **AYUSH Treatment refers to medical expenses incurred on hospitalization under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems**

2. **Bajaj Allianz Network Hospitals / Network Hospitals:**
Bajaj Allianz Network Hospitals / Network Hospitals means the Hospitals which have been empaneled by Us as per the latest version of the schedule of Hospitals maintained by Us, which is available to You on request.

3. **Family:**
For the purpose of Family Floater- includes the insured; his/her lawfully wedded spouse and dependent children. Dependent parents canal so be covered under this policy, a separate policy would be issued for parents

4. **Limit of Indemnity:**
Limit of Indemnity represents Our maximum liability to make payment for each and every claim per person and collectively for all persons mentioned in the Schedule during the policy period and in the aggregate for the person(s) named in the schedule during the policy period, and means the amount stated in the Schedule against each Cover.

5. **Named Insured/ Insured:**
Insured means the persons, or his Family members, named in the Schedule provided that an Insured or his Family Members has attained the age of 3 months and is not older than 65 years of age at the commencement of the Policy Period.

6. **Nominee:**
Nominee means a person designated by You to receive the proceeds of this Policy upon Your death.

7. **Policy:**
Policy means the proposal, the Schedule (and any endorsements attaching to or forming part thereof) and the policy document.

8. **Policy Period:**
Policy Period means the period between the commencement date and the expiry date specified in the Schedule and includes both the commencement date as well as the expiry date

9. **Schedule** means the schedule and any annexure to it.

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

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

SECTION C) COVERAGE

➢ **Scope of Cover**
The Company hereby agrees to pay reasonable and customary expenses in respect of an admissible claim, any or all of the following covers subject to the Sum Insured, limits, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.

➢ **Tenure of Policy**
- Extra Care: 1year, 2 years or 3 years

➢ **Coverage**

1. Medical Expenses:
If You/Your family member(s) named in the schedule are hospitalized on the advice of a Doctor because of Illness or accidental Bodily Injury sustained or contracted during the Policy Period, then We will pay You, Reasonable charges of Medical Expenses incurred in excess of the deductible stated in the schedule. (As explained below)
The company's liability to make any payment for each and every claim under the policy is in excess of the deductible. Each and every hospitalization would be considered as a separate claim. (If You suffer a relapse within 45 days of the date when You last obtained medical treatment or consulted a Doctor and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.)

a. **Hospitalization Expenses:**
As an in-patient in a Hospital for accommodation; Boarding Expenses including patients' diet as provided by the hospital / nursing home, nursing care, the attention of medically qualified staff, undergoing medically necessary procedures, medical consumables.

b. **Pre-Hospitalization Expenses:**
In respect of the medical treatment of an Illness during the consecutive 60-day period immediately preceding Your admission to Hospital for that Illness, provided that the aforesaid 60 day period commences and ends within the Policy Period.

c. **Post-Hospitalization Expenses:**
In respect of medical treatment and essential investigations for a period of up to 90 days after discharge from a Hospital for medical treatment related to the Illness or Accidental Bodily Injury;

2. Ambulance Expenses:
If a claim under Cover 1) is accepted, we will also pay the ambulance expenses to a maximum of Rs 3000 per valid hospitalization claim for transferring You/Your family member(s) named in the schedule to or between Hospitals in the Hospital's ambulance or in an ambulance provided by any ambulance service provider.

3. Modern Treatment Methods and Advancement in Technologies:
Modern Treatment Methods and Advancement in Technologies (as per below list) shall be covered up to Base Sum Insured, subject to policy terms, conditions, coverage, waiting periods and exclusions.
a. Uterine Artery Embolization and HIFU
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy- Monoclonal Antibody to be given as injection
f. Intra vit real injections
g. Robotic surgeries
h. Stereotactic radio surgeries

i. Bronchical Thermoplasty
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM -(Intra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered.

SECTION D) EXCLUSIONS UNDER THE POLICY - STANDARD EXCLUSIONS

I. **Waiting Period:**

1. Pre-existing Diseases waiting period (Excl01):
a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Extra Care Policy with us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured 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.
d. Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. Specified disease/procedure waiting period- Code (Excl02):
a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Extra Care policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures.

- Joint Replacement Surgery unless necessitated by accidental bodily injury,

3. 30-daywaiting period (Excl03):
a. Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however, apply if the Insured has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

II. **General Exclusions:**

1. **Investigation & Evaluation (Excl04):**
a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. **Rest Cure, rehabilitation and respite care- (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 medical, physical, social, emotional and spiritual needs.

3. **Obesity/Weight Control (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:
i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

4. **Change-of-gender treatments (Excl07):**
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. **Cosmetic or plastic Surgery (Excl08):**
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner

6. **Hazardous or Adventure Sports (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, skydiving, deep-sea diving

7. **Breach of law (Excl10):**
Expenses for treatment directly arising from or consequent upon any Insure Person committing or attempting to commit a breach of law with criminal intent.

8. **Excluded Providers (Excl11):**
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/ notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim

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

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

11. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. (Excl14)

12. **Refractive Error (Excl15):**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

13. **Unproven Treatments (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.

14. **Sterility and Infertility (Excl17):**
Expenses related to sterility and infertility. This includes:
a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

15. **Maternity (Excl18):**
a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SECTION D) EXCLUSIONS UNDER THE POLICY - SPECIFIC EXCLUSIONS

1. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not) [except for compelling the Government or any other person to do or abstain from doing any act as defined under the definition of Terrorist act], civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority. Any Medical expenses incurred due to Acts of Terrorism will be covered under the policy.

2. Circumcision unless required for the treatment of Illness or Accidental bodily injury,

3. The cost of spectacles, contact lenses, hearing aids, crutches, dentures, artificial teeth and all other external appliances and/or devices whether for diagnosis or treatment except for Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents etc.

4. External medical equipment of any kind used at home as post hospitalization care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition

5. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)

6. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating doctor.

7. Treatment for any other system other than modern medicine (also known as Allopathy) and AYUSH therapies

8. All non-medical Items as per Annexure I provided in Policy Wordings

9. Any treatment received outside India is not covered under this policy.

10. Venereal disease or any sexually transmitted disease or sickness.

11. Surgery to correct deviated septum and hypertrophied turbinate.

12. Expenses related to donor screening, treatment, including surgery to remove organs from a donor in the case of transplant surgery

13. Any dental treatment that comprises of cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization.

14. Congenital external diseases or defects or anomalies, growth hormone therapy, stem cell implantation or surgery except for Hematopoietic stem cells

for bone marrow transplant for hematological conditions.

SECTION E) CONDITIONS - STANDARD GENERAL TERMS AND CLAUSES

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

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. Moratorium Period:
After completion of sixty continuous months of coverage (including portability and migration) no look back would be applied. This period of sixty months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and 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. 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, deductibles as per the policy contract.

4. Premium Payment in Instalments (Wherever applicable):
If the insured person has opted for Payment of Premium on an instalment basis i.e. Annual (for long term polices only), Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.
ii. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
iii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
iv. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
v. No interest will be charged If the instalment premium is not paid on due date.
vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
viii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

5. 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.

6. Claim Settlement (provision for Penal interest):
a. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
c. 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 15 days from the date of receipt of last necessary document.
d. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

7. 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

8. Multiple Policies:
a) In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the 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.
b) 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.
c) 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.
d) 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.

9. Renewal of Policy:
The policy shall ordinarily be renewable except on misrepresentation by the insured person. grounds of fraud, misrepresentation by the insured person.
a) The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
b) Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
c) Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
d) 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.
e) No loading shall apply on renewals based on individual claims experience

10. Withdrawal of Policy:

a. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

b. Insured Person will have the option to 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.

11. Migration:

The Insured beneficiary will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy 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 beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

12. Portability:

The Insured beneficiary 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 east 45days before, but not earlier than 60days 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 beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link https://irdai.gov.in/document-detail?documentId=393128
(Please note referred link is of the IRDAI website and subject to change from time to time.)

13. Cancellation:

A) Cancellation by the Policyholder
The Policyholder can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired policy period as detailed below:

1. Cancellation of policy where full premium received at policy inception -

- Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.
- Multi-year Policy:
  - For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
  - For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

2. Cancellation of policy where Premium Received on Instalment Basis
The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

(B) Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

(C) Cancellation by the Company
The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Policyholder/insured person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

14. 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.

15. Fraud:

a. If any claim made by the Insured beneficiary, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured beneficiary or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

b. 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.

c. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured beneficiary or by his agent or the hospital/ doctor/any other party acting on behalf of the Insured beneficiary, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
   i. The suggestion, as a fact of that which is not true and which the Insured beneficiary does not believe to be true;
   ii. the active concealment of a fact by the Insured beneficiary 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

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

16. Free Look Period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of 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

a. 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
b. 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
c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

17. Grievance Redressal Procedure:

The company has always been known as a forward-looking customer centric organization. It takes immense pride in its approach of "Caringly Yours". To provide you with top-notch service on all fronts, the company has provided with multiple platforms via which you can always reach out to us at below mentioned touch points

1. Our toll-free number 1-800-209- 5858 or 020-30305858, say Say "Hi" on WhatsApp on +91 7507245858
2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website www.bajajallianz.com/branch-locator.html
3. Register your grievances / complaints on our website www.bajajallianz.com/about-us/customer-service.html
4. **E-mail-**
   a. Level 1:bagichelp@bajajallianz.co.in and for senior citizens to seniorcitizen@bajajallianz.co.in
   b. Level 2: Incase you are not satisfied with the response given to you at Level 1 you may write to our Grievance Redressal Officer at ggro@bajajallianz.co.in
   c. Level 3: If incase, your grievance is still not resolved, and you wish to talk to our care specialist, please give a missed call on +91 80809 45060 OR SMS To575758 and our care specialist will call you back
5. If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at www.cioins.co.in/ombudsman.html The contact details of the Ombudsman offices are mentioned in Annexure II

SECTION E) CONDITIONS - SPECIFIC TERMS AND CLAUSES

18. Discounts:

Long Term Policy Discount:

a. 4 % discount is applicable if policy is opted for 2 years
b. 8 % discount is applicable if policy is opted for 3 years This is not applicable if premium is paid in instalments

19. Basis of claim payment:

a. We shall make payment in Indian Rupees only.
b. If claim event falls within two policy periods the claims shall be administered taking into consideration the available sum insured in the two policy periods, including the deductibles, for each policy period. The claim amount to be payable shall be reduced up to the extent of the premium to be received for renewal by due date of renewal of this policy, if the same is not received earlier.
c. Notwithstanding what is mentioned in clause 3 of SECTION E) GENERAL TERMS AND CLAUSES - STANDARD GENERAL TERMS AND CLAUSES or any other clauses of this Policy:
   - In-patient Treatment for Mental Illness shall be covered up to Base Sum Insured subject to Policy Terms, Conditions, coverages, Waiting Period and exclusions.
   - Modern Treatment Methods and Advancement in Technologies (as per list in Annexure III) shall be covered up to Base Sum Insured, subject to Policy Terms, Conditions, coverages, Waiting Period and exclusions.

20. Arbitration and Reconciliation:

Arbitration Clause shall not be applicable.

21. Territorial Limits & Governing Law:

i. This Policy is restricted to insured events occurring in and Medical Expenses incurred in India.
ii. The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.
iii. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

22. Sum Insured Enhancement:

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal. You can apply for enhancement of Sum Insured by submitting a fresh proposal form to the company.
ii. The acceptance of enhancement of Sum Insured would be at the discretion of the company, based on the health condition of the insured members & claim history of the policy. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

23. Insured

Only those persons named, as the Insured in the Schedule shall be covered under this Policy. Cover under this Policy shall be withdrawn from any Insured upon such Insured giving 15 days written notice to be received by the Company.

24. Communications

Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule.

25. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except

Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

SECTION E) CONDITIONS – OTHER TERMS AND CONDITIONS

26. Claims Procedures

If You/your family member(s) named in the schedule meets with any accidental Bodily Injury or suffer an Illness that may result in a claim which is above the deductible as stated in the schedule, then as a condition precedent to Our liability, you must comply with the following:

A. Cashless Claims Procedure:

Cashless treatment is only available at a Network Hospital. In order to avail cashless treatment, the following procedure must be followed by You:

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You must call Us and request pre-authorization by way of the written form.
ii. In case of Planned hospitalization, You/the insured person/ insured representative shall intimate such admission within 48 hours of such hospitalization
iii. In case of Emergency hospitalization, You/the insured person/ insured representative shall intimate such admission within 24 hours of such hospitalization
iv. On receipt of your pre-authorization form duly filled and signed by you, our representative then within 2 hours will respond with Approval, Rejection or an more information
v. After considering Your request and after obtaining any further information or documentation We have sought, We may, if satisfied, send You or the Network Hospital, an authorization letter. The authorization letter, the ID card issued to You along with this Policy and any other information or documentation that We have specified must be produced to the Network Hospital identified in the preauthorization letter at the time of Your admission to the same.
vi. If the procedure above is followed, You will not be required to directly pay for the bill amount in the Network Hospital that We are liable under In-Patient Hospitalization Treatment above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorization does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

B. Reimbursement Claims Procedure:

If pre-authorization per a) above is denied by Us or if treatment is taken in a Hospital other than a Network Hospital or if You do not wish to avail cashless facility , then

i. You or someone claiming on Your behalf must inform Us in writing immediately, and in any event within 30 days of the aforesaid Illness or Bodily Injury.
ii. You must immediately consult a Doctor and follow the advice and treatment that he recommends.
iii. You must take steps or measure to minimize the quantum of any claim that may be made under this Policy.
iv. You must have Yourself examined by Our medical advisors if We ask for this, at the insurers cost.
v. You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation.
vi. In the event of the death of the insured person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 30 days
vii. We shall not indemnify you for any period of hospitalization of less than 24 hrs.
viii. We shall make claim payment in Indian Rupees only.
ix. In event of a claim, the original documents to be submitted & after the completion of the claims assessment process the original documents may be returned if requested by the insured in writing, however we will retain the Xerox copies of the claim documents.
x. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted along with the letter confirming the status of the claim & settlement details if any

***Note:** Waiver of conditions (i), (v) and (vi) may be considered where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible from him or any other person to give notice or file claim within the prescribed time limit. This would be considered in case of every claim where insured may have intimated primary insurer only, as he may not know initially that his claim will cross deductible.

- In case of any other concurrent insurance cover , the amount paid by the primary insurer for ambulance expenses would be deducted from the amount claimed under C 2) of Extra care policy , subject to the actuals or Rs.3000/- whichever is less. Documents to be submitted for Claims

1. First Consultation letter from the Doctor
2. Duly completed claim form and NEFT Form signed by the Claimant
3. Original Hospital Discharge Card
4. Original Hospital Bill giving detailed break up of all expense heads mentioned in the bill. Clear break ups have to be mentioned for OT Charges, Doctor's Consultation and Visit Charges, OT Consumables, Transfusions, Room Rent, etc.
5. Original Money Receipt, duly signed with a Revenue Stamp
6. All original Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc.
7. In case of a Cataract Operation, IOL Sticker will have to be enclosed
8. Claim settlement letter from the co insurer if any
9. Other documents as may be required by Bajaj Allianz to process the claim
10. Aadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)

Annexure I:-
List I: List of Non-Medical Items

Sl No	Item	
1	Baby Food	Not Payable
2	Baby Utilities Charges	Not Payable
3	Beautyserv Ices	Not Payable

4	Belts/ Braces	Not Payable
5	Buds	Not Payable
6	Cold Pack/Hotpack	Not Payable
7	Carry Bags	Not Payable
8	Email I Internet Charges	Not Payable
9	Food Charges (Other Thanpatient's Dietprovided By Hospita L)	Not Payable
10	Leggings	Essential In Bariatric And Varicose Vein Surgery And Should Be Considered For These Conditions Where Surgery Itself Is Payable.
11	Laundry Charges	Not Payable
12	Mineral Water	Not Payable
13	Sanitary Pad	Not Payable
14	Telephone Charges	Not Payable
15	Guest Services	Not Payable
16	Crepebandage	Not Payable
17	Diaper Of Anytype	Not Payable
18	Eyelet Collar	Not Payable
19	Slings	Not Payable
20	Blood Grouping And Cross Matching Of Donors Samples	Not Payable
21	Servicechargeswhere Nursingcharges Alsocharged	Not Payable
22	Television Charges	Not Payable
23	Surcha Rges	Not Payable
24	Attendant Charges	Not Payable
25	Extradiet Of Patient (Other Than Thatwhich Forms Part Of Bed	Not Payable
26	Birth Certificate	Not Payable
27	Certificate Charges	Not Payable
28	Courier Charges	Not Payable
29	Conveyance Charges	Not Payable
30	Medical Certificate	Not Payable
31	Medical Records	Not Payable
32	Photocopies Charges	Not Payable
33	Mortuarycharges	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Not Payable
64	Pan Can	Not Payable
65	Trolly Cover	Not Payable
66	Urometer, Urine Jug	Not Payable
68	Vasofix Safety	Not Payable

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

S. No.	Item
1	Baby Charges (Unless Specified/Indicated)

2	Handwash
3	Shoe Cover
4	Caps
5	Cardle Charges
6	Comb
7	Eau-De-Cologne/Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Papper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinefctant 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	Admissionkit
28	Diabetic Chart Charges
29	Documentation Charges/Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chartcharges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Inctdental Expenses / Mtsc. Charges (Notexplatned)
36	Patient Identification Band / Name Tag
37	Pulseoxymeter Charges

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

S. No.	Item
1	Hairremoval Cream
2	Disposables Razors Charges(For Site Preparations)
3	Eye Pad
4	Eye Sheild
5	Cameracover
6	Dvd ,Cd Charges
7	Gause Soft
8	Gauze
9	Ward And Theatre Booking Charges

10	Arthroscope And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades,Harmonicscalpel,Shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-Ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet
23	Orthobundle, Gynaec Bundle

List IV: items that are to be subsumed into costs of treatment

S. No.	Item
1	Admission/Registration Charges
2	Hospitalization 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 Perpoxide\Spirit\Disinfection Etc
9	Nuttrition Planning Charges - Dietician Charges - Diet Charges
10	Hiv Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouthpaint
14	Vaccination Charges
15	Alcohol Swabes
16	Scrub Solution/Sterillium
17	Glucometer& Strips
18	Urinebag

Annexure II : **Contact details of the Ombudsman offices**

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 – 25501201 /02 /05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu

Office Details	Jurisdiction of Office Union Territory, District)
BENGALURU - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL - Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR – Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 – 2596461 / 2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 – 4646394 / 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 - Insurance Ombudsman 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, Puducherry Town and Karaikal (which are part of Puducherry)
DELHI – Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

Office Details	Jurisdiction of Office Union Territory, District)
HYDERABAD - Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 –2740363 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
KOCHI – Insurance Ombudsman 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 – Insurance Ombudsman 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.
LUCKNOW – Insurance Ombudsman 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 - Insurance Ombudsman 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	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA - Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam 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.

Office Details	Jurisdiction of Office Union Territory, District)
PATNA – Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020- 24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Note: Address and contact number of Governing Body of Insurance Council:
Council for Insurance Ombudsmen, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W),Mumbai - 400 054.
E-mail: inscoun@cioins.co.in , Tel: 022 -69038800/69038812, Website: https://www.cioins.co.in