UNITED SHRAMIK SEVA POLICY

TERMS AND CONDITIONS

1. PREAMBLE

This policy is a contract of insurance issued by United India Insurance Company Limited (hereinafter called the '**Company**') to the Proposer mentioned in the schedule (hereinafter called the '**Insured**') to cover the person(s) named in the schedule (hereinafter called the '**Insured Persons**'). The policy is based on the statements and declaration provided in the Proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

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

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

3. DEFINITIONS

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

- **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- **Age** means age of the Insured Person on last birthday as on date of commencement of the Policy.
- **Any One Illness** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where the treatment has been taken.
- **Associated Medical Expenses** means hospitalisation related expenses on Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital; Anesthesia, blood, oxygen, operation theatre charges, surgical appliances and such other similar expenses with the exception of:

    i. cost of pharmacy and consumables medicines
    ii. cost of implants/ medical devices
    iii. cost of diagnostics

The scope of this definition is limited to admissible claims where a proportionate deduction is applicable, as per Note 2 of Section 4.1.

- 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 any of the following:

    i. Central or State Government AYUSH Hospital or

ii. Teaching hospital attached to AYUSH College recognised by the Central Government/Central Council of Indian Medicine/ Central Council for Homeopathy; or

iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognised 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 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.

- **AYUSH Day Care Centre** means and includes Community Health Care 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.

- **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

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

- **Co-morbidity** is the presence of one or more additional conditions co-occurring with a primary condition; in the countable sense of the term, a comorbidity is each additional condition.

- **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

- **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

  a. Internal Congenital Anomaly

  Congenital Anomaly which is not in the visible and accessible parts of the body.

  b. External Congenital Anomaly

  Congenital Anomaly which is in the visible and accessible parts of the body.

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

- **Day Care Centre** means any institution established for day care treatment of disease/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:
    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 shall make these accessible to the Company's authorized personnel.

- **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under general or local anesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
    ii. which would have otherwise required a hospitalisation of more than twenty-four hours.
  Treatment normally taken on an out-patient basis is not included in the scope of this definition.

- **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, filings (where appropriate), crowns, extractions and surgery.

- **Disclosure to information norm:** 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.

- **Emergency Care:** Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the Insured Person's health.

- **Epidemic:** The occurrence of more cases of a disease than would be expected in a community or region spreading rapidly during a given time period; and declared as such by the appropriate Government Authority in India.

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

- **Hospital** means any institution established for in-patient care and day care treatment of disase/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 Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient 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 shall make these accessible to the Company's authorized personnel.

- **Hospitalisation** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

- **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
  i. **Acute Condition** means 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.
  ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
    i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
    ii. it needs ongoing or long-term control or relief of symptoms
    iii. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
    iv. it continues indefinitely
    v. it recurs or is likely to recur

- **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.

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

- **Insured Person** means person(s) named in the schedule of the Policy.

- **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.

- **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

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

- **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.

- **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.

- **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 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 the medical community in India.

- **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.
- **Network Provider** means hospitals enlisted by Insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured by cashless facility.
- **Non-Network Provider** means any hospital that is not part of the network.
- **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognised modes of communication.
- **Out-Patient (OPD) Treatment** means 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.
- **Pandemic** means an epidemic of disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of people; and declared as such by the World Health Organisation and appropriate Government Authority in India.
- **Pre-Existing Disease (PED):** Pre-existing disease means any condition, ailment or injury or disease:
  i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Insurer or
  ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
- **Pre-Hospitalisation Medical Expenses** means medical expenses incurred during the period of 30 days preceding the hospitalisation of the Insured Person, provided that:
  i. Such medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
  ii. The In-Patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
- **Post-Hospitalisation Medical Expenses** means medical expenses incurred during the period of 60 days immediately after Insured Person is discharged from the hospital, provided that:
  i. Such medical expenses are for the same condition for which the Insured Person's hospitalisation was required, and
  ii. The in-patient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.
- **Policy** means these Policy Wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured Person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured Person.
- **Policy period** means period of one policy year as mentioned in schedule for which the Policy is issued.
- **Policy Schedule** means the Policy Schedule attached to and forming part of Policy.

- **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 Insurer.
- **Qualified Nurse** means any person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- **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.
- **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.
- **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
- **Sub-limit** means a cost sharing requirement under a health insurance policy in which an Insurer would not be liable to pay any amount in excess of the pre-defined limit.
- **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
- **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 of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
- **Third Party Administrator (TPA)** means a company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
- **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
- **We/Our/Us** means the United India Insurance Company Limited.
- **You/Your/Policyholder** means the person named in the Policy Schedule who has concluded this Policy with Us.

4. COVERAGE

BASE COVER:

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

4.1 Hospitalization

The company shall indemnify medical expenses incurred for Hospitalisation of the Insured Person during the Policy period, up to the Sum Insured specified in the policy schedule, for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital/Nursing Home up to 1% of the sum insured per day.
ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses up to 2% of the sum insured per day.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, implants, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

4.1.1 Other Expenses

i. Actual expenses incurred on treatment of cataract (including cost of the lens) upto 15% of Sum Insured or Rs. 30,000/-, whichever is lower, per eye during the Policy period.
ii. Dental treatment, necessitated due to injury
iii. Plastic surgery necessitated due to disease or injury
iv. All the day care treatments
v. Expenses incurred on Road Ambulance subject to a maximum of Rs. 2000/- per hospitalisation.

Note to 4.1

1. Expenses of Hospitalisation for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. In case of admission to a room—at rates exceeding the aforesaid limits in Clause 4.1.i, the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.

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

4.1.2 Notwithstanding the provisions mentioned in 4.1 above, the maximum city-wise* limit of payment for following medical procedures shall be as under:

Medical Procedure/ Treatment	City-wise* Maximum Limit upto Rs. (Inclusive of Room/ICU/OT Charges; Surgeon's, Anaesthetist's, doctor's fees, medicines, internal appliances and the charges incurred during hospitalization period); Procedure Performed in		
	Tier I Cities	Tier II Cities	Tier III Cities
Appendicectomy - laparoscopic	50,000	35,000	30,000
Appendicectomy – open	40,000	30,000	25,000
Arthroscopy	28,000	19,000	17,500
Cholecystectomy – laparoscopic	50,000	37,500	35,000
Cholecystectomy – open	35,000	25,000	23,000
Coronary Angiogram (including dye)	15,000	12,000	11,000
Exploratory Laparotomy	30,000	25,000	20,000
Fissurectomy	25,000	18,500	17,500
Haemorrhoidectomy (Excluding staples & tackers)	36,000	24,000	22,500
Hernia repair – laparoscopic	32,000	23,000	21,000

Hernia repair – Open (including mesh)	31,000	22,000	21,000
Hydrocelectomy – Bilateral	50,000	35,000	30,000
Hydrocelectomy – Unilateral	30,000	18,000	17,000
Hysterectomy – laparoscopic	60,000	50,000	45,000
Hysterectomy – vaginal /open	31,000	22,000	21,000
Mastectomy (Radical)	60,000	38,000	36,000
PID-Discectomy	72,000	47,500	45,000
Septoplasty	22,500	17,000	16,000
Thyroidectomy - HEMI	35,000	25,000	23,000
Thyroidectomy - TOTAL	68,000	43,000	40,500
Tonsillectomy	20,000	14,000	13,000
TURP	51,000	41,000	39,000
Tympanoplasty	41,000	25,000	23,000
Ureterorenoscopic Lithotripsy	35,000	25,000	23,000

City classification*	City
Tier-I	Ahmadabad (including Gandhinagar); Bengaluru; Chennai; Delhi; Greater Mumbai (incl. Thane); Hyderabad (incl. Secunderabad); Kolkata; Pune
Tier-II	Agra; Ajmer; Aligarh; Amravati; Amritsar; Asansol; Aurangabad; Bareilly; Belgaum; Bhavnagar; Bhiwandi; Bhopal; Bhubaneshwar; Bikaner; Bokaro Steel City; Chandigarh (including Panchkula and Mohali); Coimbatore; Cuttack; Dehradun; Dhanbad; Durgapur; Durg-Bhilai Nagar; Erode; Faridabad; Firozabad; Ghaziabad; Gorakhpur; Greater Visakhapatnam; Gulbarga; Guntur; Gurugram; Guwahati; Gwalior; Hubli-Dharwad; Indore; Jabalpur; Jaipur; Jalandhar; Jammu; Jamnagar; Jamshedpur; Jhansi; Jodhpur; Kannur; Kanpur; Kochi; Kolhapur; Kollam; Kota; Kozhikode; Lucknow; Ludhiana; Madurai; Malappuram; Malegaon; Mangalore; Mathura-Vrindavan; Meerut; Moradabad; Mysore; Nagpur; Nanded-Waghala; Nashik; Nellore; Noida; Patna; Prayagraj; Puducherry; Raipur; Rajkot; Ranchi; Raurkela; Saharanpur; Salem; Sangli; Siliguri; Solapur; Srinagar; Surat; Thiruvananthapuram; Thrissur; Tiruchirappalli; Tiruppur; Ujjain; Vadodara; Varanasi; Vasai-Virat City; Vijayawada and Warangal
Tier-III	All other cities/towns not covered by classification Tier-I or Tier-II

4.2 AYUSH Treatment

The company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of Rs. 15000 in any AYUSH Hospital.

4.3 Pre Hospitalisation

The company shall indemnify pre hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, upto a period of 30 days prior to the date of admissible hospitalisation covered under the policy.

4.4 Post Hospitalisation

The company shall indemnify post hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, upto 60 days from the date of discharge from the hospital, following an admissible hospitalisation covered under the policy.

4.5 Modern Treatment Methods & Advancement in Technologies:

The following procedures will be covered (wherever medically indicated) either as inpatient care or as part of day care treatment in a hospital with a co-payment of 20%, up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization & HIFU (High intensity focused ultrasound)
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral Chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra Vitreal Injections
G. Robotic Surgeries
H. Stereotactic radio surgeries
I. Bronchial Thermoplasty
J. Vaporisation of the Prostate (Green laser treatment or holmium laser treatment)
K. IONM – Intra Operative Neuro Monitoring
L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

OPTIONAL COVERS:

4.6 Out-patient Treatment Cover: (within the Base Sum Insured)

We will cover the Reasonable and Customary Charges incurred on an out-patient basis for medically required consultations, visit(s) to a doctor, diagnostic tests and pharmacy expenses as per standard medical protocol for any epidemic/ pandemic only up to Rs.5000.
The Benefit payable will be within the Base Sum Insured.
For the purpose of this Cover, Out-patient means an Insured Person who is not hospitalized but who visits a hospital, clinic or associated facility for diagnosis or treatment.

The relevant part of Exclusion 6.29 under the policy will stand deleted for this Option.

All claims under this Benefit can be made as per the process defined under Section 8 of the policy, as applicable.

4.7 Daily Cash Allowance on Hospitalisation

We will pay Daily Cash Allowance of Rs. 500 per day subject to a maximum of Rs. 7500 per policy period to the Insured Person for every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy.

Daily Cash Allowance will not be payable for Day Care Procedure claims where the hospitalisation is less than 24 hours. Deductible equivalent to Daily Cash Allowance for the first 24 hours Hospitalization will be levied on each Hospitalisation during the Policy Period.

The payment under this benefit is over and above the Base Sum Insured.

All claims under this Benefit can be made as per the process defined under Section 8 of the policy, as applicable.

4.8 Benefit Cover for First Diagnosis of Any Epidemic/ Pandemic:

If an Insured Person is First Diagnosed with any Epidemic/ Pandemic during the Period of Cover, then We will pay Rs. 25000 as a lump sum amount, provided that the Illness/disease was first diagnosed after 14 days from the Risk Inception Date.

On the acceptance of a claim under this Benefit, the cover under this Benefit will terminate in relation to the Insured Person.

This Benefit shall be payable subject to the following:

a. The Insured must have tested positive for the Epidemic/ Pandemic by a Government authorized/ Government designated laboratory in India, appointed for testing of the Epidemic/ Pandemic.
b. The diagnosis must be confirmed by only those specific test(s) as defined by Government authorities or as per standard medical protocol.
c. The lab diagnosis must have been performed after the completion of the initial waiting period of 14 days.

4.8.1 No benefit will be payable if the Insured has been quarantined for any suspected epidemic/ pandemic OR diagnosed with any epidemic/ pandemic prior to the risk inception date or within the initial waiting period of 14 days.

4.8.2 The initial waiting period of 14 days will not apply for this Benefit Cover if the Optional Cover for '**Waiver of Initial Waiting Period of 30 days for any epidemic/ pandemic** has been opted for**.**

4.8.3 The payment under this benefit is over and above the Base Sum Insured.

4.8.4 Claim documents for this Benefit Cover:

On the occurrence of an Insured Event which may give rise to a claim under this benefit of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of occurrence of the Insured Event:

- Duly filled claim form (physical or digital) by the Insured Person/claimant.
- Lab report with sign and stamp, confirming positive for Epidemic/ Pandemic.
- Certificate from Government medical officer confirming diagnosis or from any medical practitioner authorised by Government to issue such certificates.

4.9 Waiver of Initial Waiting Period of 30 days for any epidemic/ pandemic:

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that Exclusion no. 5.2 shall not apply for claims arising out of the hospitalisation due to any Epidemic/ Pandemic.

4.10 Waiver of Co-Payment clause for pre-existing co-morbidities in case of any epidemic/ pandemic:

On payment of additional Premium as mentioned in Schedule, it is hereby agreed and declared that co-payment condition no. 8.5 shall not apply for claims arising out of the hospitalisation due to any Epidemic/ Pandemic.

4.11 Maternity Benefit Cover:

We will pay a lump sum benefit amount of Rs. 20000 to the female Insured Person above 18 years during the Policy Period for the delivery of a child in a Hospital (including but not limited to caesarean section, vacuum birthing, water birthing, hypnobirthing, midwife birthing).

4.11.1 This Benefit will be available subject to the following:

a. After a waiting period of 9 months from the Date of Inception of cover for the first time under this policy for the Female Insured Member;
b. Up to a maximum number of two deliveries;
c. Payment under this cover will be limited to per event and will be over and above the Base Sum Insured.

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

i. Medical Expenses incurred in respect of the delivery/ termination of pregnancy.

ii. Medical Expenses for ectopic pregnancy, which will be covered under Section 4.1 of the Base Cover Terms and Conditions.

iii. Complications arising as a result of infertility Treatment (assisted conception).

4.11.3 The payment under this benefit is over and above the Base Sum Insured.

4.11.4 Claim documents for this Benefit Cover:

On the occurrence of an Insured Event which may give rise to a claim under this Base Benefit of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of occurrence of the Insured Event:

- Duly filled claim form (physical or digital) by the Insured Person/claimant.
- Birth Certificate issued by local Government Body.
- Proof of delivery at Hospital/ Medical Centre equipped for conducting delivery.

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

5 WAITING PERIOD

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

5.1 Pre-Existing Diseases (Code-Excl01)

i. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.

ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

iv. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

5.2 First Thirty Days Waiting Period (Code-Excl03)

i. 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.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

5.3 Specific Waiting Period (Code-Excl02)

i. Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the Insurer. This exclusion shall not be applicable for claims arising due to an accident.

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

24 Months Waiting Period

- Benign ENT disorders
- Tonsillectomy
- Adenoidectomy
- Mastoidectomy
- Tympanoplasty
- Hysterectomy
- All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
- Benign prostate hypertrophy
- Cataract and age related eye ailments
- Gastric/Duodenal Ulcer
- Gout and Rheumatism
- Hernia of all types
- Hydrocele
- Non Infective Arthritis
- Piles, Fissure and Fistula in anus
- Pilonidal sinus, Sinusitis and related disorders
- Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
- Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
- Varicose Veins and Varicose Ulcers
- Internal Congenital Anomalies

48 Months Waiting Period

- Treatment for joint replacement unless arising from accident
- Age-related Osteoarthritis & Osteoporosis

6 EXCLUSIONS

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

6.1 Investigation & Evaluation (Code-Excl04)

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

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

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6.3 Obesity/Weight Control (Code-Excl06)

Expenses related to the surgical treatment of obesity that does not fulfill 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:
        1. Obesity-related cardiomyopathy
        2. Coronary heart disease
        3. Severe Sleep Apnoea
        4. Uncontrolled Type2 Diabetes

6.4 Change-of-Gender Treatments: (Code-Excl07)

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

6.5 Cosmetic or Plastic Surgery: (Code-Excl08)

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

6.6 Hazardous or Adventure sports: (Code-Excl09)

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

6.7 Breach of law: (Code-Excl10)

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

6.8 Excluded Providers: (Code-Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible.

However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

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

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

6.12 Refractive **Error: (Code-Excl15)**

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

6.13 Unproven Treatments: (Code-Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

6.14 Sterility and Infertility: (Code-Excl17)

Expenses related to sterility and infertility. This includes:

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

6.15 Maternity Expenses (Code-Excl18):

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

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

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

i. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

ii. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

iii. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

6.18 Any expenses incurred on Domiciliary Hospitalisation

6.19 Treatment taken outside the geographical limits of India

6.20 a) Stem cell implantation/Surgery/therapy, harvesting, storage or any kind of Treatment using stem cells except as provided for in Clause 4.6.L above; b) Growth Hormone Therapy.

6.21 Congenital External Diseases, Defects or anomalies.

6.22 Circumcision unless necessary for Treatment of an Illness or Injury not excluded hereunder or due to an Accident.

6.23 Cost of routine medical examination and preventive health check-up.

6.24 a) Cost of hearing aids; including optometric therapy; b) cochlear implants unless necessitated by an Accident or required intra-operatively.

6.25 Intentional self-inflicted Injury, attempted suicide

6.26 Treatments other than Allopathy and Ayurvedic, Homeopathic & Unani branches of medicine.

6.27 Any expenses incurred on Outpatient treatment (OPD treatment)

6.28 Unless used intra-operatively, any expenses incurred on prosthesis, corrective devices; External and or durable Medical / Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support including instruments used in treatment of sleep apnoea syndrome; Infusion pump, Oxygen concentrator, Ambulatory devices, sub cutaneous insulin pump and also any medical equipment, which are subsequently used at home.

6.29 Change of treatment from one system of medicine to another system unless recommended by the consultant/ hospital under whom the treatment is taken.

6.30 Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, chondrocyte or osteocyte implantation, procedures using platelet rich plasma, Trans Cutaneous Electric Nerve Stimulation; Use of oral immunomodulatory/ supplemental drugs.

6.31 Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state

7 MORATORIUM PERIOD

After completion of eight continuous years under the policy no look back would be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the Sums Insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of Sums Insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim 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.

8 CLAIM PROCEDURE

8.1 Procedure for Cashless Claims:

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

8.2 Procedure for reimbursement of claims:

For reimbursement of claims the Insured Person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder:

Sr. No.	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalisation, day care and pre hospitalisation expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment

8.3 Notification of Claim

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

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

8.4 Documents to be submitted:

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

i. Duly completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First Information Report) if registered, wherever applicable)
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled Cheque

xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate, wherever applicable.
xiv. Any other relevant document required by Company/TPA for assessment of the claim

[Note: The Company may specify the documents required in original and waive off any of above required as per our claim procedure]

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other Insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other Insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

8.5 Co-Payment in the event of Claims due to any epidemic/ Pandemic in presence of a pre-existing co-morbid condition:

In the event of each and every Claim for hospitalisation due to any epidemic/ Pandemic in presence of a pre-existing co-morbid condition, a co-payment will be applicable as per the following table:

Co-pay applicable for Pre-Existing Co-morbidities				
Pre-existing Co-morbid Condition	**Policy Year**			
	1st	**2nd**	**3rd**	**4th**
Any one disease	33%	25%	17%	8%
Any two diseases	50%	38%	25%	13%
More than two diseases	67%	50%	33%	17%

8.6 Claim Settlement (provision for Penal Interest)

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

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

8.7 Services offered by TPA (To be stated where TPA is involved)

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

The services offered by a TPA shall not include

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

8.8 Payment of Claim

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

9 GENERAL TERMS AND CONDITIONS

9.1 Disclosure of Information

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

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

9.2 Condition Precedent to Admission of Liability

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

9.3 Parties to the Policy

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

9.4 Eligibility

i. To be eligible for coverage under the Policy, the Insured Person must be an employee of the policyholder.
ii. Minimum Group size: The Policyholder shall ensure that the minimum number of Employees who will form a group to avail the Benefits under this Policy shall be 7 (Seven).
iii. Renewals will be available for lifetime, provided the Insured Person is still employed with the Policyholder/continues to be a member of the group.

9.5 Premium

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

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

NOTE: Where Instalment facility is granted by Us for the payment of premium, it is to be in accordance with the schedule of payments agreed between the Policyholder and Us in writing.

Where premium is payable on an instalment basis, the revival period shall be 15 days. Wherever premiums are not received within the revival period, the Policy will be terminated effective from instalment due date and all claims that fall beyond such instalment due date shall not be paid. However, we will be liable to pay in respect of all claims where the Treatment/Admission/Accident has commenced/ occurred before the date of termination of such Policy.

9.6 Role of Group Administrator/ Policyholder

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

9.7 Material Change

The Policyholder shall immediately notify the Company in writing of any material change in the risk in relation to the declaration made in the RFQ/ Proposal during the policy period and at each Renewal and We may, in Our discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

9.8 Records to be Maintained

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

9.9 Complete Discharge

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

9.10 Notice & Communication

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

9.11 Territorial Limit

The geographical scope of this Policy applies to events limited to India. All medical treatment for the purpose of this insurance will have to be taken in India only and all admitted or payable claims shall be settled in India in Indian rupees.

9.12 Multiple Policies

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

9.13 Fraud

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

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

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

iv. any such act or omission as the law specially declares to be fraudulent

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

9.14 Addition and Deletion of a Member

We shall include/exclude a group member/Employee of the Policyholder and/or Policyholder's Contractor's / Sub Contractor's Employee as an Insured Person under the Policy in accordance with the following procedure:

A. Additions

Newly appointed employee may be added to the Policy as an Insured Person during the Policy period provided that the application for cover has been accepted by Us; additional premium as per the table given below for the Insured Person has been received by Us and We have issued an endorsement confirming the addition of such person as an Insured Person:

Premium Chargeable for Additions	
Duration of Cover	**% of Annual Premium chargeable**
Not Exceeding 3 Months	25%
Exceeding 3 Months but not exceeding 6 Months	50%
Exceeding 6 Months but not exceeding 9 Months	75%
Exceeding 9 Months	100%

B. Deletions:

An Employee leaving the company/organization on account of resignation/ retirement/ termination of for reasons whatsoever shall be deleted from the policy effective from the date of resignation/ retirement/termination or till the last day of the month of resignation/retirement/termination at the option of the Insured. Refund of premium shall be made as per the table given below, provided that no claim is paid/outstanding in respect of that Insured Person.

Premium Refundable for Deletions	
Duration of Cover	**% of Annual Premium Refundable**
Not Exceeding 3 Months	75%
Exceeding 3 Months but not exceeding 6 Months	50%
Exceeding 6 Months but not exceeding 9 Months	25%
Exceeding 9 Months	0%

No refund shall be made for deletion of employees if the premium retainable under the policy after the refund is lower than the Incurred Claims plus 10% towards Administrative and Claims servicing costs.

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

9.15 Cancellation

i. The Policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired Policy Period as detailed below:

The grid is applicable for single premium Policy

Cancellation Grid	
Period for which risk is retained	Refund
Up to 1 Month	75%
>1 Month- less than 3 Month	50%
>3 Months – less than 6 months	25%
>6 Months – less than 9 months	15%
>9 Months	Nil
Note: For installment premium, we will refund premium on pro rata basis after deducting Our expenses	

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

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

9.16 Our Right of Termination

A. Termination of Policy:

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

i. there is misrepresentation, fraud, non-disclosure of material fact by Policyholder / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.

ii. there is non-cooperation by Policyholder / Insured Person, with refund of premium on pro rata basis for all lives which have not registered a claim with Us, after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
iii. the Policyholder does not pay the premiums owed under the Policy within the Grace Period.

Upon termination, cover and services under the Policy shall end immediately. Treatment and costs incurred after the date of termination shall not be paid. If Treatment has been authorized or an approval for Cashless facility has been issued, we will not be held responsible for any Treatment costs if the Policy ends. However, we will be liable to pay in respect of all claims where the Treatment/admission has commenced before the date of termination of such Policy.

B. Termination for Insured Person's cover

Cover will end for a group member:

i. If the Policyholder stops paying premiums for the Insured Person(s);
ii. When this Policy terminates at the expiry of the period shown in the Policy Schedule/ Certificate of Insurance.
iii. If he or she dies;
iv. If the Insured Person ceases to be a member of the group.

9.17 Limitation of Liability

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

9.18 Territorial Jurisdiction

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

9.19 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the Policy.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

9.20 Migration

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

For Detailed Guidelines on Migration, kindly refer the link:

https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

9.21 Renewal of Policy

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

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

A. Renewal Terms

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

b. We will make adjustments to Premium Rates for renewals based on the experience of expiring policy for groups with at least 100 members in both expiring policy period and upcoming policy period.

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

9.22 Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change made by the Company shall be evidenced by a written endorsement signed and stamped.

9.23 Terms and Conditions of the Policy

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

9.24 Nomination

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

9.25 Withdrawal of Policy

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

10 REDRESSAL OF GRIEVANCE

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

Website: www.uiic.co.in
Toll free: 1800 425 333 33
E-mail: customercare@uiic.co.in
Courier: Customer Care Department, Head Office, United India Insurance Co. Ltd., 19, IV Lane, Nungambakkam High Road, Chennai, Tamil Nadu- 600034

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance. If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at customercare@uiic.co.in
For updated details of grievance officer, kindly refer the link https://uiic.co.in/en/customercare/grievance

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach **the office of Insurance Ombudsman** of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Insurance Ombudsman offices have been provided as ***Annexure – B***

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

Insurance is the subject matter of solicitation.

UNITED INDIA INSURANCE COMPANY LIMITED

Policy Issuing Office Address
Phone: (****) ***** **EMAIL: ****@******

UNITED SHRAMIK SEVA POLICY

UIN:
POLICY NO:

PERIOD OF INSURANCE
FROM --: -- Hrs on dd/mm/yyyy
To MIDNIGHT on dd/mm/yyyy

Policyholder

Name

Address

IMPORTANT NOTICE: KINDLY UPDATE YOUR AADHAAR NO. AND PAN/FORM 60. PLEASE IGNORE IF ALREADY UPDATED.

Agent/Broker Name	:	
Agent/Broker Code	:	
Mobile/Landline Number/Email	:	/

The genuineness of the policy can be verified through "Verify Your Policy" link at www.uiic.co.in.

For any Information, Service Requests and Grievances please write to officecode@uiic.co.in

For ID Cards & Claim Intimations Please contact the TPA mentioned in the Policy document.

REGISTERED OFFICE: 24, WHITES ROAD, CHENNAI – 600014

Website: http://www.uiic.co.in

Attached to and forming part of Policy No.: <>
UIN No.: <>

UNITED SHRAMIK SEVA POLICY

POLICY SCHEDULE CUM TAX INVOICE

QR CODE

Policy No.:
Previous Policy No.:
Insured Name:
Insured Address:
Insured contact no. & email id:
Period of Insurance:
Coinsurance:

Risk Coverage Details:

Customer Relationship Type	Employer-Employee
Cover Type	Individual Sum Insured Basis
Family Definition	Self
Total No. of Members covered	
Base Cover Sum Insured Type	(Flat or Graded)
Base Cover Sum Insured Slab/s	
Total Base Cover Sum Insured (in Rs.)	
Total Base Cover Sum Insured (in words)	

	Sum Insured (In Rs.)					
Coverage	**Per Member**					**Group Total**
Base Cover	100000	200000	300000	400000	500000	
Daily Cash Allowance on Hospitalisation	7500	7500	7500	7500	7500	
Benefit Cover for First Diagnosis of Any Epidemic/ Pandemic	25000	25000	25000	25000	25000	
Maternity Benefit Cover on delivery in hospital	20000	20000	20000	20000	20000	
Maximum Total Cover Limit	152500	252500	352500	452500	552500	
Out-patient Treatment Cover (within Base Cover Sum Insured)	5000	5000	5000	5000	5000	Not Applicable
Waiver of Initial waiting Period of 30 days for any epidemic/ pandemic	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Waiver of Co-Payment clause for pre-existing co-morbidities in case of any epidemic/pandemic	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

(NOTE 1: This table will be displayed only when at least one Optional Cover is opted for.)
(NOTE 2: Only those Optional Covers & Base Cover Sum Insured Slabs will be listed here, which are opted for by the User. Accordingly, the adjusted figure in "Maximum Total Cover Limit" row and "Group Total" column will display.)

Sum Insured wise demography of Insured Persons:

Base Cover Sum Insured	No. of Members covered
100000	
200000	
300000	
400000	
500000	
Grand Total	

(NOTE: This table will be displayed only when “Sum Insured Type” is “Graded” and members are covered for various Sum Insured slabs.)

Attached to and forming part of Policy No.: <>
UIN No.: <>

Details of Insured Persons: As per **Annexure 1** attached.

Premium Details:

Base Cover Premium			Receipt Number	
Premium for Daily Cash Allowance on Hospitalisation	(+)		Receipt Date	
Premium for Benefit Cover for First Diagnosis of Any Epidemic/ Pandemic	(+)		Agent/Broker Code	
Premium for Maternity Benefit Cover	(+)		Agent/Broker Name	
Premium for Waiver of Initial waiting Period of 30 days for any epidemic/ pandemic	(+)		Development Officer Code	
Premium for Waiver of Co-Payment clause for pre-existing co-morbidities in case of any epidemic/pandemic	(+)		Development Officer Name	
Premium for Out-patient Treatment Cover	(+)		Customer GST No.	
Premium for Claim Experience Loading/Discount (on Base Cover Premium)	(+)		Office GST No.	
Net Premium			SAC Code	
IGST @ 18% of Net Premium / CGST@ 9% of Net Premium and SGST @ 9% of Net Premium	(+)		Invoice No. & Date	
Total Premium (including GST)			Amount Subject to Reverse Charges	

Anti-Money Laundering Clause:- In the event of a claim under the policy exceeding 1 lakh or a claim for refund of premium exceeding 1 lakh, the Insured will comply with the provisions of AML policy of the company. The AML policy is available in all our operating offices as well as Company's web site.

Warranted that in case of dishonour of premium cheque(s) the Company shall not be liable under the policy and the policy shall be void ab initio (from inception).

The insurance under this policy is subject to conditions, clauses, warranties, endorsements as per forms attached.

This Schedule and the attached policy shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear the same meaning wherever it may appear.

Date of Proposal and Declaration:
IN WITNESS WHEREOF, the undersigned being duly authorised has hereunto set his/her hand at <Office Location> <Office Code> on this __ day of, <Month>, <Year>.

Affix Policy Stamp Here

For and On behalf of
United India Insurance Co. Ltd.

Authorised Signatory

Attached to and forming part of Policy No.: <>
UIN No.: <>

Details of TPA

Please contact the following TPA for Issue of Identity Cards, Cashless Approvals & Claims Settlement.

Name of TPA				
Address				
Toll Free number				
Contact Details	**For General Enquiries**	**For Cashless approval**	**For Claim intimation**	**For Grievances**
Telephone Numbers				
Email IDs				

Attached to and forming part of Policy No.: <>
UIN No.: <>

Annexure 1:

UIIC ID NO	MEMBER ID	NAME	GENDER	DATE OF BIRTH	DATE OF JOINING	SUM INSURED	DATE OF EXIT (This column will display only for deletion endorsement.)

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

Sr. No	Item	Sr. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSTDE THE 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	TROLLEY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY

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

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

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

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

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

Sr. No	Item	Sr. No	Item
1	ADMISSION/REGISTRATION CHARGES	10	HIV KIT
2	HOSPITALISATION FOR EVALUATION/DIAGNOSTIC PURPOSE	11	ANTISEPTIC MOUTHWASH
3	URINE CONTAINER	12	LOZENGES

4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	13	MOUTH PAINT
5	BIPAP MACHINE	14	VACCINATION CHARGES
6	CPAP/ CAPD EQUIPMENTS	15	ALCOHOL SWABS
7	INFUSION PUMP-COST	16	SCRUB SOLUTIONS / STERILLIUM
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC	17	GLUCOMETER & STRIPS
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES, DIET CHARGES	18	URINE BAG

Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel No: 079 - 25501201/02/05/06. Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049. Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh, Chhattisgarh	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202. Fax: 0755 – 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Orissa	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455. Fax: 0674 – 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468. Fax: 0172 – 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284. Fax: 044 – 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/2321350 4. Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM). Tel.: 0361 - 2632204 / 2602205. Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana, and Yanam - part of Territory of Pondicherry	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122. Fax: 040 – 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363. Email: Bimalokpal.jaipur@ecoi.co.in
Kerala, Lakshadweep, Mahe- a part of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338. Fax: 0484 – 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340. Fax: 033 - 22124341

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

The updated details of Insurance Ombudsman are also available at:

- IRDAI website: https://www.irdai.gov.in/
- General Insurance Council website: https://www.gicouncil.in/
- Our Company Website: https://uiic.co.in/
- From any of the offices of our Company.