

THE ORIENTAL INSURANCE COMPANY LIMITED,

Regd. Office: Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi 110002



ORIENTAL BANK MEDICLAIM POLICY

(WITH FAMILY FLOATER)

FOR THE ACCOUNT HOLDERS / EMPLOYEES OF THE ORIENTAL BANK OF COMMERCE

PROSPECTUS

1.1 Salient Features of the policy.

- a. a) The Group Mediclaim Policy will be available to any Account Holders / Employees of ORIENTAL BANK OF COMMERCE - (OBC)
- b) The group policy will be issued in accordance with IRDA guidelines, in the name of ORIENTAL BANK OF COMMERCE (called insured) with a schedule of names of the Account Holders / Employees of ORIENTAL BANK OF COMMERCE including his/her eligible family members as per the following definition.
- b. **Definition of Family :** FAMILY TO INCLUDE THE PROPOSER i.e., ACCOUNT HOLDER/EMPLOYEE of the Oriental Bank of Commerce (OBC). HIS/HER SPOUSE AND TWO DEPENDENT CHILDREN (i.e. legitimate or legally adopted children) AGED 3 COMPLETED MONTHS ONWARDS UPTO 79 YEARS AS UNDER:
 - FEMALE CHILD UNTIL SHE IS MARRIED. IMMEDIATELY CONSEQUENT UPON HER MARRIAGE SHE SHALL BE CEASED TO BE COVERED UNDER THE POLICY AND NO CLAIM SHALL BE ADMISSIBLE.

- MALE CHILD UPTO THE AGE OF 26 YEARS IF HE IS A BONAFIDE REGULAR STUDENT AND FULLY DEPENDENT ON PROPOSER i.e., THE OBC ACCOUNT HOLDER.

1.2 The policy reimburses reasonable and necessary expenses of Hospitalisation and / or Domiciliary Hospitalisation expenses as detailed below only for illness / diseases contracted or injury sustained by the Insured Persons during the policy period upto the limit of Sum Insured.

- a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1 % of the Sum Insured or Rs. 5000 /- per day whichever is less.
- b. **I.C. Unit expenses** not exceeding 2% of the Sum Insured or Rs. 10,000 /- per day whichever is less. (Room stay including I.C.U. stay should not exceed total number of admission days).
- c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.
- d. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray etc.
- e. **Ambulance services** - 1% of the sum insured or Rs 1000/- whichever is less.
- f. **Hospital Cash:** Reimbursement of incidental expenses during the period of hospitalisation of the Proposer i.e., the ORIENTAL BANK OF COMMERCE Account Holder only - actual subject to a maximum of Rs.1,000 during the entire policy period.
- g. **Reimbursement of Funeral Expenses:** In the event of death of the Insured Person due to an insured peril covered under the scope of the Policy the company shall reimburse actual funeral expenses subject to a maximum of Rs.1,000 during the policy period.
- h. **Domiciliary Hospitalisation:** Surgeon, Medical Practitioner, Consultants, Specialists Fees, Blood, Oxygen, Surgical Appliances, Medicines & Drugs, Diagnostic Material and Dialysis, Chemotherapy, Nursing expenses - 10% of Sum Insured, Maximum Rs.25000/- during policy period.

1.3 **Cash less Facility:** This facility is available in the Network Hospitals through the appointed TPAs of the company.

2. DEFINITIONS

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

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

The term 'Hospital/Nursing Home' shall not include an establishment which is a place of rest and / or recuperation, a place for the aged persons, a rehabilitation centre for drug addicts or alcoholics, a hotel or a similar place.

Note: In case of Ayurvedic / Homeopathic / Unani treatment, the Company shall be liable only when the treatment is taken as in patient in a Government Hospital / Medical College Hospital.

2.2 SURGICAL OPERATIONS: 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 or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

2.3 HOSPITALISATION PERIOD: Expenses on Hospitalisation are admissible only if hospitalisation is for a minimum period of 24 (twenty four) hours. However,

(A)This time limit SHALL not apply to following specific treatments taken in the Network Hospital / Nursing Home where the Insured is discharged on the same day. Such treatment SHALL be considered to be taken under Hospitalisation Benefit.

- 1 Dialysis (haemo dialysis, Peritoneal dialysis)
- 2 Parental Chemotherapy (injectible)
- 3 Radiotherapy,
- 4 Eye Surgery,
- 5 Lithotripsy (kidney stone removal),

- 6 Tonsillectomy,
- 7 Dilation and Curettage (D&C)
- 8 Dental surgery following an accident
- 9 Hysterectomy
- 10 Coronary Angioplasty
- 11 Coronary Angiography
- 12 Surgery of Gall bladder, Pancreas and bile duct
- 13 Surgery of Hernia
- 14 Surgery of Hydrocele.
- 15 Surgery of Prostate.
- 16 Gastrointestinal Surgery.
- 17 Genital Surgery.
- 18 Surgery of Nose.
- 19 Surgery of throat and ear.
- 20 Surgery of Appendix.
- 21 Surgery of Urinary System.
- 22 Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
- 23 Arthroscopic Knee surgery.
- 24 Laproscopic therapeutic surgeries.
- 25 Any surgery under General Anaesthesia.
- 26 Any such disease / procedure agreed by TPA/Company before treatment.

2.4 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 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:-

1. has qualified nursing staff under its employment,
2. has qualified medical practitioner (s) in charge,
3. has a fully equipped operation theatre of its own, where surgical procedures are carried out-
4. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel,

2.5 DAY CARE TREATMENT: Day care treatment refers to medical treatment, and/or surgical procedure which is:

- i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs 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.

2.6 DOMICILIARY HOSPITALISATION BENEFIT: Domiciliary hospitalization means medical treatment for a period **exceeding three days** for such an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non availability of room in a hospital.

Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover

- a) Expenses incurred for pre and post hospital treatment and
- b) Expenses incurred for treatment for any of the following diseases :
 - a) Asthma
 - b) Bronchitis,
 - c) Chronic Nephritis and Nephritic Syndrome,
 - d) Diarrhoea and all types of Dysenteries including Gastro-enteritis,
 - e) Diabetes Mellitus and Insipidus,
 - f) Epilepsy,
 - g) Hypertension,
 - h) Influenza, Cough and Cold,
 - i) All Psychiatric or Psychosomatic Disorders,
 - j) Pyrexia of unknown origin for less than 10 days,
 - k) Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis,
 - l) Arthritis, Gout and Rheumatism.

2.7 AMBULANCE SERVICES: Means ambulance service charges reasonably and necessarily incurred in case the insured person is to be shifted from residence to hospital or from one hospital to another hospital. The ambulance service charges are payable only if the hospitalisation expenses are admissible. Further the ambulance service charges are admissible only if such expenses are paid to registered ambulance services providers.

3. OTHER DEFINITIONS AND INTERPRETATIONS:

- 3.1 INSURED PERSON:** Means Person(s) named on the schedule of the policy which includes family comprising of the proposer, his /her legally wedded spouse, dependent unemployed children (upto two only) between 3 (three months) to the age of 26 years, The dependent children may also include unmarried daughters including divorcee, and widowed daughters provided the maximum number of dependent children under the entire policy does not exceed two. The person should not be more than 80 yrs of age. The entry age for the policy is before 79 years of age .
- 3.2 ENTIRE CONTRACT:** This POLICY, SCHEDULE, PROPOSAL / DECLARATION given by the insured constitute a complete contract. Only Insurer may alter the terms and conditions of the policy and such alterations made by the insurer shall only be evidenced by a duly signed endorsement on the policy with the Company stamp.
- 3.3 TPA (THIRD PARTY ADMINISTRATOR):** means any company / body who has obtained licence from IRDA to practice as a third party administrator and is appointed as TPA by the Company and as reflected in the schedule of the policy.
- 3.4 NETWORK HOSPITAL:** means hospitals or healthcare providers enlisted by an insurer, or by a TPA and insurer together, to provide medical services to an insured on payment , by a cashless facility.
- 3.5 HOSPITALISATION PERIOD:** The period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24 hours except for specified procedures/ treatment where such admission could be for a period of less than 24 consecutive hours.
- 3.6 PRE-HOSPITALISATION:** Medical Expenses incurred during the period upto 30 days prior to the date of admission, provided that:
- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
 - ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
- 3.7 POST-HOSPITALISATION:** Medical Expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:

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

3.8 MEDICAL PRACTITIONER: A Medical practitioner is 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.

3.9 QUALIFIED NURSE: Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.10 PRE EXISTING HEALTH CONDITION OR DISEASE: Any condition, ailment or injury or related condition(s) for which the insured had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.

3.11 IN-PATIENT: An Insured person who is admitted to hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

3.12 REASONABLE & 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 .

For a networked hospital means the rate pre-agreed between Network Hospital and the TPA / Company, for surgical / medical treatment that is necessary for treating the insured person who was hospitalized.

NOTE: Any expenses other than the above have to be borne by the insured person himself.

3.13 CASHLESS FACILITY: It means a facility extended by the insurer to the insured where the payments of the costs of the 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 of pre- authorization approved.

- 3.14 I.D. CARD:** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.
- 3.15 LIMIT OF INDEMNITY:** means the amount stated in the schedule which represents maximum liability for any and all claims admissible during the policy period in respect of that **insured family**.
- 3.16 ANY ONE ILLNESS:** Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation OR 105 days from the date of discharge ,whichever is earlier, from the Hospital/Nursing Home where treatment may have been taken.
- 3.17 PERIOD OF POLICY:** This insurance policy is issued for the period as shown in the schedule. The benefits under the policy will seize, the moment the insured attains the age of 80 yrs.

4 EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

- 4.1 Pre-existing health condition or disease or ailment / injuries:** Any ailment / disease / injuries / health condition which are pre-existing (treated / untreated, declared / not declared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person upto 3 years of this policy being in force continuously.

For the purpose of applying this condition, the date of inception of the first indemnity based health policy taken shall be considered provided the renewals have been continuous and without any break in period, subject to portability condition.

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104.This exclusion will also apply to any complications arising from pre existing ailments / diseases / injuries. Such complications shall be considered as a part of the pre existing health condition or disease.

- 4.2** The expenses on treatment of following ailment / diseases / surgeries for the specified periods are not payable if contracted and / or manifested during the currency of the policy.

If these diseases are pre-existing at the time of proposal the exclusion no 4.1 for pre-existing condition SHALL be applicable in such cases.

i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
ii	Polycystic ovarian diseases .	1 year
iii	Surgery of hernia.	2 years
iv	Surgery of hydrocele.	2 years
v	Non infective Arthritis.	2 years
vi	Undescendent Testes.	2 Years
vii	Cataract.	2 Years
viii	Surgery of benign prostatic hypertrophy.	2 Years
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus.	2 Years
x	Fissure / Fistula in anus.	2 Years
xi	Piles.	2 Years
xii	Sinusitis and related disorders.	2 Years
xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
xiv	Surgery of genito- urinary system excluding malignancy.	2 Years
xv	Pilonidal Sinus.	2 Years
xvi	Gout and Rheumatism.	2 Years
xvii	Hypertension.	2 Years
xviii	Diabetes.	2 Years
xix	Calculus diseases.	2

		Years
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
xxi	Surgery of varicose veins and varicose ulcers.	2 Years
xxii	Joint Replacement due to Degenerative condition.	3 Years
xxiii	Age related osteoarthritis and Osteoporosis.	3Years

If the continuity of the renewal is not maintained with the Company then subsequent cover SHALL be treated as fresh policy and clauses 4.1., 4.2, SHALL apply afresh unless agreed by the Company and suitable endorsement passed on the policy. Similarly if the sum insured is enhanced subsequent to the inception of the policy, the exclusions 4.1, and 4.2 will apply afresh for the enhanced portion of the sum insured for the purpose of this section.

- 4.3** Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.
- 4.4** Circumcision (unless necessary for treatment of a disease not excluded under the policy or as may be necessitated due to any accident), vaccination, inoculation, cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- 4.5** Surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc.
- 4.6** Any dental treatment or surgery, unless arising from injury and which requires hospitalisation, which is corrective, cosmetic or of aesthetic in nature, filling of cavity, root canal treatment including treatment for wear and tear etc
- 4.7** Convalescence, general debility, “run down” condition or rest cure, congenital external and internal diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to and / or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.
- 4.8** Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.

- 4.9** All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.
- 4.10** Expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period OR expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalisation or primary reasons for admission, referral fee to family doctors, out station consultants / Surgeons fees, Doctor's home visit charges/ Attendant / Nursing charges during pre and post hospitalisation period. etc.
- 4.11** Expenses incurred on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician and / or all non medical expenses including personal comfort and convenience items or services.
- 4.12** Any Treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy.
- 4.13** Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.
- 4.14** Genetic disorders and stem cell implantation / surgery.
- 4.15** Cost of external and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker , Crutches, Belts ,Collars ,Caps , splints, slings, braces ,Stockings etc. of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items etc. and also any medical / non medical equipment which is subsequently used at home.
- 4.16** Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, services or supplies etc...

- 4.17** Change of treatment from one system to another system of medicine unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- 4.18** Any treatment arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.
- 4.19** Outpatient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.
- 4.20** Massages, Steam bathing, Shirodhara and like treatment under Ayurvedic treatment.
- 4.21** Any kind of Service charges/Surcharges, unless payable to the Govt. Authority, levied by the hospital.

5 CONDITIONS

- 5.1 ENTIRE CONTRACT:** the policy, SCHEDULE, proposal form, prospectus and declaration given by the insured shall constitute the complete contract of insurance. Only insurer may alter the terms and conditions of this policy/ contract. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.
- 5.2 COMMUNICATION:** Every notice or communication to be given or made under this policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator as shown in the Schedule.
- 5.3 PAYMENT OF PREMIUM:** The premium payable under this policy shall be paid in advance. No receipt for premium shall be valid except on the official form of the Company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorised official of the Company.

5.4 NOTICE OF CLAIM: Immediate written notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease / illness / injury and Name and Address of the attending medical practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home by Fax, Email. Such written notice should be given within 48 (forty eight) hours of admission or before discharge from Hospital / Nursing Home, whichever is earlier unless waived in writing.

5.5 CLAIM DOCUMENTS: Final claim along with originals of hospital Bills/Cash memos/reports, claim form and list of documents as listed below should be submitted to the Company / TPA within 7 (seven) days of discharge from the Hospital / Nursing Home.

1. Original bills, receipts and discharge certificate / card from the hospital.
2. .Medical history of the patient recorded by the Hospital.
3. Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.
- 4 Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by the note from attending medical practitioner / surgeon demanding such tests.
- 5 .Attending Consultants' / Anaesthetists' / Specialists' certificates regarding diagnosis and bill / receipts etc. in original.
- 6 .Surgeons' original certificate stating diagnosis and nature of operation performed along with bills / receipts etc.
7. Any other information required by TPA / the Company.

All documents must be duly attested by the insured person.

In case of post hospitalisation treatment all supporting claim papers / documents as listed above should also be submitted within 7 (seven) days after completion of such treatment to the Company / T.P.A. In addition, insured should also provide to the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim.

NOTE: Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company / TPA has a right to reject the claim.

5.6 PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME :

- i) Claim in respect of Cashless Access Services SHALL be through the TPA/ Insurer provided treatment is undertaken in a network hospital / Nursing Homes and is subject to pre admission authorization. The TPA/ Insurer shall, upon getting the related medical details / relevant information from the insured person / network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself SHALL issue a pre-authorisation letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.
- ii) The TPA/ Insurer reserves the right to deny pre-authorisation in case the hospital / insured person is unable to provide the relevant information / medical details as required by the TPA/ Insurer. In such circumstances denial of Cashless Access should in no way be construed as denial of claim. The insured person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the TPA/ Insurer for reimbursement within 7 (seven) days of the discharge from Hospital / Nursing Home.
- iii) Should any information be available to the TPA/ Insurer which makes the claim inadmissible or doubtful requiring investigations, the authorisation of cashless facility may be withdrawn. However this shall be done by the TPA/Insurer before the patient is discharged from the Hospital and notice to the effect given to the treating hospital / the insured

5.7 Any medical practitioner authorised by the TPA/Company shall have deemed permission to examine the Insured Person in case of any alleged injury or Disease requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the TPA/Company. In such examinations the cost of medical examination will be borne by the Company.

5.8 DISCLOSURE TO INFORMATION NORM

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

5.9 REPUDIATION:

A (I): The Insurer, shall repudiate the claim if not covered / not payable under the policy. The Insurer shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the **Grievance Redressal Cell of the company at its policy issuing office, concerned Divisional Office, concerned Regional Office or the Grievance Cell of the Head Office of the Company, situated at A-25/27, Asaf Ali Road, New Delhi-110002.** against the repudiation.

B If the insured is not satisfied with the decision / of the reply of the Grievance Cell under 5.9 (A), he / she may approach the Ombudsman of Insurance, established by the Central Government for redressal of grievances. The Ombudsman of Insurance is empowered to adjudicate on personal lines of insurance claims upto Rs.20 lacs.

5.10 CANCELLATION CLAUSE: Company may at any time, cancel this Policy by sending the Insured 30 (Thirty) days notice by registered letter at the Insured's last known address and in such an event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. (Such cancellation by the Company shall be only on grounds of moral hazards such as intentional misrepresentation / malicious suppression of facts intended to mislead the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy). The Company shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given here below) provided no claim has occurred during the policy period up to date of cancellation.

Period on Risk	Rate of premium to be charged
Upto 1 Month	1/4th of the annual rate
Upto 3 Months	1/2 of the annual rate
Upto 6 Months	3/4th of the annual rate
Exceeding 6 months	Full annual rate

5.11 **ARBITRATION CLAUSE:** If any dispute or difference shall arise as to the quantum to be paid under 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 or if they cannot agree upon a single arbitrator within 30 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.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

5.12 **DISCLAIMER OF CLAIM:** It is also hereby further expressly agreed and declared that if the TPA/Company shall disclaim liability in writing to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.13 **PAYMENT OF CLAIM:** The policy covers illness, disease or accidental bodily injury sustained by the insured person during the policy period any where in India* and all medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

5.14 Mid term inclusion of newly wed spouse, new born child and adopted child is permitted provided such inclusion is within three months of marriage, birth and adoption respectively or at the time of renewal of the policy. In the case of new born child and adopted child the inclusion is permitted only if both the parents are covered under the policy.

5.15 **PORTABILITY:** This policy is portable, in such case, it maintains the credit gained by the insured for pre-existing conditions and time bound exclusions as per IRDA Guidelines.

If the Insured desires to port this policy, request for the same has to be made atleast 45 days prior to renewal date.

IMPORTANT

6 **PERIOD OF POLICY:** This insurance policy is issued for a period of one year.

7 RENEWAL OF POLICY:

- a) The Company shall not be responsible or liable for non-renewal of policy due to non-receipt or delayed receipt (i.e. After the due date) of the proposal form or of the medical practitioners report wherever required or due to any other reason whatsoever.
- b) Notwithstanding this, however, the decision to accept or reject for coverage any person upon renewal of this insurance shall rest solely with the Company. The company may at its discretion revise the premium rates and / or the terms & condition of the policy every year upon renewal thereof. Renewal of this policy is not automatic; premium due must be paid by the proposer to the company before the due date.
- c) The Company shall not ordinarily deny the renewal of this policy unless on moral hazard grounds of the insured such as intentional misrepresentation / malicious suppression of facts intended to mislead the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy, subject to policy terms.

8 **SUM INSURED:** The Company's liability in respect of all claims admitted in during the period of Insurance shall not exceed the sum insured opted under the policy.

9. AUTHORITY TO OBTAIN RECORDS:

- a) The insured person hereby agrees to and authorises the disclosure to the insurer or the TPA or any other person nominated by the insurer of any and all Medical records and information held by any Institution / Hospital or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability there under.
- b) The insurer and the TPA agree that they SHALL preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and SHALL only use it in connection with any claim made under this policy or the insurer's liability there under.

10. **QUALITY OF TREATMENT :** The insured hereby acknowledges and agrees that payment of any claim by or on behalf of the insurer shall not constitute on part of the insurance company a guarantee or assurance as to the quality or effectiveness of any

medical treatment obtained by the insured person, it being agreed and recognized by the policy holder that insurer is not in any way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital) whether pre-authorized or not.

11. ID CARD: The card issued to the insured person by the TPA to avail cash less facility in the Network Hospital only. Upon the cancellation or non renewal of this policy, all ID cards shall immediately be returned to the TPA at the policy holder's expense and the policy holder and each insured person agrees to hold and keep harmless, the insurer and the TPA against any or all costs, expenses, liabilities and claims (whether justified or not) arising in respect of the actual or alleged use, misuse of such ID cards prior to their return.

12. FRAUD / MISREPRESENTATION / CONCEALMENT: The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner intentionally or recklessly or otherwise misrepresented or concealed or non disclosure of material facts or making false statements or submitting false bills whether by the Insured Person or Institution / Organization on his behalf . Such action shall render this policy null and void and all claims hereunder shall be forfeited. Company may take suitable legal action against the Insured Person / Institution / Organization as per Law.

13. SCHEDULE OF PREMIUM: As agreed and Annexed.

This Prospectus shall form part of your proposal form. Signatures hereunder confirm that you have noted the contents of the prospectus.

Name:

Signature

Address:

Place:

Date:

Note: For legal interpretation only English version will be valid.

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:

Any person making default in complying with provision of this section shall be punishable with fine, which may extend to Rs.500/-.

No person shall allow, or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.

ANNEXURE

THE ORIENTAL INSURANCE CO LTD : HO NEW DELHI	
GROUP MEDICLAIM INSURANCE (FAMILY FLOATER) SCHEME FOR ORIENTAL BANK OF COMMERCE ACCOUNT HOLDERS /EM- PLOYEES	
PREMIUM CHART (PREMIUM RATES ARE INCLUSIVE OF SERVICE TAX)	
SUM IN- SURED (In Rupees)	MEDICLAIM (In Rupees)
	AGE GROUP 03 MONTHS TO 79 YEARS
1,00,000	1749
2,00,000	3320
3,00,000	4620
4,00,000	5780
5,00,000	6830