Group Mediclaim Prospectus

Introduction

Group Mediclaim policy provides financial assistance to employees/members of corporate (including their eligible family members), it covers you against hospitalization expenses towards illness / injury in India.

The Policy, provides, basic cover for medical expenses on hospitalisation incurred for medical treatment of illness, injury by the Insured/Insured Person. The Policy covers Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anesthetist, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs.

Scope of cover

The Policy Schedule and all Endorsement Schedules shall be as per terms and conditions accepted and agreed with the Policyholder.

The Company hereby agrees subject to the terms, conditions and exclusions contained or expressed in the Policy, to compensate the Insured Person as per the covers and limits specified in the Policy Schedule.

In addition to the terms laid out herein, liability arising due to any treatment relating to Mental Illness shall be assessed in accordance with the relevant provisions of The Mental Healthcare Act, 2017.

The total payment under all benefits under the Policy shall not exceed the Sum Insured mentioned in the Policy Schedule

Eligibility

The group formed should be as per the definition of Group Guidelines as defined by IRDA from time to time. The Proposer/Policyholder shall ensure that all eligible members are eligible as per the defined Group.

Policy Period

Master Policy can be issued for a period of 1 Year

Sum Insured

Sum insured options are ranging from Rs 15,000 to Rs 500,000

Benefits

Basic Cover

1. **InPatient Treatment**

   If during the Policy Period any of the Insured Person undergoes Hospitalization for Inpatient Treatment on the written advice of a Medical Practitioner, then the Company will indemnify the Policyholder/Insured Person for the below incurred Medical Expenses:

   - Room Rent
   - Nursing
   - Intensive care Unit (ICU),
   - Medical Practitioner(s),
   - Anesthesia, blood, oxygen, operation theatre charges, surgical appliances,
   - Medicines, drugs and Consumables
   - Diagnostic procedures

   The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure

2. **Pre-Hospitalization**

   The Company will indemnify the Policyholder/ Insured Person for the Pre- Hospitalisation Expenses upto 30 days, provided that:

   i. such Medical Expenses are incurred in respect of the same condition for which Insured Person has taken Inpatient Treatment, an

   ii. Company has accepted the Claim for these Inpatient Treatment expenses under Benefit 1 InPatient Treatment

3. **Post Hospitalization**

The Company will indemnify the Policyholder/Insured Person for the Post Hospitalisation Expenses upto 60 days, provided that:

i. Such costs are incurred in respect of the same condition for which the Insured Person has taken Inpatient Treatment, and

ii. Company has accepted the Claim for these Inpatient Treatment expenses under Benefit 1 InPatient Treatment

4. **Day Care Treatment**

The Company will indemnify the Policyholder/ Insured Person for the Medical Expenses on the written advice of the Medical Practitioner, if during the Policy Period, any of the Insured Person undergoes a Day Care Treatment as defined and listed under this Policy

5. **Domiciliary Hospitalisation**

Domiciliary Hospitalisation means medical treatment for a period exceeding three days for disease/injury which in the normal course would require care and treatment at a hospital/nursing home but is actually taken whilst confined at home in India under any of the following circumstances namely

i. The condition of the patient is such that he/she cannot be removed to Hospital/Nursing home, or

ii. The patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

Domiciliary hospitalisation benefits shall be subject to the Sum Insured as specified in the Schedule, and shall, in no case cover expenses incurred for:

Treatment of any of the following diseases/illness/injury:

I. Asthma

ii. Bronchitis

iii. Chronic nephritis and nephritic syndrome

iv. Diarrhea & all types of dysenteries including gastroenteritis.

v. Diabetes mellitus and insipidus

vi. Epilepsy

vii. Hypertension

viii. Influenza, cough and cold

ix. All psychiatric or psychosomatic disorders

x. Pyrexia of unknown origin for less than 10 days

xi. Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis

xii. Arthritis, gout and rheumatism.

6. **Ayush Treatment**

The Company will indemnify the Policyholder /Insured Person against the Medical Expenses which are incurred on treatment under AYUSH up to the Sum Insured under the Policy. The AYUSH treatment should be carried out in an AYUSH Hospital or AYUSH Day Care Centre as defined under the Policy.

The Company shall not be liable for payment of any Claim under this Benefit directly or indirectly arising out of or relating to:

i. Treatment other than **Inpatient Treatment** or **Day Care Treatment**

ii. **Medical Expenses** incurred for evaluation, Investigation only.

iii. Treatment availed outside India.

iv. Treatment at a healthcare facility which is NOT an **AYUSH Hospital** or **AYUSH Day Care Centre.**

v. **Pre-Post Hospitalization** expenses

vi. All preventive and rejuvenation treatments (non-curative in nature), or treatments that are not **Medically Necessary.** This includes but not limited to treatments at Spa, Massages and Health Rejuvenation Procedure.

7. **Modern Treatment**

The Company will indemnify the **Insured Person** up to 50% of **Sum Insured** for the **Medical Expenses** incurred during the **Policy period** on Inpatient Treatment or Day Care Treatment or Domiciliary Treatment of below mentioned Modern Treatment Methods

- Uterine Artery Embolization and HIFU
- Balloon Sinuplasty
- Deep Brain Stimulation
- Oral Chemotherapy

- Immunotherapy-Monoclonal Antibody to be given as injection
- Intra Vitreal injections
- Robot surgeries
- Stereotactic radio surgeries
- Bronchial Thermoplasty
- Vaporization of the prostrate (Green laser treatment or holmium laser treatment)
- IONM- (Intra Operative Neutro Monitoring)
- Stem Cell therapy: Including Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

The claim under this benefit shall be subject to all other terms under Benefits 1 to 6

Additional Benefit

Maternity Expenses Benefit

"Maternity expense" Maternity expense / treatment shall include the following Medical treatment Expenses:

I. Medical Treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation);

II. Expenses towards lawful medical termination of pregnancy during the policy period.;

III. These benefits are applicable only if the expenses incurred in Hospital/Nursing Home as an inpatient.

IV. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesaream section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, mis-carriage or abortion induced by accident or other medical emergency or on payment of extra premium.

V. Claim in respect of a delivery for only first two children and/or operations associated therewith will be considered in respect of any one Insured Person covered under the policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.

VI. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.

VII. Pre-natal and post natal expenses are not covered unless admitted in Hospital/Nursing Home and treatment is taken there.

Premium Payable

The premium payable will depend upon Demography, Proposed Sum Insured & coverage & claim experience for current policy (in case of renewal/rollover policies).

Mid term changes in coverage/sum insured shall be subject to insurer's discretion. Please refer the proposal to our branch/nearest office for premium quote.

Waiting Period

The Waiting Periods as defined in Section 3 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly, irrespective of whether the Sum Insured is on individual or floater basis.

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

1. Pre-Existing Diseases - Code- Excl01
   a) 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 insurer.
   b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   c) 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.
   d) 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 Insurer.
2. Specified disease/procedure waiting period- Code- Excl02
   a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage after the date of inception of the first **Policy** with us. This exclusion shall not be applicable for claims arising due to an **Accident.**
   b. In case of enhancement of **Sum Insured** the exclusion shall apply afresh to the extent of **Sum Insured** increase.
   c. If any of the specified disease/procedure falls under the waiting period specified for **Pre-Existing Diseases,** then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the **Policy** or declared and accepted without a specific exclusion.

e. If the **Insured Person** is continuously covered without any break as defined under the applicable norms on f stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage

f. List of specific diseases/procedures in respect of which 12 months waiting period is imposed is mentioned below:

i. Cataract,

ii. Benign prostatic hypertrophy

iii. Hysterectomy or menorrhagia or fibromyoma

iv. Hernia,

v. Hydrocele

vi. Internal congenital diseases/anomalies

vii. Fistula in anus

viii. Piles

ix. Sinusitis

3. 30-day waiting period- Code- Excl03

a. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

General Exclusion

The Company shall have no liability and no Claim shall be admissible in respect of any Insured Person under any benefit(s) where such liability or Claim arises directly or indirectly due to any of the following:

1) **Investigation & Evaluation (Code:Excl04)**

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2) **Rest Cure, rehabilitation and respite care (Code:Excl05)**

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

- 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.
- Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3) **Obesity/ Weight Control (Code:Excl06):** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

- greater than or equal to 40 or
- 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:
  - o Obesity-related cardiomyopathy
  - o Coronary heart disease
  - o Severe Sleep Apnea
  - o Uncontrolled Type2 Diabetes

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

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) **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.

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.

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.(For updated and detailed list of Excluded Providers refer website- www.reliancegeneral.co.in)

9) **Substance Abuse and Alcohol (Code: Excl12):** Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.

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

11) **Dietary Supplements & Substances (Code: Excl14):** Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of hospitalization claim or day care procedure

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

13) **Unproven Treatments-Code (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.

14) **Sterility and Infertility (Code: Excl17):** Expenses related to sterility and infertility. This includes:

    a. Any type of contraception, sterilization

    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

    c. Gestational Surrogacy

    d. Reversal of sterilization

15) Maternity: Code (Excl18)

    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

16) Circumcision unless necessary for treatment of a disease not excluded here in above or as may be necessitated due to an accident,.

17) Cost of spectacles, contact lenses and hearing aids.

18) Dental treatment or surgery of any kind unless requiring hospitalisation

19) Convalescence, general debility, 'run-down' condition venereal disease

20) All expenses arising out of any condition, directly or indirectly, caused to or associated with human T-Cell Lymphotropic Virus type III (HTLV III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

21) .Disease or injury directly or indirectly caused by or contributed to by nuclear weapons/materials.

22) Non-medical expenses: Any non-medical expenses mentioned in Annexure A

23) 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..

24) Permanent Exclusions

    A permanent exclusion will be applied on **Pre-Existing** medical or physical condition or treatment of an Insured Person, if such exclusion is accepted by the Proposer and specifically mentioned in the Policy Schedule. This option, as per Company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under the **Policy** to such **Insured Person.** The list of such diseases/ conditions or treatments are attached as Annexure-F to the Policy wording

Claim Procedure

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying

with the following steps, shall be the condition precedent to the admissibility of the Claim.

Upon the discovery or happening of any Illness / Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admissibility of the Claim, the Policyholder/ Insured Person shall undertake the following:

Claims Intimation

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a Claim covered under the Policy, the Policyholder/ Insured Person, must notify the Company either at the call center or in writing immediately.

In the event of

- planned Hospitalization, the Policyholder /Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.
- Emergency Hospitalization, the Policyholder /Insured Person will intimate such admission within 24 hours of such admission.

The following details are to be provided to the Company at the time of intimation of Claim:

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by the Company

Claims Procedure

Cashless: Cashless facility is available only at a Network Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured Person:

Claims Procedure

Cashless: Cashless facility is available only at a Network Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured Person:

i. Pre-authorization : Prior to Hospitalization, the Policyholder/ Insured Person must call the call center of the Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.

ii. The Company/TPA will process the Policyholder's/ Insured Person's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Policyholder/ Insured Person and the Company/TPA will confirm such Cashless authorization / rejection in writing or by other means.

iii. If the procedure above is followed and the Policyholder's/ Insured Person's request for Cashless facility is authorized, the Policyholder/ Insured Person will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit).Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

iv. The Company/TPA (on behalf of Company) reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Policyholder/ Insured Person shall, in any event, be required to settle all other expenses, co-payment and

/ or deductibles (if applicable), directly with the Hospital.

v. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.

vi. There can be instances where the Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder/ Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the Company which will be considered subject to the Policy Terms &Conditions.

vii. The Policyholder/ Insured Person shall be required to submit the documents as mentioned with the Network Hospital.

Note: Under Cashless facility, the Company may authorize upon the Policyholder's / Insured Person's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the

Company. In such cases, the Company will directly settle all eligible amounts as per the Policy Terms &Conditions with the Network Hospital to the extent the Claim is covered under the Policy.

The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on the Company's website.

Re-imbursement :

In case of any Claim under the Benefits, where cashless facility is not availed, the list of documents as mentioned shall be provided by the Policyholder/Insured Person, immediately but not later than 30 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

Policyholder's / Insured Person's duty at the time of Claim

a. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.

b. Forthwith intimate / file / submit a Claim

c. If so requested by the Company, the Insured Person will have to submit himself for a medical examination by the Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.

d. The Policyholder/ Insured Person is required to check the applicable list of Network Hospitalization the Company's website or call center before availing the Cashless services.

e. On occurrence of an event which will lead to a Claim under this Policy, the Policyholder/ Insured Person shall :

- Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
- Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

  If the Policyholder / Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

Claim Documents

The Policyholder / Insured Person shall submit to the Company/ Network Hospital (as applicable) the following documents for or in support of the Claim:

- Duly completed and signed Claim Form, in original
- Medical Practitioner's referral letter advising Hospitalization
- Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
- Original bills, receipts and discharge card from the Hospital / Medical Practitioner
- Original bills from pharmacy / chemists
- Original pathological / diagnostic test reports and payment receipts
- Indoor case papers
- Ambulance receipt and bill
- First Information Report/ Final Police Report, if applicable
- Post mortem report, if available
- Any other document as required by the Company to assess the Claim

  When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

  Note :

  - Claim once paid under one Benefit cannot be paid again under any other Benefit.
  - All invoices / bills should be in Insured Person's name.

Proportionate Deduction

Subject to the other Terms and Conditions of this Policy The Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

- The Insured Person chooses a higher room category than the category that is eligible as per the terms and conditions of the Policy. In this case, higher room category means a room category in which the room rent expenses charged by the Hospital is more expensive than the eligible room category as per the terms and conditions of the Policy.
- The Insured Person chooses a room category in which the room rent charges are more than the applicable Sum Insured sub-limit (in percentage or Rupee terms) on the room rent as per the Policy terms and conditions.

In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in Benefit 1 (i.e. Inpatient Treatment) barring the below mentioned expense break ups:

- Cost of Pharmacy and Consumables
- Cost of Implants and Medical Devices
- Cost of Diagnostics

The proportional reduction will be done in a manner consistent with the below table :

Sr. No.	Header	Explanation
A	Actual Medical Bills Incurred	As per submitted documents
B	Covered Medical Expenses	A – Any expense not covered under Policy Benefits
C	Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
D	Covered Medical Expenses which shall be subject to Proportionate Deduction	B - cost of Pharmacy and consumables, implants and medical devices and diagnostics
E	Claim after Proportionate Deduction	D * Eligible Room Rent Limit ÷ Actual Room Rent (If Actual Room Rent is within eligibility, then no deduction to be applied [E=D])
F	Ground up claim amount	E + cost of Pharmacy and consumables, implants and medical devices and diagnostics
G	Amount after Co-pay	F - Co-payment, if any on account of age
H	Payable claim amount	G – Deductions for Policy Deductibles and Limits

Proportionate Deduction is subject to the following:

- Apart from the **Associate Medical Expenses,** no other expenses will be proportionately reduced
- If the given **Hospital** do not follow differential billing or if there are items in the claim for which the **Hospital** do not follow differential billing, the Insurer shall not be proportionately reducing the **Claims.** This shall be applied in case of admissions in Government Hospitals and the **Network Hospitals** of the **Insurer.**
- **ICU** charges shall not be proportionately reduced in all cases.

Payment Terms

This Policy covers medical treatment taken within India, and payments under this Policy shall be made in Indian Rupees within India.

Claims shall not be admissible under this Policy unless the Company/TPA has been provided with the complete documentation / information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.

The Company shall not indemnify the Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure D (List of Day Care Treatments).

The amount payable under Benefits is part of the Base Sum Insured, unless specifically provided in the Policy Schedule.

The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Period.

The claim under Benefit 2 to 7 shall be admissible provided a Claim under the Benefit 1 is admissible, unless specifically provided for.

The Company shall have no liability under the Benefits 1 to 7 in respect of an Insured Person, once the Sum Insured or the limit mentioned against the Benefit as stated against such Insured Person is exhausted.

The Company is not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if the Policyholder/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Policyholder/Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

If the Policyholder/ Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any one Illness under this Policy shall be applied as if they were under a single Claim.For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.

For the Reimbursement Claims, the Company will pay the Policyholder/Insured Person. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to any adult Insured Person in the Policy whose discharge shall be treated as full and final discharge of its liability under the Policy.

The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form.

The Company shall settle the claim within 30 days from the date of receipt of last necessary document. However, where the circumstances of a claim warrant an investigation in Company's opinion 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, Company shall settle the claim within 45 days from the date of receipt of last necessary document.

Terms & Conditions

1. **Disclosure of Information**

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

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

2. **Claim Settlment (Provision for Penal Interest)**

   a. 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.

   b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

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

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

      (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)

3. **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.

4. **Reasonable Care**

   The Policyholder/ Insured Person shall take all reasonable steps to safeguard the interests against any Illness / Injury that may give rise to a Claim.

5. **Material Change**

   The Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation / business at his own expense and the Company may adjust the scope of cover and/or premium, if necessary, accordingly.

6. **Records to be maintained**

   The Policyholder/ Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period and up to three years after the policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

7. **No constructive Notice**

   Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in possession of the Company and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

8. **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. **Multiple Policies**

   a. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

   b. Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other Policy / Policies even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this Policy.

c. If the amount to be claimed exceeds the sum insured under a single Policy, the Insured Person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

d. Where an Insured Person has policies from more than one insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy

10. 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:

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

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

c. any other act fitted to deceive; and

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

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

11. **Policy Disputes**

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

12. **Cancellation / Termination**

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

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.

No refund of premium shall be made on Policy where premium is paid in installments.

Refund % to be applied on Policy Premium

Policy Tenure - >	**1 year**
Cancellation date up to (x months) from Policy Period Start Date	**Refund**
Up to 1 month	75.0%
Up to 3 months	50.0%
Up to 6 months	25.0%
Beyond 6 Months	0%

b. 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.

13. **Limitation Period**

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 4 above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

14. **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 atleast 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 www.irdai.gov.in(Circular-IRDA/HLT/REG/CIR/003/012020, Dated-01012020)

15. **Portability**

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire Policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the Policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in Waiting Periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the www.irdai.gov.in(Circular- IRDA/HLT/REG/CIR/003/012020, dated 01012020)

16. **Renewal of Policy**

The Policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the Insured Person.

a. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

b. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding Policy periods.

c. Request for renewal along with the requisite premium shall be received by the Company before the end of the Policy Period

d. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period (as agreed at the time of issuance of the Policy) to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

f. Renewal premium may vary and shall be as per the respective master policy issued by Reliance Genereal Insurance to the group at the time of renewal.

17. **Withdrawal of Policy**

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

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

18. **Moratorium Period**

After completion of eight continuous years under the Policy no look back to 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.

19. **Premium Payment in Instalments (wherever applicable)**

If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period as (as agreed at the time of issuance of the Policy) would be given to pay the instalment premium due for the Policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the 'Waiting Periods' ' Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the Policy.

20. **Possibility of Revision of Terms of the Policy Including the Premium Rates**

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

21. **Communication**

Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder will be sent by the Company to his last known address or the address as shown in the Policy Schedule.

All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf.

Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

22. **Alterations in the Policy**

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company..

23. **Cause of Action**

Claims shall be payable under this Policy only if the cause of action arises in India.

24. **Overriding effect of Policy Schedule**

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

25. **Special Provisions**

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

26. **Withdrawal/Revision/Modification of the Product**

The Company reserves the right to withdraw, revise or modify this product /policy in the future. The revision/ modification may be in respect of Benefits, coverage, premiums, policy terms and conditions &/or exclusions.

In the event of any such withdrawal of product/terms of policy, premium the company would give a 3 months notice in advance to the policyholder. In the event of any revision or modification of the product the company will notify the policyholder in advance of such changes.

27. **Arbitration Clause**

If any dispute or difference shall arise as to the quantum to be paid under this 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 thereto 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 preferable to arbitration, as hereinbefore 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 the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

28. **Grievances**

If the Policyholder /Insured Person has a grievance that the Policyholder/Insured Person wishes the Company to redress, the Policyholde/Insured Personr may contact the Company with the details of his grievance through:

Website :	https://reliancegeneral.co.in
e-mail :	rgicl.services@relianceada.com
Telephone :	1800-3009 / For Senior Citizen 022-33834185 (Paid)
Post/Courier :	Any branch office, the correspondence address, during normal business hours
Write to us at (Correspondence Only)	Reliance General Insurance, Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001
For further details on Grievance redressal procedure please refer: https://reliancegeneral.co.in/Insurance/About-Us/Grievance-Redressal.aspx	

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 are mentioned below:

Ombudsman Office

Jurisdiction of Office Union Territory, District)	Office Details
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	**AHMEDABAD - Shri Kuldip Singh** Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka	**BENGALURU - Smt. Neerja Shah** 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, Chattisgarh	**BHOPAL - Shri Guru Saran Shrivastava** 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	**BHUBANESHWAR - Shri Suresh Chandra Panda** 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	**CHANDIGARH - Dr. Dinesh Kumar Verma** 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).	**CHENNAI - Shri M. Vasantha Krishna** 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	**DELHI - Shri Sudhir Krishna** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**GUWAHATI - Shri Kiriti .B. Saha** 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, Yanam and part of Territory of Pondicherry.	**HYDERABAD - Shri I. Suresh Babu** 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	**JAIPUR - Smt. Sandhya Baliga** 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.	**ERNAKULAM - Ms. Poonam Bodra** 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.	**KOLKATA - Shri P. K. Rath** 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, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	**LUCKNOW -Shri Justice Anil Kumar Srivastava** 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.	**MUMBAI - Shri Milind A. Kharat** 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, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	**NOIDA - Shri Chandra Shekhar Prasad** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, 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.	**PATNA - Shri N. K. Singh** 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.	**PUNE - Shri Vinay Sah** 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 available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.giccouncil.in, our website www.reliancegeneral.co.in

Contact us

For any product or service related information or assistance, here's how you can reach us.

Email us on rgicl.services@relianceada.com

Contact No.- 022-41112600

Call our Customer Service :18003009

You can also visit us at : www.reliancegeneral.co.in and locate us

Write to us at (Correspondence Only) :

Reliance General Insurance., Winway Building 2nd & 3rd Floor,11/12 Block No-4,Old no-67,South Tukoganj

Indore(M.P) -452001

Registered & Corporate Office:

Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055.

Toll Free No: 1800-3009

Website: www.reliancegeneral.co.in

Reliance General Insurance Co Ltd., IRDAI Registration No:103 Corporate Identity Number U66603MH2000PLC128300

Disclaimer:

This is only a summary of the product features. The actual benefits available are as described in the policy, and will be subject to the policy terms, conditions and exclusions. Please seek the advice of our insurance advisor if you require any further information or clarification.

Statutory warning:

Section 41 of Insurance Act 1938 as amended by Insurance Laws(Amendment) Act,2015. (Prohibition of Rebates)

1) 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 prospectuses or tables of the insurer.
2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.