RELIANCE GENERAL INSURANCE

Reliance Healthwise Policy Wording

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IRDAI Registration No. 103.
Reliance General Insurance Company Limited.
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UIN: IRDA/NL-HLT/RGI/P-H/V.I/315/13-14
Corporate Identity No.: U66603MH2000PLC128300.

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An ISO 9001:2008 Certified Company

A RELIANCE CAPITAL COMPANY

Preamble

WHEREAS the policyholder designated in the Schedule to this Reliance HealthWise Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of the contract and shall be deemed to be incorporated herein, has applied to Reliance General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the policy period as specified in the Schedule.

NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the Policy Period as specified in the policy schedule, any claim is incurred which becomes admissible and payable under this Policy then the Company shall pay for such claim, as per terms, conditions and benefits and exclusions and the limit of Sum insured as set forth in this policy.

1. Definitions

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meanings set forth:

1. "Accident(al)" is a sudden, unforeseen and involuntary event caused by external, visible & violent means.

2. "Cashless Facility" means a facility extended by the Company to the Insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent of pre-authorization approved.

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

   (a) Internal Congenital which is not in the visible and accessible parts of the body.

   (b) External Congenital which is in the visible and accessible parts of the body.

4. "Day Care Treatment"refers to medical treatment, and /or surgical procedure which is :

   I. Undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hours because of technological advancement, and

   ii. Which would have otherwise required a hospitalisation of more than 24 hours.

   Treatment normally taken on out-patient basis is not included in the scope of this definition.

5. "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:

   i. Has qualified nursing staff under its employment;

   ii. Has qualified medical practitioner(s) in charge;

   iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out ;

   iv. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

6. "Dependent Child" refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his/her independent sources of income. The age of the dependant child should be less than 21 years as on the start of Policy period.

7. "Domicilliary hospitalisation" means medical treatment for an illness/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:

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

b. The patient takes treatment at home on account of non availability of room in a hospital.

8. "Family" means the Insured, his/her lawful spouse and maximum of two dependent children below the age of 21 years.

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

   I. Has qualified nursing staff under its employment round the clock;

   ii. Has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and atleast 15 inpatient beds in all other places;

   iii. Has qualified medical practitioner(s) in charge round the clock;

   iv. Has a fully equipped operation theatre of its own where surgical procedures are carried out

   v. Maintains daily records of patients and make these accessible to the Insurance company's authorized personnel.

10. "Hospitalisation" means admission in a hospital for a minimum period of 24 consecutive hours for Inpatient care except for day care treatment , where such admission could be for a period of less than 24 consecutive hours.

11. "Illness" means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

12. "Injury" means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

13. "In-patient care" means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event..

14. "Insurer" means Company i.e., Reliance General Insurance Co. Ltd.

15. "Insured Person/Insured" means the person specifically named as such in the Schedule to this Policy, who has a permanent place of residence in India and for whom the insurance is proposed and the appropriate premium paid.

16. "Medical Advise" means any consultation or advice from a medical practitioner including the issue of any prescription or repeat prescription.

17. "Medical Expenses" means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or injury on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or Medical Practitioners in the same locality would have charged for the same medical treatment.

18. "Medical Practitioner" is a person who holds a valid registration from the Medical Council of any state or Medical Council of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license and should not be the policy holder/ insured or close family member of the policyholder/ insured.

19. "Medically necessary treatment" is any treatment, tests, medication, or stay in hospital or part of stay in a hospital which

    I. Is required for the medical management of the illness or injury suffered by the insured;

    II. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

    III. Must have been prescribed by a medical practitioner;

    IV. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

20. "Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

21. "Non- Network" any hospital, day care centre or other provider that is not part of the network.

22. "Policy" is the Company's contract of insurance with the policyholder providing cover as detailed in this Policy Terms & conditions, the Proposal Form, Policy Schedule ,Endorsements, if any and Annexures, which form part of the contract and must be read together.

23. "Policy period" means the period between the start date and the end date as specified in the Schedule to this Policy or the cancellation of this policy, whichever is earlier.

24. "Post hospitalisation medical expenses" Medical expenses incurred immediately after the Insured person is discharged from the hospital, provided that:

    (I) Such medical expenses are incurred for the same condition for which the Insured Person's hospitalisation was required, and

    (ii) The in-patient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.

25. "Pre-existing Disease" means any condition, illness or injury or related condition(s) for which the Insured/Insured person had signs or symptoms and/or were diagnosed and/or received medical advice/treatment, within 48 months prior to the first policy under which the Insured Person was covered with us.

26. "Pre-hospitalisation medical expenses "

    Medical expenses incurred immediately before the Insured person is hospitalized, provided that:

    (i) Such medical expenses are incurred for the same condition for which he Insured Person's hospitalisation was required, and

    (ii) The in-patient hospitalisation claims for such hospitalisation is admissible by the Insurance Company..

27. "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.

28. "Reasonable & 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.

29. "Schedule"means the document attached name so and to and the forming part of this Policy mentioning the details of the Insured/ Insured Person/s, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

30. "Sum Insured"means the sum as specified in the schedule, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period.

31. "Surgery"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.

32. "Unproven/ Experimental treatment "is treatment including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

2. Scope Of Cover

The company undertakes, subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon that if during the Policy Period, the Insured/Insured Person shall contract any illness or injury and if such illness or injury shall upon the written medical advise of a Medical Practitioner require any such Insured/Insured Person within the policy period, to incur hospitalisation at any Hospital, day care treatment at any day care centre or domiciliary hospitalisation in India, for the medically necessary treatment of the Insured/Insured Person, under any of the Basic cover as mentioned hereunder, then the Company will indemnify the Insured/Insured Person, for the amount of such medical expenses, which should be reasonable & customary charges,

as would fall under the different heads mentioned below and are incurred by or on behalf of such Insured/Insured Person for

- Hospital (Room & Boarding and Operation theatre) charges
- Fees of Surgeon, Anesthetist, Nurse, Specialists etc.,
- Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
- Pre hospitalisation medical expenses and post hospitalisation medical expenses
- Ambulance charges
- Medical expenses on day care treatment
- Medical expenses on Domiciliary hospitalisation

in manner, for the period and to the extent of the Sum Insured as specified in this Policy. The company's total liability in aggregate for all claims paid under the policy shall not exceed the Sum Insured.

Benefits

Basic Cover

1. Hospitalisation

   This benefit covers payment of medical expenses incurred for medically necessary treatment taken during for Hospitalization of the Insured/Insured Person for illness/injury contracted or sustained by the Insured/Insured Person during the Policy period in a Hospital, , which, includes, Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anesthetist, Nurses, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs.

2. Domiciliary Hospitalisation

   This benefit covers payment of medical expenses incurred for medically necessary treatment pertaining to domiciliary hospitalisation of the insured person subject to the following

   i. The period of domiciliary hospitalization should exceed three consecutive days for illness or injury, which in the normal course, would require inpatient care and medically necessary treatment at a Hospital/, but is actually taken whilst the Insured / Insured Person is confined at home in India,

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

      a. Pre hospitalisation medical expenses and Post Hospitalisation medical

      b. 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.

   Domiciliary hospitalisation benefits also cover medical expenses on qualified nurses engaged on the written medical advise of the attending medical practitioner. The same shall be subject to the Sum Insured as specified in the Schedule.

3. Day Care Treatment

   This benefit covers payment of medical expenses incurred for medically necessary treatment pertaining to Day care treatment of the Insured/Insured person.

   Treatment normally taken on out-patient basis is not included in the scope of this definition.

   The list of covered Day Care Treatment/Surgical Procedure is appended as per Annexure 1

4. Pre-Hospitalisation medical expenses

   This benefit covers relevant Pre-hospitalization medical expenses incurred by the Insured/ Insured Person during a period , as specified in Schedule, prior to hospitalization

5. Post-Hospitalisation medical expenses

   This benefit covers relevant Post-hospitalization medical expenses incurred by the Insured/ Insured Person during a period , as specified in Schedule, post hospitalization

6. Pre-Existing Disease

   This Policy covers relevant medical expenses of the respective insured/insured person(s) incurred from the 3rd year/5th year of the policy after 2 or 4 continuous renewals under this Policy , depending upon the plan chosen and as specified in the Schedule , with the Company, for medically necessary treatment of preexisting disease during Hospitalization in a Hospital .

7. Critical Illness

   The Policy provides as applicable to the relevant plan specified in the schedule to the policy, for an additional amount equivalent to the Sum Insured opted under Hospitalisation, towards treatment of listed critical illnesses. For the purposes of this Policy and the determination of the Company's liability under it, the Insured Event in relation to the Insured, shall mean any illness, medical event or surgical procedure as specifically defined below whose signs or symptoms first commence

more than 30 days after the commencement of Policy Period and shall only include those defined hereunder. If these illness, medical event or surgical procedure are found to be pre-existing at the time of taking the Policy then the relevant waiting period as defined under pre-existing disease shall apply.

Cancer of specified severity

I. A malignant tumour characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded :

(i) Tumors showing the malignant changes of carcinoma in situ & tumors which are histologically described as pre-malignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CI N-1, CI N-2 & CIN-3.

(ii) Any skin cancer other than invasive malignant melanoma

(iii) All tumors of the prostrate unless histologically classified as having a Gleason score greater than 6 or having progressed to atleast clinical TNM classification T2N0M0

(iv) Papilary Micro-carcinoma of the thyroid less than 1 cm in diameter

(v) Chronic lymphocyctic leukaemia less than RAI stage 3

(vi) Microcarcinoma of the bladder

(vii) All tumors in the presence of HIV infection

Open chest Coronary Artery Bypass Graft

I. The actual undergoing of open heart chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

- Angioplasty and/or any other intra-arterial procedures
- Any key-hole or laser surgery

First Heart Attack – Of Specified Severity

I. The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

(I) A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for eg. Typical chest pain)

(ii) New characteristic electrocardiogram changes

(iii) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers

II. The following are excluded:

(i) Non ST-segment elevation myocardial infarction (NSTEMI) with elevation of Tropon in I or T

(ii) Other acute Coronary Syndromes

(iii). Any type of angina pectoris

Kidney Failure Requiring Regular Dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

Multiple Sclerosis With Persisting Symptoms

I. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

(i). Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis

(ii). There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of atleast 6 months, and

(iii). Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

(iv) Other causes of neurological damage such as SLE and HIV are excluded.

Major Organ/ Bone Marrow Transplant

I. The actual undergoing of a transplant of:

(i). One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

(ii) Human bone marrow using haematopoietic stem cell.The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

(i) Other stem-cell transplants

(ii) Where only islets of langerhans are transplanted

Stroke Resulting in Permanent Symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical finding in CT scan or MRI of the brain.Evidence of permanent neurological deficit lasting at least 3 months has to be produced.

II. The following are excluded:

(i) Transient ischemic attacks (TIA)

(ii) Traumatic injury of the brain

(iii) Vascular disease affecting only the eye or optic nerve vestibular functions

Aorta graft surgery

The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon. The diagnosis to be evidenced by any two of the following:

- Computerised tomography (CT) scan
- Magnetic resonance imaging (MRI) scan
- Echocardiography (an ultrasound of the heart)
- Abdominal ultrasound (for associated abdominal aneursysms) - Angiography (an x-ray of the blood vessels)

Permanent Paralysis of Limbs

I. Total and irrecoverable loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

Primary Pulmonary Arterial Hypertension

The first occurrence of narrowing of the arteries of the lungs causing it harder for the right side of the heart to circulate the blood to the lungs which is evidenced by shortness of breath, dizziness, fainting etc., all of which are exacerbated by exertion which is evidenced by the following:

- Physical examinations
- Pulmonary function test
- Arterial Blood Gas Levels
- Right-sided Cardiac Catheterisation.

Primary Pulmonary Hypertension caused due to the following are excluded:

- A genetic defect
- Intake of diet medications
- As a consequence of HIV infection

This additional Sum Insured mentioned above is exclusive and specific for the medically necessary treatment of the diagnosed critical illness as defined herein above undertaken in a Hospital under in-patient care and will not be available for other treatments/ hospitalization. For all other treatments/hospitalization benefits the limits shall be Sum Insured as specified in the Schedule. Once a claim is accepted and paid for an Insured Person under this section of the policy, coverage under this section will not be available for that particular Insured Person for all future renewals of the Policy.

8. Donor Expenses

This benefit covers the medical expenses towards hospitalization of donor in case of major organ transplant subject to the overall limit of the Sum Insured and Plan opted as specified in the Schedule.

9. Cost of health check up

Reimbursement of the cost of medical check-up up to 1% of average Sum Insured for Individual Policies and up to 1.25% for Floater covers, once at the end of a block of four consecutive years provided there are no claims reported under the Policies by any member, during this block. The limit specified for floater cover is the overall limit available for all members.

Value Added Covers

Benefits under this Section are Value added services payable up to the limit of the Sum Insured as specified in the Schedule to this Policy and shall not exceed the overall limit of Sum Insured under Hospitalisation opted by the Policyholder / Insured during the policy period. Benefits under each value added cover shall be available separately to each Insured/Insured Person and available per hospitalisation.

A valid claim should have been admitted under the basic cover of the Policy, for admission of liability under each of the value added covers.

1. Daily Hospitalisation Allowance

   This benefit provides for payment to the Insured/ Insured Person of Daily Hospital Allowance up to limits specified in the Schedule in case of hospitalisation exceeding 3 days.

2. Nursing Allowance

   This benefit provides for payment to Insured/ Insured Person of an allowance up to the limit as specified in the schedule for services of a qualified nurse at the Insured / Insured Person's residence or the Hospital on the medical advise which is confirmed as medically necessary by the attending Medical practitioner and the same relate directly to a illness / injury for which the Insured/ Insured Person has been hospitalized.

3. Ambulance Charges

   This benefit provides the payment to the Insured/ Insured Person of reasonable & customary charges up to the limit as specified in the schedule incurred for his / her transportation by ambulance to the Hospital for medically necessary treatment of the illness/ injury necessitating his/ her admission to Hospital.

4. Recovery Benefit

   This Policy provides for payment to the Insured/ Insured Person of the sum as specified in the Schedule in the event of his/ her hospitalisation for a illness/ injury exceeds a period of 10 days or more. This benefit is applicable, separately, to all the members of the floater irrespective of the number of occurrences during the Policy period subject to overall limit of the Sum Insured.

5. Expenses on Accompanying Person

   This benefit provides for payment to Insured / Insured Person of expenses incurred by the accompanying person at the Hospital during medically necessary treatment of Insured / Insured Person for an illness, injury necessitating his / her hospitalisation, as per limits specified in the schedule.

3. Policy Exclusions

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. All pre-existing diseases, until 24/48 months of continuous cover for the respective Insured Person has elapsed as per the plan opted, since inception of the first Policy with us.

2. Any disease contracted by the Insured and treatment undertaken during the first 30 days from the commencement date of the Policy except in case of accidental injuries. This exclusion doesn't apply for Insured/Insured Person having any health insurance policy in India atleast for 1 year prior to taking this policy as well as for subsequent renewals with the Company without a break.

3. Expenses incurred on treatment of following diseases, illness, injury within the first year from the inception of this Policy:

   Cataract

   Benign Prostatic Hypertrophy

   Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy

   Dilation and curettage

   Hernia, hydrocele, congenital internal anomaly/diseases, fistula in anus, sinusitis

   Skin and all internal tumors/cysts/nodules/polyps of any kind including breast lumps unless malignant/adenoids and hemorrhoids

   Dialysis required for chronic renal failure

   Gastric and Duodenal ulcers

   This exclusion doesn't apply for Insured/Insured Person having any health insurance policy in India atleast for 1 year prior to taking this Policy as well as for subsequent renewals with the Company without a break.

4. Circumcision unless necessary for treatment of a illness or injury not excluded hereunder, or, as may be necessitated due to an accident.

5. Dental treatment or surgery of any kind unless requiring hospitalisation with minimum of 24 hours stay and treatment.

6. Birth control procedures, hormone replacement therapy, treatment arising from or traceable to pregnancy, childbirth including caesarean section and voluntary medical termination of pregnancy during the first 12 weeks from the date of conception. However, this exclusion will not apply to Ectopic Pregnancy proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner.

7. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for correction of refractive error, contact lenses or hearing aids, vaccinations, issue of medical certificates and examinations as to suitability for employment or travel.

8. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases/ illness/injury caused by and/or related to HIV.

9. Vitamins and tonics unless forming part of treatment for disease, illness or injury as certified by the Medical Practitioner,

10. Treatment of obesity, general debility, convalescence, run down condition or rest cure, congenital external disease/ illness or defects or anomalies, sterility, venereal disease or intentional self-injury and use of intoxicating drugs/alcohol.

11. Sex change or treatment, which results from, or is in any way related to, sex change.

12. Vaccination and inoculation of any kind.

13. Treatment by a family member and self-medication or any treatment that is not scientifically recognised.

14. Any criminal act.

15. Illness / injury, directly or indirectly, caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion.

16. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.

17. Any medical, physical or mental condition or treatment or service, which is specifically excluded under this Policy.

18. Alcohol or drug abuse.

19. Prostheses, corrective devices and medical appliances, which are not, required intraoperatively or for the illness/ injury for which the Insured/Insured Person was hospitalised.

20. Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.

21. Treatment of mental illness, stress, psychiatric or psychological disorders.

22. Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to accident or as a part of any illness / injury.

23. Any loss, directly or indirectly, due to contamination due to an act of terrorism, regardless of any contributory causes (if the Company alleges that by reason of this exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured /Insured Person).

24. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

25. illness, injury, directly or indirectly, caused by or contributed to by nuclear weapons/materials or radioactive contamination.

26. Experimental and unproven treatment.

27. Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a Hospital/or at home under domiciliary hospitalisation as defined.

28. Costs of donor screening or treatment, unless specifically covered and specified in the Schedule to this Policy.

29. Naturopathy treatment, any other form of Non Allopathic treatment or local medication.

30. Any treatment received outside India.

31. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

32. Insured/Insured Person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing,

abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports.

33. Insured/Insured Person whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or air charter Company.

4. Claims 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:

4.1 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

4.2 Claims Procedure

4.2.1 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:

a. 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.

b. The Company 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 will confirm such Cashless authorization / rejection in writing or by other means.

c. 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.

d. The 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.

e. 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.

f. 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.

g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 4.4 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.

4.2.2 Re-imbursement : In case of any Claim under the Benefits, where cashless facility is not availed, the list of documents as mentioned in Clause 4.4 shall be provided by the Policyholder/Insured Person, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

4.3 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 in accordance with Clause 4 of this Policy.

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.

4.4 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.

4.5 Payment Terms

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

4.5.2. Claims shall not be admissible under this Policy unless the Company 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.

4.5.3. 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 1 (List of Day Care Treatments).

4.5.4. 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.

4.5.5. For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.

4.5.6. For the Reimbursement Claims, the Company will pay the Policyholder. 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.

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

5. Terms And Conditions

1. Floater Policy

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy period, upto the limit of Sum Insured specified in the Schedule to this Policy Where the Policy is issued on Floater basis, the Policy can cover only the Insured, his/her lawful spouse and 2 dependant children who are upto the age of 21 years. A Floater Policy

cannot cover any other person apart from the above category of persons.

2. Duty of disclosure

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

In the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or device being used by the Policyholder/ Insured Person or any one acting on his/ their behalf to obtain a benefit under this Policy, the Company may cancel this Policy at its sole discretion and the premium paid shall be forfeited in its favor.

3. Observance of Terms and Conditions

The due observance and fulfillment of the Policy Terms & Conditions and Endorsements of this Policy in so far as they relate to anything to be done or complied with by the Policyholder / Insured Person, shall be a condition precedent to any of the Company's liability to make any payment under this 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

Payment made by the Company to the Policyholder/ adult Insured Person or the Nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

9. Subrogation

Subrogation shall mean the right of the Company to

assume the rights of the Insured Person/Policyholder to recover expenses paid out under the Policy that may be recovered from any other source.

The Policyholder/ Insured Person shall at his own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which the Company is/or would become entitled upon the Company paying for a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after its payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at his own expense provide the Company with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and any costs and expenses incurred by the Company of effecting a recovery, where after the Company shall pay any balance remaining to the Policyholder. This clause shall not apply to any Benefit offered on fixed benefit basis.

10. Contribution

Contribution is essentially the right of the Company to call upon other Insurers liable to the same Insured to share the costs of an indemnity claim on a rateable proportion of Sum Insured.

If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company shall not be liable to pay or contribute more than its ratable proportion of any Claim.

This clause shall not apply to any Benefit offered on fixed benefit basis.

11. Fraudulent Claims

If a Claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a Claim, or if any fraudulent means or devices are used by the Policyholder / Insured Person or anyone acting on his/ their behalf to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to the Company by the Policyholder / all Insured Persons who shall be jointly liable for such repayment.

12. 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.

13. Free Look Period

The Policyholder would be given a period of 15 days (Free Look Period) from the date of receipt of the Policy to review the entire Policy. Where the Policyholder disagrees to any of those terms or conditions, the Policyholder has the option to return the Policy stating the reasons for his objection and the Policyholder shall be entitled to a refund of the premium paid, provided no Claim has been incurred under this Policy, subject only to a deduction of the expenses incurred by the Company on medical

examination and the stamp duty charges. In cases where the risk has already commenced when the option of returning this Policy is exercised, within the free look period, by the Policyholder, the refund of the premium paid will also be subject to a deduction for proportionate risk premium for the period on cover. Where only part of the risk (e.g. only accidental hospitalization risk) has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period.

This clause shall not be applicable on renewal of this Policy and Portability cases.

14. Renewal Notice

a. This Policy will automatically terminate at the end of the Policy Period. All renewal applications should reach the Company before the end of the Policy Period.

b. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein prior mentioned and that nothing is known to the Policyholder/ Insured Person(s) that may result in enhancing the Company's risk.

c. This Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of this Policy and in any case not later than the expiry of the Grace Period.

Grace period refers to a period of 30 days immediately following the premium due date during which a payment can be made to renew this Policy without loss of continuity benefits such as Waiting Periods and coverage of Pre-existing Disease. Coverage is not available for the period for which Premium is not received by the Company and the Company shall not be liable for any Claims incurred during such period.

d. Ordinarily renewals will not be refused by the Company except on ground of fraud, moral hazard or misrepresentation.

e. Renewal premium can vary subject to prior regulatory approval.

f. Renewal Discount equivalent to 5%, on cumulative basis, of renewal premium for each continuous claim free year will offered as No claim Bonus subject to maximum up to 20%, where the Policy which is claim free & is renewed without a break. In case of a claim all discount shall be forfeited at renewal.

15. Cancellation / Termination

- The Company may at any time, cancel this Policy on grounds as specified in Clause 5.2, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address.

- The Policyholder may also give 15days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy by the Policyholder/ Insured Person.

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%

In case of demise of the Policyholder, this Policy shall continue till the end of Policy Period or next premium due whichever is earlier. In case the other Insured Person want to continue with the same Policy, the Company would renew the Policy providing all continuity benefits, subject to there being atleast one adult member as an Insured Person who would then become the Policyholder. This will be subject to the Company receiving a written application in this regard before Policy Period End Date. For long term contracts, the Company shall, from the date of receipt of notice cancel the Policy after retaining proportionate premium for the covered period and 30% of the premium relating to the balance premium for the unexpired period.

16. 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.

17. 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.

18. 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.

19. Cause of Action

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

20. 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.

21. Electronic Transactions

The Policyholder/ Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company'sother products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

22. 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.

23. Portability

Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from one Insurer to another.

If the Policyholder/ Insured Person renew with the Company, without break, any similar individual health insurance policy from any insurance company registered with IRDA, then the Waiting Periods as defined in exclusions shall be reduced by the number of years of continuous coverage under such health insurance policy with the previous insurer(s).

The Company's total liability for payment of all claims in aggregate, incurred during the Policy Period, on account of Portability shall not exceed Sum Insured Limit for Portability with a capping upto Applicable Sub-limit for Portability for each Insured Person as defined in Policy Schedule

The Waiting Periods as defined in policy exclusion 1,2, & 3 and shall be applicable individually for each Insured Person and Claims shall be assessed accordingly.

24. 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, coverages, premiums, policy terms and conditions &/or exclusions.

In the event of any such withdrawal of product the company will notify in advance to the policyholder providing him the option to port to the specified existing health products of the company with continuity benefit.

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

25. Payment of Interest

In case of delay of seven days or more in payment of claim after the acceptance by the insured, the Company will pay interest on the claim amount at a rate which is 2% above the bank rate for the period of delay

26. Pre- policy Health check-up

The prospect whose medical test is conducted and for whom the company grants an insurance cover under this policy and whose name specifically appears as Insured person in the schedule, the company shall reimburse 50% of the cost of such medicals conducted at the Company's designated centre.

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 referable 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 has a grievance that the Policyholder wishes the Company to redress, the Policyholder 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
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 the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned below:

Address of the Ombudsman Offices
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@gbic.co.in
BHOPAL 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@gbic.co.in
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in
CHENNAI 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@gbic.co.in
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
HYDERABAD 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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in

Address of the Ombudsman Offices
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in
ERNAKULAM 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@gbic.co.in
KOLKATA 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@gbic.co.in
LUCKNOW 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@gbic.co.in
MUMBAI 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@gbic.co.in
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@gbic.co.in
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna-800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@gbic.co.in

The details of Insurance Ombudsman are available on IRDA website: www.irda.gov.in, on the website of General Insurance Council: www.gbic.co.in, the Company's website www.reliancegeneral.co.in or from any of the Company's offices.

Address and contact number of Governing Body of Insurance Council –

(Monitoring Body for Offices of Insurance Ombudsman)

3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz(West), Mumbai – 400054, Tel: 022 - 26106889 / 671

Email id: inscoun@gbic.co.in