Universal Protection Plus

Policy wordings

1) **Preamble**

The insurance cover provided under this Policy to the Insured / Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium and (c) Disclosure to Information Norm (including by way of the Proposal or Information Summary Sheet) and (d) Schedule of Benefits.

2) **General Definitions**

- **"Accident"** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
- **"Any one illness"** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
- **"AYUSH Day Care Centre"** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
  i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
  ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
  iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
- **"An AYUSH Hospital"** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
  a. Central or State Government AYUSH Hospital; or
  b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
  c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of

any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
i.Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

- **"Cashless facility"** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured / Insured Person in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
- **"Condition Precedent"** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
- **"Congenital Anomaly"** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
  a) Internal Congenital Anomaly
  Congenital anomaly which is not in the visible and accessible parts of the body.
  b) External Congenital Anomaly
  Congenital anomaly which is in the visible and accessible parts of the body
- **"Co-payment"** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
- **"Cumulative Bonus"** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

- **"Day care centre"** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under –
  i) has qualified nursing staff under its employment;
  ii) has qualified medical practitioner/s in charge;

iii) has 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.

- **"Day care treatment"** means medical treatment, and/or surgical procedure which is:
  i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
  ii. which would have otherwise required hospitalization of more than 24 hours.
  Treatment normally taken on an out-patient basis is not included in the scope of this definition.
- **"Deductible"** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
- **"Dental treatment"** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
- **"Disclosure to information norm"** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

- **"Domiciliary hospitalization"** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
  i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
  ii) the patient takes treatment at home on account of non-availability of room in a hospital.
- **"Emergency care"** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the Insured /Insured Person's health.
- **"Grace period"** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
- **"Hospital"** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and 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 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii) has qualified medical practitioner(s) in charge round the clock;
iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

- **"Hospitalization"** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
- **"Illness"** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
  (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
  (b) (Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
  1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
  2. it needs ongoing or long-term control or relief of symptoms
  3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
  4. it continues indefinitely
  5. it recurs or is likely to recur
- **"Immediate dependent(s)"** are defined as the spouse, children and parents of the insured member. The Sum Insured for immediate dependent would be less than or equal to the Sum Insured of the insured member
- **"Injury"** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
- **"Inpatient care"** means treatment for which the Insured / Insured Person has to stay in a hospital for more than 24 hours for a covered event.
- **"Intensive care unit"** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
- **"ICU (Intensive Care Unit) Charges"** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
- **"Maternity expenses"** means;
  a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
  b) expenses towards lawful medical termination of pregnancy during the policy period.
- **"Medical Advice"** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- **"Medical Expenses"** means those expenses that an Insured / Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured / Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
- **"Medical Practitioner"** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby

entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
The registered practitioner should not be the insured or close member of the family of Insured Person / Insured.

- **"Medically necessary treatment"** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
  i) is required for the medical management of the illness or injury suffered by the Insured / Insured Person;
  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.
- "**Migration"** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
- **"Network Provider"** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an Insured / Insured Person by a cashless facility."
- **"Newborn baby"** means baby born during the Policy Period and is aged upto 90 days. .
- **"Notification of claim"** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address/ telephone number to which it should be notified.
- **"Non-Network"** means any hospital, day care centre or other provider that is not part of the network.
- **"OPD treatment"** means the one in which the Insured / Insured Person visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based

on the advice of a Medical Practitioner. The Insured / Insured Person is not admitted as a day care or in-patient.

- **“Pre-existing Disease”** means any condition, ailment, injury or disease:
  a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or reinstatement or
  b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.
- **“Pre-hospitalization Medical Expenses”** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person’s Hospitalization was required, and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

- **“Post-hospitalization Medical Expenses”** means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the Insured Person’s hospitalization required, and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

- **“Annexure”** means a document attached and marked as Annexure to this Policy.
- **“Bank”** means a banking company which transacts the business of banking in India or abroad.
- **“Break in policy”** - occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.
- **“Cancellation (of Policy)”** means the terms on which the policy contract can be terminated either by the Company (insurer) or the Insured by giving sufficient notice to other which is not lower than a period of fifteen days. The terms of cancellation may differ from insurer to insurer.
- **“Certificate of Insurance”** means the document issued by the Company detailing the effective date, Insured Person(s), benefits, sums insured, Deductible, premium and all special condition(s) and or endorsement(s).
- **“Civil War”** means armed opposition, whether declared or not, between two or more parties belonging to the same country where the opposing parties are of different ethnic, religious or ideological groups. Included in the definition: armed rebellion, revolution, sedition, insurrection, Coup d' Etat, and the consequences of Martial law.
- “Company” means ICICI Lombard General Insurance Company Lim.ited
- **“Financial Institution”** shall have the same meaning assigned to the term under section 45 I of the Reserve Bank of India Act, 1934 and shall include a Non Banking Financial Company as defined under section 45 I of the Reserve Bank of India Act, 1934. Additionally Financial Institution would include any institution that is authorised by the Reserve Bank of India to lend money.
- **“Insured/You/Your”** means the primary Insured mentioned in the Policy Schedule/Certificate of Insurance
- **“Insured Person”** means the Person covered as a part of the group policy as detailed in the Certificate of Insurance.
- **"Information Summary Sheet"** means the record and confirmation of information provided to Company or Company’s representatives over the telephone for the purposes of applying for this Policy.
- **"Loan"** means the sum of money lent at interest or otherwise to the Insured by any

Bank/Financial Institution as identified by the Loan Account Number

- **“Master Policy”** means An Insurance contract specifies matters such as the eligibility criteria for insurance coverage. This ensures group managers to make objective decisions about who to enroll in the policy.
- **“Policy”** means this document of Policy describing the terms and conditions of this contract of insurance including the Company’s covering letter to the Insured, if any, the Schedule attached to and forming part of this Policy, the Insured’s Proposal Form and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.
- **“Policy period”** means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier. Policy period is inclusive of both the inception date and expiry date. Policy period in case of Insured Person will be as specified in the Certificate of Insurance
- **“Policy holder”** means the entity named in the Policy Schedule who is responsible for payment of premiums.
- **“Policy Period End Date”** means the date on which the Policy expires, as specified in the Policy Schedule. Policy Period End Date in case of Insured Person will be as specified in the Certificate of Insurance
- **“Policy Period Start Date”** means the date on which the Policy commences, as specified in the Policy Schedule. Policy Period Start Date in case of Insured Person will be as specified in the Certificate of Insurance.
- **“Principal Outstanding”** means the principal amount of the Loan outstanding as on the date of occurrence of Insured Event less the portion of principal component included in the EMIs payable but not paid from the date of the loan agreement till the date of the Insured Event/s.
- **“Proposal”** means the application form that the Insured signs for this insurance and which contains information provided by the Insured regarding the risk or which is given to the Us on behalf of the Insured and which shall form part of the Policy.

- **“Public Authority”** means any governmental, quasi-governmental organization or any statutory body or duly authorized organization with the power to enforce laws, exact obedience, and command, determine or judge.

  “Reducing Balance Sum Insured” means the sum as specified in the Schedule to this Policy against the name of Insured Person or the principle amount of the loan outstanding as on the date of Insured event whichever is less and the sum represents the Company's maximum liability for any or all claims on aggregate basis for Critical illness, Personal Accident & Involuntary Loss of Job during the Policy period.

- **“Schedule”** means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period, special terms applicable and the limits to which benefits under the Policy are subject to.
- **"Schedule of Benefits"** means the Product Benefits Table issued by the Company and accompanying this Policy and annexures thereto.
- **“Sum Insured”** means the sum as specified in the Policy Schedule / Certificate of Insurance to this Policy against the name of Insured Person, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy period for the respective benefit(s) against which the sum is mentioned in the Schedule to this Policy.
- **“Terrorism/ Terrorist Incident”** means an act or series of acts, including but not limited to the use of force of violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), or unlawful associations, recognized under Unlawful Activities(Prevention) Amendment Act, 2008 or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activity in the nation for the time being in force, committed for political, religious, ideological or similar purpose including the intention to influence any government and/or to put the public, or any section of the public in fear for such purpose.

- **"War"** means war, whether declared or not or any warlike activities, including use of the military force by any sovereign nations to achieve economic, geographic, nationalistic, political racial religious or other ends.

4. General Exclusions

A Exclusion Name: 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 us.

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

c) If the Insured 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 us.

B. Exclusion Name: 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 24 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 portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f) List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis
7. Stones in the urinary and biliary systems

8. Surgery on ears/tonsils/adenoids/ paranasal sinuses
9. Cataracts,
10. Hernia of all types and Hydrocele
11. Fistulae in anus
12. Fissure in anus
13. Fibromyoma
14. Hysterectomy
15. Surgery for any skin ailment
16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy
17. Dialysis required for Chronic Renal Failure.
18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.
19. Dilatation and curettage
20. Varicose Veins and Varicose Ulcers
21. Non Infective Arthritis and other form arthritis
22) Gout and Rheumatism
23) Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

C. 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.

D. 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.

E. Exclusion Name: Rest Cure, rehabilitation and respite care- Code- Excl05

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

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

F. Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

G. 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.

H. 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.

I. 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.

J. 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.

K. Excluded providers: Code- Excl 11

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.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and

consequences thereof. **Code- Excl 12**

M. 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.**Code- Excl13**

N. 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. **Code- Excl14**

O. Refractive Error: Code- Excl15
Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Exel 16
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.

Q. Sterility and Infertility: Code- Excl 17
Expenses related to sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv)Reversal of sterilization

R. 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.

S. 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.

T. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/

fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

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

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

U. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

V. Treatment taken outside the geographical limits of India

W. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule(based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

5. General Conditions (Applicable to All Sections)

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

b. Premium Payment: Premium to be paid for the Policy Period before Policy Commencement date as opted by Insured / Policyholder in the enrolment form / proposal form. If Insured Person/Policyholder has opted to pay premium in full (lumpsum) upfront then the entire premium for the Policy Period shall be paid before the policy commencement date.

c. Premium Payment in instalments

If the Insured has opted for Payment of Premium on an installment 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 of 15 days 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 Installment 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 installments 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.

2. There is no grace period for first instalment.

3. If remaining instalment premium is not paid within the grace period then policy shall cease to exist at midnight of such due date and cannot be revived

4. If Insured / Insured Person makes a claim under the policy (applicable for both annual and multi-year policy), Insured / Insured Person will be liable to pay the premium for the entire policy period in full before the claim is paid or Insured / Insured Person authorizes us to deduct from claim amount due any outstanding premiums due.

5. If any claim occurs prior to policy ceases to exist and is reported after policy ceases to exist on grounds of non-payment of the installment premium, as provided in iii) above, then such claim shall be admitted subject to policy terms & conditions and payment of the balance unpaid premium. However, policy shall not be revived and stand terminated as in iii) above.

6. In case of Death of Insured / Insured person, the Nominee/Legal Heir shall have the option to pay the balance premium in full or authorize us to deduct the balance outstanding premium from claim.

7. Effective Date

For Master Policy

The Policy will start on the date specified on the Policy Schedule provided it is countersigned by the Company and the total premium has been paid and realized by the Company. However the coverage for the Insured / Insured Person under this Policy begins on the latest of:

(1) the Policy Effective date and hour as stated above; or
(2) the date on which the premium is paid when due.

For Certificate of Insurance

The Certificate of Insurance takes effect on the Policy Period Start Date stated in the Certificate of Insurance. After taking effect each Certificate of Insurance may continue in effect after the renewal date subject to “Renewal” Section set forth herein. All subsequent Insured Periods shall begin and end at midnight.

d. Duty of Disclosure:

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 policy holder / Insured / Insured Person.

"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

e. Fraud:

If any claim made by the Insured / 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 / 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 / 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 / Insured Person does not believe to be true;
b) the active concealment of a fact by the Insured / 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 / 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.

f. Free Look Period:

Insured has a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If the Insured has any objections to any of the terms and conditions, he / she have the option of cancelling the Policy stating the reasons for cancellation and in such a case, the Company will refund premium subject to:

1. A deduction of the expenses incurred on any medical check-up, stamp duty charges, if the risk has not commenced.
2. A deduction of the expenses incurred on any medical check-up, stamp duty charges and proportionate risk premium for period on cover, if the risk has commenced.
3. A deduction of such proportionate risk premium commensurating with the risk covered during such period, where only a part of risk has commenced.

The Policy can be cancelled only if Insured has not made any claims under the Policy. Free look provision is not applicable and/or available at the time of renewal of the Policy.

g. Cancellation/Termination:

Master Policy

The Company may cancel this Policy, by giving 15 days' notice in writing by registered post acknowledgment due to the Insured at his / their last known address. The Company shall exercise its right to cancel only on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the Policyholder in implementing the terms and conditions of this Policy, in which case the Policy shall be void and all premium paid thereon shall be forfeited to the Company as per the disclosure to information norm: The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of notice, cancel the Policy and retain the premium for the period this Policy has been in force as opted for by the Policyholder and mentioned in the Renewal &

Refund section of this Policy. Provided that, refund on cancellation of Policy by the Insured shall be made only if no claim has/is occurred/reported up to the date of cancellation of this Policy.

Certificate of Insurance

Each Certificate of Insurance will terminate on the earliest of the following dates:

1. The date the master Policy is terminated,

2. The date Insured or Company cancel the Certificate of Insurance.

The Company may cancel this Certificate of Insurance, by giving 15 days' notice in writing by registered post acknowledgment due to the Insured at his / their last known address. The Company shall exercise its right to cancel only on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the Insured / Insured Person in implementing the terms and conditions of the Policy, in which case the Certificate of Insurance shall be void and all premium paid thereon shall be forfeited to the Company as per the disclosure to information norm. The Insured may also give 15 days' notice in writing, to the Company, for the cancellation of this Certificate of Insurance, in which case the Company shall from the date of receipt of notice, cancel the Certificate of Insurance and retain the premium for the period this Certificate of Insurance has been in force, as opted for by the Policyholder and mentioned in the Renewal & Refund section of this Policy. Provided that, refund on cancellation of Certificate of Insurance by the Insured shall be made only if no claim has/is occurred/reported up to the date of cancellation of this Certificate of Insurance

6. REDRESSAL OF GRIEVANCE:

The Company is committed to extend the best possible services to its customers/Insured / Insured Person. However, If Policyholder/ Insured / Insured Person have a grievance that he/she wish us to redress, he/she may contact the Company with the details of their grievance via:

•Website: www.bharti-axagi.co.in
•Email: customersupportba@icicilombard.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office Policyholder/Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.

Escalation Level 1

In case the Policyholder/Insured/Insured Person has not got his/her grievances redressed through one of the above methods (After 5 days of intimating of your complaint), Policyholder/ Insured/ Insured Person may contact the National Grievance Redressal Officer at :
Write to: ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025
•Phone: 18001032292
Email: https://www.bharti-axagi.co.in/grievance-redressal/procedure

Escalation Level 2

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed through any of the above methods (After 5 days of approaching National Grievance Redressal Officer), Policyholder/ Insured/ Insured Person may contact the Chief Grievance Redressal Officer at:
Email : https://www.bharti-axagi.co.in/grievance-redressal/procedure

Escalation Level 3

In case the Policyholder/ Insured/Insured Person has not got his/her grievances redressed by

the Company within 14 days, or, If Policyholder/ Insured/Insured Person is not satisfied with Company's redressal of the grievance through one of the above methods, Policyholder/ Insured/ Insured Person may approach the nearest Insurance Ombudsman for resolution of their grievance. The contact details of Ombudsman offices are mentioned below. Policy holder may also obtain copy of IRDAI circular Ref No. F. No. IRDAI/Reg/8/145/2017, notification on Insurance Regulatory and Development Authority (Protection of Policy holders' interests) Regulations, 2017 from any of our offices.

Grievance of Senior Citizens:

In respect of Senior Citizens, the Company has established a separate channel to address the grievances. Any concerns may be directly addressed to the Senior Citizen's channel of the Company for faster attention or speedy disposal of grievance, if any.
•Website: www.bharti-axagi.co.in
•Email: customersupportba@icicilombard.com
•Phone: 18001032292
•Courier: Any of the Company's Branch office or corporate office
Insured/ Insured Person may also approach the grievance cell at any of the Company's branches with the details of the grievance during working hours from Monday to Friday.
Grievance Redressal Cell of the Consumer Affairs Department of IRDAI
The insurance company should resolve the complaint within a reasonable time. In case if it is not resolved within 15 days or if the Insured/Insured Person is unhappy with their resolution you can approach the Grievance Redressal Cell of the Consumer Affairs Department of IRDAI.
•Website: igms.irda.gov.in
•Email: complaints@irda.gov.in
•Toll Free Number 155255 (or) 1800 4254 732

List of Ombudsmen

The contact details of the **Insurance Ombudsman** offices are as below. These details can also be found at http://www.cioins.co.in/ombudsman.html.

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES		
Location	**Office Details**	**Jurisdiction of Office, Union Territory, District**
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@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu

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@cioins.co.in	Karnataka
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@cioins.co.in	Madhya Pradesh Chattisgarh
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@cioins.co.in	Orissa
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@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.

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@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
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@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh
Guwahati	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
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 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry

Jaipur	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 – 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
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@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
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@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands

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@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Noida	Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120- 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of 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

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@cioins.co.in	Bihar, Jharkhand
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@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

h. Cause of action/Currency of payment:
No claim shall be payable under this Policy unless the cause of action arises in India. This clause is not applicable to Critical Illness and Personal Accident section. All claims shall be payable in India in Indian Rupees only.

i. Territory:
This Policy applies to incidents anywhere in the world unless limited by the company through endorsement or specifically restricted in the policy.

j. Policy Disputes:
The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

k. Arbitration:
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 to the dispute/difference, 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 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

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

It is 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 shall be first obtained.

l. Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to;

1. In case of the Insured, at the address given in the Schedule to the Policy.
2. In case of the Company, to the Policy issuing office/nearest office of the Company.

m.Policy Period:

The Company may offer Policy period starting from 6 Months maximum upto 5 years in multiple of 6 Months.

n. Renewal & Refund:

a. The Company offers life-long renewal unless the Insured Person or Policyholder or any one acting on behalf of an Insured/ Insured Person or Policyholder has acted in an improper, dishonest or fraudulent manner or has made misrepresentation in relation to this Policy or the Policy poses a moral hazard

b. The Policy and Certificate of Insurance may be renewed by upfront payment of the total premium specified by the company, . Such premium shall be at company's premium rate in force at the time of renewal

c. Company will not load the premium for any adverse claims experience of particular Insured/Insured Person at the time of renewal, if there is no change in the coverage of continuing Policy

d. The Company may change the renewal premium and/or benefits payable subject to approval from regulator (IRDAI) and inform the same to the Insured at least 3 months prior to the effective date of revision and/ or modification or renewal

e. In the likelihood of this Policy being withdrawn in future, the Company will inform the same to the Insured at least 3 months prior to expiry of the Policy. Insured will have the option to migrate to other plan under similar health insurance Policy at the time of renewal, provided the Policy is maintained without a Break in Policy.

f. All applications for renewal of the Policy must be received by us before the expiry of current Policy. A Grace Period of minimum 30 days for renewing the Policy is provided under this Policy. However, due to this Break in policy there is no coverage for Injury sustained or Disease contacted during this grace period/break period.

w. Renewal Notice:

The Company shall allow renewal of the Policy and accept renewal premium in all cases except in case of noncooperation of the Policyholder/Insured Person in implementing the terms and conditions of this Policy. 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 original proposal or declaration herein before mentioned and that nothing is known to the Insured that may result to enhance the risk of the Company. However sending the renewal notice is not mandatory for the company.

1. **Upon the lapse of Master Policy** or the Insured Person ceasing to be a part of the Master policy, on request of the Insured Person the Company will provide an option to migrate to other plan under similar health insurance Policy, provided the existing Policy is maintained continuously without a break

2. **Refund:** As opted for by the Policyholder and indicated in the Master Policy refund will be done in the following proportion:

	Premium to be Retained									
	Policy Period (Months)									
Cancellation Period (Months)	**6**	**12**	**18**	**24**	**30**	**36**	**42**	**48**	**54**	**60**
Up to 3	50%	30%	20%	15%	12%	10%	9%	8%	7%	6%
Above 3 and Up to 6	100%	60%	40%	30%	24%	20%	17%	15%	13%	12%
Above 6 and Up to 9		90%	60%	45%	36%	30%	26%	23%	20%	18%
Above 9 and Up to 12		100%	80%	60%	48%	40%	34%	30%	27%	24%
Above 12 and Up to 15			100%	75%	60%	50%	43%	38%	33%	30%
Above 15 and Up to 18			100%	90%	72%	60%	51%	45%	40%	36%
Above 18 and Up to 21				100%	84%	70%	60%	53%	47%	42%
Above 21 and Up to 24				100%	100%	80%	69%	60%	53%	48%
Above 24 and Up to 27					100%	90%	77%	68%	60%	54%
Above 27 and Up to 30					100%	100%	86%	75%	67%	60%
Above 30 and Up to 33						100%	94%	83%	73%	66%

Above 33 and Up to 36						100%	100%	90%	80%	72%
Above 36 and Up to 39							100%	100%	87%	78%
Above 39 and Up to 42							100%	100%	93%	84%
Above 42 and Up to 45								100%	100%	90%
Above 45 and Up to 48								100%	100%	100%
Above 48 and Up to 51									100%	100%
Above 51 and Up to 54									100%	100%
Above 54 and Up to 57										100%
Above 57 and Up to 60										100%

Endorsement in Sum Insured in event of part prepayment of the Loan and/ or, no refunds of premium as a result of such endorsement request shall not be allowed under this Policy. No refunds of premium will be made under the Policy during the last year of the Policy Period. In event of prepayment of the entire Loan and upon making any refund of premium under this Policy in accordance with the terms and conditions hereof in respect of the Insured Person, the cover in respect of the Insured Person shall forthwith terminate and the Company shall not be liable hereunder. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured Person where any claim has been admitted by the Company or has been lodged with the Company.

7. Claim Procedure;

Claim Notification - Multi Model Intimation:

It is the endeavor of Company to give multiple options to the Insured Person to intimate the claim to the Company. The intimation can be given in following ways:

i) Toll Free call Centre of the Insurance Company (24x7) - 1800-103-2292
ii) Login to the website of the Insurance Company and intimate the claim - http://www.bharti-axagi.co.in/contact-us
iii) Send an email to the Company - customersupportba@icicilombard.com
iv) Post/courier to Company - ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District,Nanakram Guda, Gachibowli, Hyderabad-500032
v) Directly Contacting our Company office but in writing ICICI Lombard General Insurance Company Ltd., ICICI Lombard House, 414, Veer Savarkar Marg, Prabhadevi, Mumbai – 400025

In all the above, the intimations are directed to a central team for prompt and immediate action

Notice of Claim/Loss:

On the happening of any loss or damage to the property, the Insured shall forthwith give notice thereof to the Company and shall within 15 days after the loss or damage, or such further time as the Company may in writing allow in that behalf but not later than 30 Days after an actual or potential loss.

Claim Form

Upon the notification of the claim, the Company will dispatch the claim form to the Insured/Covered person. Physical Claim forms will also be available with the Company offices and on its website in a digital format.

Claim Procedure

i) The Company shall be under no obligation to make any payment under this Policy unless all the premium payments are received in full and all payments have been realized.
ii) Payments:- The Company shall be duly discharged of its obligations under this Policy and the Insured shall hold the Company harmless, upon making the payment of the claim to the Insured his assigns or the Bank/Financial Institution or his nominee/ legal heirs as the case may be.
iii) 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 Insured/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Insured/ Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
iv) If there is any deficiency in the documents/ information submitted by Insured person, the company will send the deficiency letter within 7 days of receipt of the claim documents.
v) On receipt of the complete set of claim documents to the Company's satisfaction, the Company will send offer of settlement, along with a settlement statement within 30 days to the insured. Payment will be made within 7 days of receipt of acceptance of such settlement offer.

Claim Service Guarantee

Notwithstanding the above, upon the receipt of all required documents and processing of the claim, the offer of settlement will be made to the Insured in any case not later than 30 days maximum. Settlement (payment) of claim will be made within 7 days of receipt of acceptance in response to offer of settlement, failing which penal interest (in compliance with applicable regulations) at a rate of 2% higher than bank rate (prevailing as on the date of beginning of financial year in which the claim is reviewed) will be paid.

8. Assignments Clause: :- (applicable if assignment section in the enrolment form is filled and signed by insured member)

It is hereby declared and agreed that:-

1. From the policy start date, the sum of money not exceeding the Sum Insured as mentioned in the policy schedule payable by the company to the Insured and all rights, title, benefits and interest of the Insured under this policy stand assigned in the favor of the Bank / Financial institution as informed by you to the company.

2. Upon any sum of money becoming payable under this policy the same shall be paid by the company to the “bank / financial institution’ directly without any notice to the Insured / Insured members but not exceeding the principal outstanding. In the event of any sum of money payable under this policy exceeding the principal outstanding, the company shall pay such some to Insured Member / Nominee / Legal Heir.
3. The receipt of sum of money in the manner aforesaid by the Bank / Financial institution and the Insured shall completely discharge the company from all liability under the policy and shall be binding on the Insured and his legal heirs.

o. Observance of terms and conditions:

The due observance and fulfillment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Insured / Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy

p. Material Change:

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

q. No Constructive Notice:

The Company shall not take notice of any information relating to the Insured / Insured Person unless such information is submitted in writing by the Insured, even if such information was available with the Company.

r. Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Insured or legal representative or Bank or Financial Institution shall be binding on all concerned and shall be considered as complete discharge by the Company.

s.Special Provisions:

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

t. Electronic Transaction:

The Insured / 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 confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, 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 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. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDAI regulations for protection of Policy holder's interests.

u. Duty of the Insured on occurrence of loss/event leading to claim:

On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Insured / Insured Person shall:

1. Forthwith file/submit a claim form (Physical/Digital) in accordance with "Claim Procedure" clause.

2. Allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalization records and to examine the Insured / Insured Person

3. Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

v.Right to Inspect:

If required by the Company, an agent/representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to examine into the circumstances of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy. The Company shall bear all the cost that shall be incurred for such examination.

w. Position after a claim:

As from the day of receipt of the claim amount by the Insured / Insured Person, unless specified otherwise, the Sum Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount. Forfeiture of claims: If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any r ights whatsoever

Fixed Sum Insured– In the Credit linked Policies where Sum Insured is linked to any loan, it remains fixed throughout the Policy tenure. In such event of claim under the policy at the option of the Insured , the Company may first pay the claim to the financer up to the outstanding loan amount or Admissible Claim amount whichever is less and any balance Sum Insured may be paid to the Insured borrower or the nominee or any assignee as the case may be.

In case of non-credit linked policy, the claim amount will be paid directly to the Insured or the nominee or any assignee as the case may be.

Reducing Sum Insured (Applicable to Critical Illness, Personal Accident & Involuntary loss of Job) – In case of Credit linked Policies where Sum Insured is linked to any loan, the liability of the company is restricted to the Principle Outstanding loan amount as on the date on which such Insured event takes place ie., the Sum Insured reduces over a period of time throughout the Policy tenure. In the event of claim under the policy at the option of the Insured, the Company may pay the claim to the financer up to the Principle Outstanding loan amount or Admissible Claim amount whichever is less. No balance Sum Insured shall be payable to the Insured borrower or the nominee or any assignee in such cases.

Unless otherwise specified in the Policy Schedule/Certificate of Insurance, the liability of the company shall be restricted to the Principle outstanding balance as per schedule of amortization less any penalties as a result of default or otherwise. Reducing Sum Insured shall not be offered to Non Credit linked policies.

First loss Sum Insured (Applicable to Critical Illness, Personal Accident & Involuntary loss of Job) – As specified in the policy Schedule/Certificate of Insurance, the maximum liability of the company shall be restricted to the Sum Insured in any one Section (if multiple sections have been opted by the Insured). The Policy shall terminate in case the Company have paid the Sum Insured in any one section. In the event of a part utilization of the Sum Insured in case of a claim, the policy continues to be inforce with balance Sum Insured and renewal of such policy shall be possible with such balance Sum Insured for the remaining covers. This shall be allowed for both Credit & Non Credit linked policies

In case of First loss Sum Insured, Sum Insured for Involuntary Loss of Job, Personal Accident and Critical Illness (if opted together) will always be equal

Discrete Sum Insured (Applicable to Critical Illness, Personal Accident, Involuntary loss of Job) –As specified in the policy Schedule/Certificate of Insurance, the maximum liability of the company shall be restricted to the sum of highest Sum Insured in each Section (if multiple sections have been opted by the Insured). The Policy will stand terminate in the event of death of the Insured or Sum Insured under all the section(s) have been exhausted as the case may be.

In the event of a part utilization of the Sum Insured in case of a claim under any one section, the policy continues to be inforce with balance Sum Insured for that particular section(s) the other sections being unaltered and renewal of such policy shall be possible with such balance Sum Insured for the section in consideration.

In the event of a total utilization of the Sum Insured in case of a claim under any one section, the policy continues to be inforce and renewal shall be allowed with Sum Insured specified for the other section(s).

This shall be allowed for both Credit & Non Credit linked policies .