Bharti AXA General Insurance Company Limited

080-49123900
customer.service@bharti-axagi.co.in
SMS <SERVICE> to 5667700
www.bharti-axagi.co.in

SmartHealth High Deductibles Insurance Policy - Policy Wordings

Preamble

WHEREAS the Insured designated in the Schedule to this Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of this contract and shall be deemed to be incorporated herein, has applied to Bharti AXA General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the 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 period as specified in the Schedule to this Policy, the Insured/Insured Person shall contract any disease, illness or sustain any injury and if such disease, illness or injury shall upon the advice of a duly qualified Medical Practitioner require such Insured/Insured Person, to incur hospitalisation and/or other related expenses towards treatment of such disease, illness or injury at any Hospital/Nursing Home in India as an inpatient expenses in any of the circumstances mentioned hereunder, then the Company will pay to the Insured/Insured Person, his/her nominee, or legal representatives, as the case may be, the amount of such hospitalisation or related expenses/charges as would fall under the different heads mentioned below and as are reasonably and necessarily incurred by or on behalf of such Insured/Insured Person for

1. Hospital (Room & Boarding and Operation theatre) charges
2. Fees of Surgeon, Anesthetist, Nurse, Specialists etc.
3. Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
4. Pre and post hospitalization expenses
5. Ambulance charges

in manner, for the period and to the extent of the Sum Insured as specified in this Policy.

This policy is offered for the person having age between 5 years to 70 years. Children below 5 years can be covered if any of the parents is covered under the policy.

The Policy can also be offered to group of individuals, association of persons, other groups, employers to cover their employees etc wherein the premium rating structure for group insurance needs to be followed.

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 meaning set forth:

"Accident" means a sudden, unforeseen, and involuntary event caused by external, visible and violent means.

"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.

"Cashless facility" means a facility extended by the insurer 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 pre-authorization approved.

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

a. Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body.

b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body.

"Contribution" is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

"Condition Precedent" shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

"Any One Illness" means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

"Deductible" is 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.

"Disclosure to information norm" means 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.

"Emergency care" means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

"Family" means the Insured, his/her lawful spouse and maximum of two dependant children up to the age of 23 years.

"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 and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

"Hospitalisation" Means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/ treatments,

where such admission could be for a period of less than 24 consecutive hours.

"Hospitalisation expenses" mean expenses on hospitalisation for minimum period of 24 hours incurred in India, which are admissible under this Policy.

"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.

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:

I) it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests

ii) it needs ongoing or long-term control or relief o f symptoms

iii) it requires your rehabilitation or for you to be specially trained to cope with it

iv) it continues indefinitely

v) it comes back or is likely to come back

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

"Insured" means the individual who has a permanent place of residence in India and on whose name the Policy is issued.

"Insured Person" means the person named in the Schedule to the Policy, who has a permanent place of residence in India and for whose benefit the insurance is proposed and appropriate premium paid.

"Medical Advice" mean **a**ny consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/Insured Person's family.

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

"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.

"Period of Insurance" means the Policy period defined hereunder.

"Policy period" means the period between the inception date and time and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.

"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.

"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.

"Post-hospitalization Medical Expenses" means 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 hospitalization was required and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

"Pre-Existing Disease" means any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer.

"Pre-hospitalization Medical Expenses" means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"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.

"Reasonable and Customary Charges" means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

"Renewal" defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods

"Third Party Administrator (TPA)" means any organisation or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured / Insured Person as well as to the Company for an insurable event.

"Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

"Sum Insured" means the sum as specified in the Schedule to this Policy against the name of Insured / each 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.

"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.

"Terrorism/Terrorist Incident" means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or the commission of an act dangerous to human life or property, against any individual, property or government, with the stated or un stated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

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

Scope of cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, to pay and/or reimburse the following benefits in manner, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

Section I

a. Hospitalisation Expenses

Hospitalisation expenses benefit provides cover for payment/reimbursement of hospitalisation expenses which are reasonably and necessarily incurred by the Insured / Insured Person for treatment of disease, illness contracted or injury sustained by the Insured / Insured Person during the Policy period as specified in the Schedule to this Policy, in a Hospital in India as in patient which among other things, 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 etc.

b. Pre-hospitalisation

This benefit covers relevant medical expenses incurred during a period up to 30 days prior to hospitalisation for treatment of disease, illness contracted or

injury sustained for which the Insured / Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

c. Post Hospitalisation

This benefit covers relevant medical expenses incurred during a period up to 60 days after discharge from Hospital for continuous and follow up treatment of the disease, illness contracted or injury sustained for which the Insured /Insured Person was hospitalised, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

d. Pre-existing Diseases

This benefit covers relevant hospitalisation expenses incurred for treatment of pre-existing disease, illness or injury, in a Hospital as an in-patient, after specific waiting period as mentioned in the Schedule to this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

e. Transplantation of Organs

Where the Insured/Insured Person undergoes major Organ Transplantation surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible under Section 1a, then this policy covers expenses incurred towards hospitalization expenses of donor for major organ transplantation. This benefit is a available over and above the original sum insured and restricted to 5% of original sum insured.

f. Ambulance Charges

This benefit provides for reimbursement to the Insured/Insured Person of expenses incurred for his/her transportation by ambulance to and from the Hospital for treatment of disease / illness / injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

g. In-patient Physiotherapy Charges

This benefit provides for reimbursement of charges incurred towards physiotherapy in the Hospital that is confirmed as being necessary by the attending Medical Practitioner and the same relates directly to the disease / illness / injury for which the Insured/Insured Person has undertaken treatment in the Hospital for which a valid claim is admissible under this Policy. This benefit is a part of benefit available under Section 1a above and is limited to the available Sum Insured under Section 1a.

h. Accompanying Person's Expenses

This benefit provides for payment of an allowance to the Insured/Insured Person towards expenses incurred on the accompanying person at the Hospital/Nursing Home during hospitalisation treatment of the Insured/Insured Person for the disease/illness/injury necessitating hospitalization for which a valid claim is admissible under this Policy. This benefit will be paid over and above limit of sum insured of section I a.

The deductible in respect of this Section I will be applicable for each and every claim separately and shall be of an amount as specified in the Schedule to this 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. The deductible as mentioned in the Schedule to this Policy and the same shall be applicable for each and every hospitalization and claim made for any one illness.
2. Pre-existing diseases / illness / injury / conditions - Benefits will not be available for any condition(s) as defined in the policy, until 48 months of continuous coverage have elapsed, since inception of the first policy with the company. However, if the renewal premium is paid within 15 days from the date of policy expiry, coverage shall be deemed to be continuous with out break for the purpose of this exclusion.
3. Hospitalization expenses incurred for treatment undertaken for disease or illness within first 30 days of the inception date of this Policy. Further it has been clarified that this exclusion will not applicable for claim arising out of accident. This exclusion, however, doesn't apply for subsequent renewals with the Company without a break. Further this exclusion shall not apply in case of the Insured person is covered under indemnity or benefit type of health insurance policy for continuous period of 12 months with any other insurance company. The continuity benefit will be given for the sum insured of previous insurance policy or sum insured opted with the company whichever is lower. The continuity benefit will be offer for renewals of individual as well as group policy. However, if the renewal premium is paid with in 15 days from the date of policy expiry, coverage shall be deemed to be continuous with out break for the purpose of this exclusion.
4. Hospitalisation Expenses incurred on treatment of following diseases, illness, injury within the first year from the inception of this Policy, will not be payable:
   - Cataract
   - Benign Prostatic Hypertrophy
   - Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
   - Dilation and curettage
   - Hernia, hydrocele, 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, however, doesn't apply for subsequent renewals with the Company without a break. Further this exclusion shall not apply in case of the Insured person is covered under indemnity or benefit type of health insurance policy for continuous period of 12 months with any other insurance company. The continuity benefit will be given for the sum insured of previous insurance policy or sum insured opted with the company whichever is lower. The continuity benefit will be offer for renewals of individual as well as group policy. However, if the renewal premium is paid with in 15 days from the date of policy expiry, coverage shall be deemed to be continuous with out break for the purpose of this exclusion.
5. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or, as may be necessitated due to an accident.
6. Dental treatment which are not excluded hereunder or surgery of any kind unless requiring hospitalisation.
7. 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.
8. Any fertility, sub-fertility or assisted conception operation.
9. Routine medical, eye and ear examinations, cost of spectacles, laser surgery, contact lenses or hearing aids, issue of medical certificates and examinations as to suitability for employment or travel.
10. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex syndrome (ARCS) and all diseases / illness / injury caused by and/or related to HIV.
11. Vitamins and tonics unless forming part of treatment for disease, illness or injury as certified by the Medical Practitioner.
12. Treatment of obesity, general debility, convalescence, rundown condition or rest cure, congenital internal and external diseases / illness or defects or anomalies, sterility, venereal disease or intentional self-injury and use of intoxicating drugs/alcohol
13. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
14. Medical treatment following use of intoxicating drugs and alcohol or drug abuse, solvent abuse or any addiction or medical condition resulting from or relating to such abuse or addiction.
15. Sex change or treatment, which results from, or is in any way related to, sex change.

16. Vaccination and inoculation of any kind unless forming a part of post bite treatment where it will form a part of hospitalization treatment cost.
17. Treatment by a family member and self-medication or any treatment that is not scientifically recognized.
18. Medical treatment required following any criminal act of the Insured / Insured Person.
19. Disease / illness / injury /critical illness, 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, strike, lockout, military or popular uprising or civil commotion.
20. Disease / illness / injury whilst performing duties as a serving member of a military or a police force.
21. Prostheses, corrective devices and medical appliances, which are not required intra-operatively or for the disease/ illness/ injury for which the Insured / Insured Person was hospitalised.
22. Any stay in Hospital without undertaking any treatment or where there is no active regular treatment by the Medical Practitioner.
23. Treatment of mental disease / illness, stress, psychiatric or psychological disorders.
24. Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated due to accident or as a part of any disease/ illness / injury not excluded hereunder.
25. Any loss, directly or indirectly, due to contamination due to an act of terrorism or terrorist incident, regardless of any contributory causes (if the Company opines 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).
26. Disease, illness, injury, directly or indirectly, caused by or contributed to by nuclear weapons/materials or radioactive contamination. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
27. Experimental and unproven treatment.
28. 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/Nursing Home.
29. Cost incurred for medicines which are not under the advice of the Medical Practitioner and which are not consistent with or incidental to the diagnosis and treatment.
30. Any treatment which is undertaken as an out-patient without any admission as an in-patient at the Hospital except those that are specifically mentioned as covered in the Schedule to this Policy.
31. Naturopathy treatment.
32. Any treatment received outside India.
33. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
34. Medical treatment in respect of the 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.
35. Medical treatment in respect of the 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.

Additional Features

1. Income Tax Relief

Premium paid under the Policy shall be eligible for income tax deduction benefit under Sec 80 D as per the Income Tax Act.

2. Renewal Discount

The Policy shall provide for a discount, equivalent to 5% of renewal premium every year on a progressive scale, as Renewal Discount at the time of renewal, provided that the Policy being renewed is claim free in the expiring year. This renewal discount on a progressive scale will be allowed up to a maximum of 25%. In case of renewal of a Policy where there is a loss, the Insured will lose the entire Renewal Discount accumulated.

This additional benefit is available only on renewal of the policies taken and renewed with our Company. Further the policy for renewal should have been taken in the insured's name.

3. Portability

Insured(s) have an option to migrate from their existing health insurance policy of any other Indian non life insurer to any other similar policy with Us, at the time of renewal, provided the previous policy/policies has been maintained without any break.

Portability benefit will be offered to the extent of previous year's sum insured, and shall not apply to additional increased sum insured in our policy.

However it may be noted that:

(a) The waiting periods specified in the Exclusion wordings of the Policy shall be reduced by the number of continuous preceding years of coverage of the Insured/ Insured Person under the previous health insurance policy / policies; AND

(b) If the proposed Sum Insured for an Insured Person is more than the Sum Insured applicable under the previous health insurance policy, then the reduced waiting period shall only be applicable to the extent of the Sum Insured in previous policy/ policies).

General Conditions

1. Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable 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 Insured/Insured Person or any one acting on his/their behalf to obtain a benefit under this Policy.

2. 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.

3. Reasonable Care

The Insured/Insured Person shall take all reasonable steps to safeguard the interests of the Insured / Insured Person against accidental loss or damage that may give rise to a claim.

4. Observance of Terms and Conditions

The due observance and fulfilment 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.

5. Material Change

The Insured / Insured Person shall immediately notify the Company by fax or In writing of any material change in the risk and cause at his own expense such additional precaution to be taken as circumstances may require to ensure safety thereby containing the circumstances that may give rise to a claim and the Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

6. Fraudulent Claims

If any claim 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 or her behalf to obtain any benefits under the Policy, all benefits under this Policy shall be forfeited. The Company will have the right to reclaim all benefits paid in respect of a claim which is fraudulent as mentioned above under this Condition as well as under Condition No 1 of this Policy.

7. No Constructive Notice

Any knowledge or information of any circumstances or condition in

connection with the Insured / Insured Person, in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of the premium.

8. Notice of Charge

The Company shall not be bound to take notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy; but the payment b y the Company to the Insured / Insured Person, his/her nominee or legal representatives, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

9. Overriding Effect

The terms and conditions contained herein and in the Schedule shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein.

10. 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 confirms that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, Electronic data interchange, call centres, teleservice 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's other 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. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of policyholder's interests.

11. Duty of the Insured/Insured Person on Occurrence of Loss

On the occurrence of loss within the scope of cover under the Policy, the Insured / Insured Person shall:

a) forthwith file/submit a claim form in accordance with "Claim Procedure" clause

b) allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalisation records and to examine the Insured/Insued Person

c) 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.

12. Right to Inspect

If required by the Company, representative of the Company including a Physician appointed in that behalf shall in case of any loss 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. 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 or such circumstance in his/her possession including presenting himself 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 will in any way assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy. Further to this it has been clarified that such examination will be conducted at the companies cost.

13. Position After a Claim

As from the day of receipt of the claim amount by the Insured / Insured Person, the Sum Insured for the remainder of the period of insurance shall stand reduced by a corresponding amount.

14. Contribution

If there shall be existing any other insurance of any nature whatsoever covering the same Insured / Insured Person for any benefit over and above the deductibles as mentioned in the Schedule to this Policy whether effected by the Insured /Insured Person or not, then the Company shall not be liable to pay or contribute more than its rateable proportion of any loss or damage. Further to this it has been clarified that the contribution clause will only apply to the part of other insurance policy which is having higher sum insured than the deductible of this policy, and is otherwise in excess of any insurance amount of the deductible.

15. Forfeiture of Claims

If any claim is made and rejected and no court action or suit commenced within 12 months after such rejection or, in case of arbitration taking place as provided herein, within 12 calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

16. Free Look Period

Insured / Insured person have 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 have any objections to any of the terms and conditions, he / she have the option of cancelling the Policy stating the reasons for cancellation and the premium will be refunded after adjusting the amounts spent on any medical check-up, stamp duty charges and proportionate risk premium.

The policy can be cancelled only if insured have not made any claims under the Policy.

Free look provision is not applicable and/or available at the time of renewal of the Policy.

Free look period is also not available where the policy period is of the tenure less than one year.

17. Grace Period

All applications for renewal of the policy must be received by us before the end of the policy. A Grace Period of 30 days for renewing the Policy is provided under this Policy.

However, there is no coverage for injury sustained or disease contacted during this period.

18. Cancellation/Termination

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 in case of non-cooperation of the Insured / Insured Person in implementing the terms and conditions of this Policy in which case the Company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of the cancellation. 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 at the Company's short period scales. Provided however that refund on cancellation of Policy by the Insured shall be made only if no claim has occurred up to the date of cancellation of this Policy.

Period of Risk	Rate Of Premium to be retained
Up to 1 month	25% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	75% of annual rate
Exceeding six months	100%

19. Cause of Action/Currency of Payment

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian Rupees only.

20. 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.

21. 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 3 0 days of any party invoking arbitration, the same shall be referred to a panel of 3 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 the 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 referable to arbitration, as hereinbefore 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.

20. Renewal Notice

The Company shall give notice for renewal of the policy and accept renewal premium in all cases except in case of non-cooperation of the Insured / 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 proposal or declaration hereinbefore mentioned and that nothing is known to the Insured / Insured Person that may result to enhance the risk of the Company. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorized official of the Company.

Disclosure on continuity: (applicable to group policy) In the group policy is not renewed or discontinued, the individual members have the option of applying for any of the similar individual health insurance policies with in 30 days from such termination of group cover. It is understood that company shall offer such insurance cover subject to underwriting guidelines and with time waivers including 30 days waiting period and waiver of exclusions for the first 1 or 2 years as applicable.

However, in case the premium for renewal is paid with in 15 days from the policy expiring date, such renewal policy shall be effective only from the time and date of receipt of premium. It is further clarified that the company shall not be liable to pay claims arising out of any disease or injury contacted during the period between policy expiring date and receipt of renewal premium by the company.

21. Notices

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

a) In case of the Insured / Insured Person, at the address given in the Schedule to the Policy.

b) In case of the Company, to the Policy issuing office/nearest office of the Company.

22. Customer Service

If at any time the Insured / Insured Person requires any clarification or assistance, the insured/ Insured Person may contact the Policy issuing office or any other office of the Company or the TPA.

23. Grievances

In case the Insured / Insured Person is aggrieved in any way, the Insured / Insured Person may contact the Company at the specified address, during normal business hours. In case the Insured/Insured Person has not got his/her grievances redressed by the Company within 14 days, then he/she may approach the Insurance Ombudsman for the redressal of the same, A list containing the addressees of Offices of Ombudsman are attached to this Policy. Policy holder may also obtain copy of IRDA circular number 1385_GI-2002_ENG dated 26-04-2002, notification on Insurance Regulatory and Development Authority (Protection of policy holders' interests) Regulations, 2002 from any of our offices.

LIST OF INSURANCE OMBUDSMEN

Office of the Ombudsman	Name of the Ombudsmen	Contact Details	Areas of Jurisdiction
AHMEDABAD	Shri P.Ramamoorthy	Insurance Ombudsman Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U.Shah College, 5, Navyug Colony, Ashram Road, **AHMEDABAD – 380 014.** Tel. 079 - 27546840. Fax: 079-27546142 E-mail: ins.omb@rediffmail.com	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL		Insurance Ombudsman Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL(M.P) - 462 023.** Tel. 0755-2569201. Fax: 0755-2769203. E-mail: bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri B. P. Parija	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, **BHUBANESHWAR - 751 009.** Tel.:- 0674-2596455 Fax : 0674-2596429 Email: ioobbsr@dataone.in	Orissa
CHANDIGARH	Shri Manik Sonawane	Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103 2nd floor, Batra Building Sector 17-D, **CHANDIGARH – 160 017.** Tel.: 0172-2706468. Fax: 0172-2708274. E-mail: ombchd@yahoo.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI		Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court , 4 th floor, 453 (old 312) Anna Salai, Teynampet, **CHENNAI – 600 018.** Tel.: 044-24333668 /5284. Fax: 044-24333664. E-mail: chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Shri Surendra Pal Singh	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, **NEW DELHI - 110 002.** Tel.:- 011-23239633 Fax : 011-23230858 Email: iobdelraj@rediffmail.com	Delhi & Rajashthan
GUWAHATI	Shri D. C. Choudhury	Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5 th floor, Near Panbazar Overbridge , S.S. Road, **GUWAHATI – 781 001 (Assam).** Tel. : 0361-2131307 Fax:0361-2732937. E-mail: omb_ghy@sify.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD		Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46 , 1 st floor, Main Court, A.C.Guards, Lakdi-Ka-Pool, **HYDERABAD – 500 004.** Tel.: 040-65504123. Fax: 040-23376599. E-mail: insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
KOCHI	Shri R. Jyothindranathan	Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM – 682 015**. Tel : 0484-2358759 Fax : 0484-2359336 Email: iokochi@asianetindia.com	Kerala, UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry
KOLKATA	Ms. Manika Datta	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, **Kolkatta – 700 072.** Tel:033 22124346 /(40) Fax: 033 22124341 Email: iombsbpa@bsnl.in	West Bengal, Bihar, Jharkhand and UT of Andeman & Nicobar Islands, Sikkim
LUCKNOW	Shri G. B. Pande	Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Bhawan, Phase 2, 6th floor, Nawal Kishore Rd., Hazratganj, **LUCKNOW – 226 001.** Tel.:0522-2231331. Fax: 0522-2231310. E-mail: insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI		Insurance Ombudsman Office of the Insurance Ombudsman, S.V. Road, Santacruz(W), **MUMBAI - 400 054.** Tel: 022-26106928 Fax: 022-26106052 Email: ombudsmanmumbai@gmail.com	Maharashtra, Goa

1. Claim notification

a) Multi Model Intimation

It is the endeavour of BhartiAxa to give multiple options to the insured/covered person/patient's care taker to intimate the claim to the Third party administrator (TPA)/Company.

The intimation can be given in following ways

- Toll free call centre of the TPA (24x7)
- Toll free call centre of the Insurance Company(24x7)
- Login to the website of the Insurance Company and intimate the claim
- Send an email to the TPA/Company
- Send a fax to TPA/Company
- Post/courier to TPA/Company
- Direct contact

In all the above the intimations are directed to a central team for prompt, standardized action. The insured/covered person will be suitably advised about the deductible and coverage under the policy.

Special Provision - In case where the cost of treatment will not ascertain in certain disease conditions, the conditions regarding the intimation of the claim is waived.

b) Information Details

When the insured/covered person/patient's care taker intimate the claim as mentioned above, the following information should be kept handy for prompt services.

- Policy number
- Name of the Insured/Covered person
- Contact details
- Nature of the disease, illness or injury
- Name and address of the attending medical practitioner/hospital

c) Claim Form

Upon the notification of the claim the TPA/Company will dispatch the claim form to the Insured/Covered person. Claim forms will also be available with the network hospitals and Company offices.

2. Claim procedure

a) Cashless hospitalisation

- Company will work with one or more TPAs for providing cashless facility to the Insured/Covered person.
- List of network hospitals will be provided to the Insured/Covered person along with the policy and it will be regularly updated and informed to them. Insured/Covered person can view the updated hospital list from the website of the TPA/Company too.
- Insured/covered person on admission (emergency) or willing to admit (planned admission) in the network hospitals a pre-authorization request form has to be filled in by the treating doctor/hospital and the same has to be faxed to the TPA by the insured/hospital. The TPA after verifying the same will decide on the issuance of authorization in excess of the deductible as specified in the policy. The action of pre-authorization will be done within 6 hours for emergency admission and 48 hours for planned admission.
- The preauthorization request form will be available in the benefit guide issued along with the policy, available in the hospitals, can be downloaded from the website of the TPA/Company, can request for the same to the TPA/Company via email or fax or can be collected in person from the branches of the TPA/Company.
- Denial of the cashless does not mean the claim has been rejected. The insured/covered person can send the requisite claim documents to the TPA/Company seeking reimbursement.
- The insured/covered person need not pay any amount to the hospital if he has received the authorization letter except,

  if the bill amount is in excess of the sum insured
  - Non medical expenses
  - Unrelated treatments
  - Excess, if any
- The hospital will receive the payment from TPA/Company within 21 days from the date of receipt of complete claim documents.

b) Reimbursement claims

- Insured/covered person unwilling to utilize the cashless facility in the network hospital can send the claim documents along with the pre/post hospitalization documents for the period specified in the policy to the TPA/Company for the reimbursement in excess of the deductible as specified in the policy with in 15 days of end of the post hospitalization period or the medical fitness certificate issued by the attending physician, which ever is earlier.
- Insured/covered person admitted in a non network hospital can send the claim documents along with the pre/post hospitalization documents for the period specified in the policy to the TPA/Company for the reimbursement in excess of the deductible as specified in the policy with in 15 days of end of the post hospitalization period or the medical fitness certificate issued by the attending physician, which ever is earlier.
- Insured/covered person should intimate the claim to the TPA/Company with in the 72 hours from the date of hospitalisation.
- After receiving the complete documents the TPA/Company will reimburse the claim amount within 14 days to the insured.

3. Documents

It is the policy of the Company to seek documents in a single shot. If any further documentation is required then it will be sought promptly.

In cases where investigation is deemed necessary, the same will be conducted in all promptitude.

Every attempt will be made to keep the process transparent.

The company can also accept the photo copies of the claim documents where the claim documents have been submitted by the insured to the other company. The claimant can submit attested photo copies of claim documents with the letter stating the details of the claim made under the different health insurance policy which covers the deductible amount.

Upon receipt of all required documents, the offer of settlement will be made within 30 days. 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 2% higher than bank rate prevailing as on the date of beginning of financial year in which the claim is reviewed.

Checklist of documents for settling Claims:

SL.NO.	CHECKLIST	Tick the boxes
1	claim form duly signed along with attending physician statement	✓☐
2	pre auth form-if cashless claim	✓☐
3	discharge summary	✓☐
4	hospital final bill	✓☐
5	Attending Surgeon's/Physician's Prescription advising hospitalization	✓☐
6	surgery/consultation bills and receipts	✓☐
7	operation theatre and pharmacy bills	✓☐
8	medicines bill with doctors prescription	✓☐
9	pre hospitalization bills with receipts	✓☐
10	post hospitalization bills with receipts	✓☐
11	hospital payment receipt in case of reimbursements	✓☐
12	diagnostic reports with doctors prescription	✓☐

4. Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country. This is also with a view to keep the guidelines of regulator in mind. In the unfortunate vevent of repudiation, the retail customers will be informed of the existence of forums for grievance redressal.

PW/HDH/THINQ/08-13


Personal Lines Growth Leadership Award 2011


Risk Manager of the Year Award 2011


Commercial Lines Growth Leadership Award 2012


Best Product Innovation Award 2012


Best Employer Brand 2012


Claims Initiative of the Year Award 2012


Hyundai Outstanding Performance Award 2013


ISO Certified