Group Personal Accident, ICICI Lombard

Preamble & Operative Clause

ICICI Lombard General Insurance Company Limited will provide insurance cover to the person(s) named in the Schedule based on the material facts recorded in the proposal and declaration made and agreed premium has been paid and realized by us in full.

We will pay the insured person(s) in respect of an insured event occurring during the policy period and subject to the Conditions, Sum Insured, Scope of Coverage, Territorial Limits, Endorsement, Deductible and Exclusions in the manner and to the extent set forth in this policy.

1. Definitions

Any words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy or Schedule. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

a. Standard Definitions

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

AYUSH Treatment refers to the medical and / or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

AYUSH Day Care Centre: 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.

"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.

"Day care treatment" means medical treatment, and/or surgical procedure which is:

a) undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
b) 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 company will not be liable for a specified rupee amount in case of indemnity sections and for a specified number of days/hours in case of hospital cash section 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 thereon shall be forfeited to the Company in the event of mis-representation, mis-description or non-

disclosure of any material fact.

"Emergency Assistance Service Provider" means or any organization or institution appointed by the Company, for providing services to the Insured Person for an Insured Event covered.
"Emergency Assistance Service Provider" that We appoint from time to time as specified in the Certificate of Insurance/Policy Schedule. This company would provide emergency assistance to the insured life in case of an accident during the course of the policy.

"Emergency care" means management for an 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.

"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:

a) has qualified nursing staff under its employment round the clock;
b) 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;
c) has qualified medical practitioner(s) in charge round the clock;
d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

'Hospital' Includes AYUSH Hospital.

AYUSH Hospital: 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.

"Hospital" outside India shall mean an institution established for the treatment of patients which is under constant medical management, has adequate diagnostic and therapeutic facilities, keeps constant medical records, is recognized as a hospital in the country in which it is situated, and which is appropriately licensed, wherever required to be so, to operate as a hospital in that country.

"Hospitalization" means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for Day care treatments, where such admission could be for a period of less than 24 consecutive hours.

"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.

"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:
   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 of symptoms
   III. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
   IV. it continues indefinitely
   V. it recurs or is likely to recur

"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 person has to stay in a hospital for more than 24 hours for a covered event.

"Insured Person(s)/You/Your" means the person(s) named in the Schedule/Certificate of Insurance.

"Intensive care unit (ICU)" 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.

"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 Person has necessarily and actually incurred for medical treatment on account of 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.

"Medically necessary treatment" means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

a) is required for the medical management of the injury suffered by the insured;
b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c) must have been prescribed by a medical practitioner;
d) Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"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.

"Newborn baby" means baby born during the Policy Period and is aged upto 90 days.

"Notification of claim" means the process of

intimating a claim to the insurer or TPA through any of the recognized modes of communication.

"OPD treatment" means the one in which the Insured 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 is not admitted as a day care or in-patient.

"Policyholder" means an Individual/Organization/Association in whose name the policy has been issued and should have an insurable interest to cover the insured person(s) under the policy.

"Qualified nurse" means 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 injury involved.

"Renewal" means the terms on which the contract of insurance may be renewed as per relevant regulatory prescriptions with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

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

"Subrogation" means the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

"Surgery or Surgical Procedure" means manual and/or operative procedure (s) required for treatment of an injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

"**Break in policy**" means the period of gap that occurs at the end of the existing policy term / instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

"**Grace period**" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

"**Migration**" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

"**Portability**" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

"**Pre-existing disease (PED)**" means any condition, ailment, injury or disease:
that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

b. Specific Definitions

"Any One Accident (AOA)" means the maximum amount payable by the Company in respect of any single Accident, irrespective of the number of Insured Persons involved in such Accident. In the event that an Accident occurs which results in insurable losses under this Policy and which ordinarily would mean that the AOA limit is exceeded, the AOA Limit amount will be distributed on a proportional basis to all Insured Persons, taking into account the maximum Sums Insured per Benefit and per Insured Person.

"Any One Year (AOY)" means the maximum amount payable under the benefit as specified in the Policy Schedule in respect of all claims by or on behalf of all Insured Persons, if at any time the total value of unpaid claims would, if paid, result in this AOY limit being exceeded, the individual benefits attributable to those outstanding claims shall be reduced pro rata as necessary to ensure that this maximum AOY limit is not exceeded.

"Company/We/Our/Ours" means ICICI Lombard General Insurance Company Limited.

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

"Dependent Child" means a natural or legally adopted child, aged between 91 days to 23 Years and pursuing full time education and financially dependent on the Primary Insured.

"Immediate Family Members" shall mean Married spouse, Children (Biological or Legally Adopted), Parents & Siblings.

"Policy Period" means the period between the inception date and the expiry date specified in the Schedule. Policy period can be less than 1 Year, 1/2/3/4/5 year(s) in context of this policy.

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

"Senior citizen" means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

"Sum Insured" means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

2. Scope of Cover

The Policy intends to offer optional coverage chosen by the Policyholder, endorsed by the Company upon payment and realization of agreed premium in full and specified under the policy schedule.

3. Specific 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:

a. Any Pre-existing Condition(s) and complications arising out of or resulting therefrom;
b. Through suicide, attempted suicide (whether sane and insane) or intentionally self-inflicted injury or illness, including abstinent from a normal behavior of having food.
c. Whilst engaging in Adventure Sports. The list of adventurous sports are Water Rafting, Wildlife/Jeep Safaris, Trekking, Camping, Boat safaris, Parasailing, Paragliding, Elephant/Camel/Horse/Yak Safaris, Cycling, House Boat stays, Motor Bike tours, Kayaking, Rock Climbing, Artificial Wall Climbing, Bungee Jumping, Paintball, Suba Diving, Hot Air Ballooning, Canoeing, Mountain Biking, Rappelling, Snorkeling, Zip wires & high Rope course, Abseiling, Surfing, Water Skiing, Skiing, Caving, Self-Drive tours, Mountaineering/Hiking, All Terrain Vehicle, Hang Gliding, Snowboarding, Ultra-Light flying, Heli-skiing, Sky Diving. .
d. While under the influence of liquor or drugs , alcohol or other intoxicants,
e. Through deliberate or intentional, unlawful or

criminal act, error, or omission, participation in an actual or attempted felony, riot, crime, misdemeanor, civil commotion,

f. Whilst engaging in aviation, whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world,

g. Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs, As a result of any curative treatments or interventions that you carry out or have carried out on your body,

h. Including alternative forms of medicines like chiropractic treatments etc, Not including AYUSH treatment which are covered in the policy.

i. Arising out of your participation in any police ,naval, military or air force operations whether peace or in war in the form of military exercises or war games or actual engagement with the enemy, Whether foreign or domestic,

j. Your consequential losses of any kind or your actual or alleged legal liability. Venereal or sexually transmitted diseases,

k. Pregnancy, resulting childbirth, maternity expenses, miscarriage, abortion, or complications arising out of any of these,

l. War (whether declared or not), civil war, invasion, act of foreign enemies, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraint or detainment, confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority, or

m. Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from burning nuclear fuel,

n. The radioactive, toxic, explosive or other dangerous properties of any explosive nuclear equipment or any part of that equipment,

o. Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft; or Scheduled Airlines

p. No benefit would be paid under this policy, unless the nature & extent of injury is established medically with appropriate investigation reports & certified by the treating doctor

q. While engaged in hazardous activity unless specifically covered under the policy

r. Expenses incurred on neck belts, wrist bandages, walking sticks, abdomen belts, CPAP and any other similar external aid /devices, the use of which has been necessitated following an accident unless specifically covered under the policy.

4. Additional exclusions applicable to the Medical Sections

a. Vaccination and inoculation of any kind unless forming part of treatment for Injury due to an Accident as prescribed by the Medical Practitioner.

b. Vitamins and tonics unless forming part of treatment for Injury due to an Accident as prescribed by the Medical Practitioner.

c. Charges related to Aesthetic treatment, cosmetic surgery and plastic surgery unless specifically covered under the policy.

d. Treatment taken from persons not registered as Medical Practitioners under respective Medical Councils. Any other medical or surgical treatment except as may be necessary solely as a result of Injury.

e. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and subject to Inpatient &/ or Outpatient Hospitalization Treatment being specifically covered under the policy.

f. Experimental, unproven or non-standard treatment.

General Conditions:

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

It is hereby declared and agreed that:-
From the policy start date, the claim 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 an assignee as informed by you to the company.

Upon any sum of claim becoming payable under this policy the same shall be paid by the company to the assignee directly without any notice to the Insured / Insured members but not exceeding the assigned amount. In the event of any sum of claim payable under this policy exceeding the assigned amount, the company shall pay such some to Insured Member / Nominee / Legal Heir

The claim in the manner aforesaid by the assignee 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.

II. 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 facts in the Proposal/Enrolment Form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or device being used by the Policyholder/Insured Person or any one acting on their behalf to obtain a benefit under this Policy.

III. Deferred Payment of Claims:

Where the mode of claim disbursal is deferred we will pay the nominee/legal heir of the Insured Person, during the course of this payment if the nominee/legal heir is unable to receive payments due to demise of the nominee/legal heir we will continue to make payment as per schedule to the legal heir of the deceased nominee/legal heir

IV. Consideration :

The Frequency of Premium payable under the policy and or each Certificate of the Insurance issued under this Policy shall be made annually or on instalment basis.

- **Annual Premium** - premium is payable before the beginning of each 12 month period when the annual premium is due.
- **Instalment Premium** - premium is payable and realized in full by the Company in monthly/quarterly/half yearly frequency (as the case may be) before the instalment due date.

V. 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 Policyholder/Insured Person, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

VI. Material Change:

The Policyholder/ 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, partial disclosure of the medical history at Policyholder's/Insured person's own expense. The Company may, adjust the scope of cover and/or the premium, if necessary, accordingly.

VII. 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 Policyholder/Insured Person or anyone acting on their 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 Duty of Disclosure condition of this Policy.

VIII. No Constructive Notice:

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

IX. 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 Person or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

X. 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.

XI. Electronic Transaction:

The Policyholder/Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and 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.

XII. 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 Policyholder/Insured Person shall:

Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.

Allow the Medical Practitioner or any representative of the Company to inspect the medical and hospitalization records and to examine the Insured Person

Assist and not hinder or prevent the Company or any of its representatives in pursuance of their duties\

In case the Policyholder/Insured Person does not comply with the provisions of this clause or other obligations cast upon the Policyholder/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

XIII. Right to Investigate:

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 Person, be permitted at all reasonable times to investigate into the circumstances of such loss/event leading to claim. The Insured Person or his representatives 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 cost of investigation required under this section.

XIV. Position after a claim:

As from the day of receipt of the claim amount by the Policyholder, the days Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount.

If due to any single accident, any Insured person sustains injury and there are admissible claims under multiple benefits of the Casualty Section, the liability of the Company shall be restricted to the highest Sum Insured specified under any one benefit of the Casualty Section. The Company shall pay upto the highest Sum Insured under any one benefit less any other amount already paid or payable under any benefits of Casualty as opted by the Policyholder and offered under this Policy, as the result of the same accident.

In the event of multiple accidents during the policy period resulting in claim in one or more than one

section, the liability of the company shall be restricted to the highest amount payable in each of the section claimed against.

The policy shall terminate from the date of payment of claim and all the covers/benefits under Casualty, Medical & Add-On sections shall cease from the date of loss, in the event of an admissible Accidental Death or Disappearance claim paid under the policy.
The Company's liability for claims shall be limited to the AOA &/ or AOY limit if the same has been opted by the Policyholder and specified in the Policy Schedule/Certificate of Insurance.

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

xvi. 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 rights whatsoever.

xvii. Free Look Period:
Every insured of new health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges.

xviii. Cancellation:
Single Policy/Master Policy
The Company may cancel this Policy, by giving 7 days' notice in writing/e-mail registered with us acknowledgment due to the Policyholder 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, 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. In case of non-cooperation of the Policyholder in implementing the terms and conditions of this Policy the policy shall be cancelled and premium shall be refunded on ratable proportion provided that no claim has/is occurred/reported up to the date of cancellation of this Policy.
The Policyholder may also give 7 days' notice in writing/ e-mail registered with us, 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. The Policy will terminate at the expiration of the period for which premium has been paid or on Expiration Date shown in the Policy Schedule, whichever is earlier

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 person or Company cancel the Certificate of Insurance.
3. The date the Insured person ceases to be part of the group unless specified otherwise.
4. The date of Expiry of the Certificate
5. Instalment premium is not received during a 15 Days Grace period.

The Company may cancel this Certificate of

Insurance, by giving 15 days' notice in writing/ e-mail 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, established fraud, non-disclosure of material facts of the Insured/ Insured Person 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.

In case of non-cooperation of the Insured/Insured Person(s) in implementing the terms and conditions of this Policy the policy shall be cancelled and premium shall be refunded on ratable proportion provided that no claim has/is occurred/reported up to the date of cancellation of this Policy

The Insured may also give 7 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

XIX. Moratorium:

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits

XX. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

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

XXI. Territorial Limits/Currency of payment:

The coverage under each of the sections of the policy shall be restricted to the Territorial limits as specified in the Schedule. All claims shall be payable in India in Indian Rupees only.

XXII. 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 Policyholder 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.

XXIII. Arbitration (For Indemnity Claims):

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 and amendments as applicable.

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.

XXIV. Renewal & Refund:

The premium for renewal will be applicable as per the premium quote issued by the company based on age; Sum Insured; Change in group size, past policy claims history and any other relevant factors affecting the risk of the group.

In the likelihood of this Policy being withdrawn in future, 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.

All applications for renewal of the Policy must be received by us before the expiry of current Policy.

The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

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

Annual Policy

Period on risk	**% Return Premium**
Upto 1 month*	3/4th of the annual rate
Upto 3 months	½ of the annual rate
Upto 6 months	1/4th of annual rate
Exceeding 6 months	Nil

* Not applicable for policies with freelook period; Premium refund for cancellations during the freelook period will be provided as per the Free look clause

Multi-Year Policy - Applicable for Multiyear policy

Loan Period(Year)	**1**	**2**	**3**	**4**	**5/5+**
Policy Period (Year)	**1**	**2**	**3**	**4**	**5**

Year Of Cancellations	**Rate of Premium to be Return (%) to Insured**				
1*		50%	67%	75%	80%
2			33%	50%	60%
3				25%	40%
4					20%
5					NIL

* Not applicable for policies with freelook period; Premium refund for cancellations during the freelook period will be provided as per the Free look clause

In event of part prepayment of the Loan, no refunds of premium shall be made 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.

XXV. Inclusion of members under the Policy:

New Person can be added to this Policy, either by way of endorsement in case of mid-term inclusion or at the time of renewal subject to acceptance by the Company.

XXVI. Entry Age:

The minimum entry age under the policy is 91 days. The Maximum entry age shall be restricted to 85 Years.

XXVII. Notices:

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

In case of the Policyholder/Insured Person, at the address given in the Schedule to the Policy/Certificate of Insurance.

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

SECTION 5- GRIEVANCES REDRESSAL PROCEDURE

In case of any grievance the insured person may contact the Company through
Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com
ICICI Lombard General Insurance Co. Ltd.
Ground floor- Interface 11, Sixth floor- Interface 16 ,
Office no 601 & 602, New linking Road, Malad (West), Mumbai – 400064

There is an interactive voice response (IVR) facility for senior citizens' grievance redressal for easy and faster resolution

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. For branch details, please visit https://www.icicilombard.com/docs/default-source/policy-wordings-product-brochure/final-gro-mapping.pdf.

If Insured person is not satisfied with the redressal of grievance ,insured person may contact the grievance redressal officer at the details provided in the below link:

https://www.icicilombard.com/grievanceredressal.com

If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority of India (IRDAI) through the Bima Bharosa Portal - https://bimabharosa.irdai.gov.in/ or IRDA Grievance Call Centre(IGCC) at their toll free no. 1800 4254 732 / 155255

Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDAI website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman has context menu

List of Ombudsmen

The details of Insurance Ombudsman are available below:

Office of the Insurance Ombudsman	**Areas of Jurisdiction**
AHMEDABAD Insurance Ombudsman 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 Insurance Ombudsman 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 Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh .
BHUBANESWAR Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-	Punjab, Haryana (excluding Gurugram, Faridabad,

27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
CHENNAI Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
DELHI Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Insurance Ombudsman 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 Insurance Ombudsman 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 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad,

Email: bimalokpal.lucknow@cioins.co.in	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 Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA Insurance Ombudsman 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 Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Insurance Ombudsman	Maharashtra, Areas of

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.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
THANE Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email:bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.

The updated details of Insurance Ombudsman are also available on IRDAwebsite: www.irdaindia.org and on the website of General Insurance Council: www.generalinsurancecouncil.org also on website of the company www.icicilombard.com or from any of the offices of the Company. For updated list of ombudsman details kindly visit https://www.cioins.co.in/Ombudsman"

SECTION 6: CLAIM SERVICING

I. Claim Notification - Multi Model Intimation:

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

Toll Free call Centre of the Insurance Company (24x7) - 1800 2666

In case you are a senior citizen, your call shall be transferred to the Priority Desk and immediate support shall be provided.

Login to the Company's website and intimate the claim - www.icicilombard.com

Post/courier to the Company –

ICICI Lombard House, 414,

Veer Savarkar Marg, Near Siddhi Vinayak Temple,

Prabhadevi, Mumbai - 400 025

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

The company may allow Emergency Assistance Service Provider that We appoint from time to time as specified in the Certificate of Insurance/Policy Schedule to offer emergency assistance with the consent of the Policyholder & other value added services at no additional cost to the insured person as agreed upon with the Emergency Assistance Service Provider in case of an accident during the course of the policy.

II. Information Details

Insured Person/Insured Person's representative should intimate the claims within 7 working days upon occurrence of the event. For emergency hospitalization claims, the Insured Person must provide notification of claim within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier. The Notification of Claim should be ideally provided by the Insured Person or his representative. In the event Insured Person is unwell, then the Notification of Claim should be provided by Insured Person's representative

However, if there is a genuine reason for delay in intimation, the Company shall not enforce any penalty if the admissibility of the claims is not contested upon.

When the Insured Person/Insured Person's representative intimates a claim as mentioned above the following information should be given for prompt services.

Aadhar Card No. Master Policy number Certificate number
Name of the Policyholder
Name of Insured Person making the claim
Contact details
Nature of the Injury
Name and address, phone number of the attending medical practitioner/hospital. Date of hospitalization

III. Claim Form

Upon the notification of the claim, The Company shall assist the Insured person/ Insured Person's

nominee/ legal heir to access the claim form electronically through web download, email or visit to the nearest branch of the Company.
Alternatively, the Company will dispatch the claim form to the Insured person/ Insured Person's nominee/ legal heir.

IV. Claim Procedure

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.
The Company will only make payment as per the Policyholder's direction. In case of Insured Person's unfortunate demise, the Company will only make payment to the Assignee or Nominee (as named in the Policy Schedule/Certificate of Insurance).
When there is an Instalment facility - if Insured Person makes a claim under the policy (applicable for both annual and multi-year policy), Insured Person will be liable to pay the premium for the entire policy period in full and premium shall be realized by the Company in full, before the claim is paid or Insured Person authorizes us to deduct from claim amount due any outstanding premiums due.
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 Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.
The Company will process the claims and make claim payments, within 15 days of the receipt of claim form along with claim documents.

V. Documents

It is the Policy of the Company to seek documents in a single request. Based on documents submitted, if any further documentation is required then it will be sought promptly, at the earliest.
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 following documents need to submitted as per the claims.

A) Mandatory Documents:

a) Death Resulting from Accident:
   i) Completely filled PA claim Form with Company Stamp & Covering Letter from Employer
   ii) Attested Copy of FIR.
   iii) Attested Copy of PM Report.
   iv) Attested Death Certificate.
   v) Attested Spot Panchnama (In case of spot accidental death)
   vi) Attested Inquest panchnama (in case of spot accidental death where dead body shifted to hospital without informing to police - In case of panchayat).
   vii)Attested Railway Police Panchnama and attested Railway station master report (In case of railway Accident)
   viii) Certificate from State electricity board, Electricity Board's Panchnama (Optional) in case of Electrocution
   ix) The Forensic Science Laboratory (FSL) Report (If recommended in PM Report) in case of Snake Bite/ Poisonous Animal Bite

b) Permanent Total Disablement:
   i) Completely filled PA claim form with Company Stamp & Covering Letter from Employer
   ii) Attested Copy of FIR. (If reported to police authority)
   iii) Disability Certificate (Authorised by medical officer/civil surgeon of civil hospital / govt. hospital of the district / units concerned, stating percentage of disablement)
   iv) Reports like X-rays, etc essential for confirmation of the type and percentage of disability
   v) Letter from the Employer stating the Description of accident.
   vi) Colour photograph of the injured reflecting disability.
   vii)Original medical bills with prescriptions/treatment papers. (If medical benefits are covered)

c) Permanent Partial Disablement
   i) Completely filled PA claim Form with Company Stamp & Covering Letter from Employer
   ii) Attested Copy of FIR. (If reported to police authority)

iii) Disability Certificate (Authorised by medical officer/civil surgeon of civil hospital / govt. hospital of the district / units concerned, stating percentage of disablement)

iv) Reports like X-rays, etc essential for confirmation of the type and percentage of disability

v) Letter from the Employer stating the Description of accident.

vi) Colour photograph of the injured reflecting disability.

vii) Original medical bills with prescriptions/treatment papers. (If medical expense is covered)

d) Temporary Total Disablement:

i) Completely filled PA claim Form with Company Stamp & Covering Letter from Employer

ii) Medical Certificate (Medical Practitioner's certificate confirming injury and advising rest/ unfit to work for specified number of days. fitness certificate from treating Doctor).

iii) Attested copy of FIR. (If reported to police)

iv) Leave certificate from the employer.

v) Original Medical Bills with prescription, photocopy of Discharge Card, X-ray report in case of fracture or as the case may be. (Original medical bills required if medical expense is covered)

e) In case of Hospitalization and other specific ailments related benefits:

i) Discharge Summary of the hospitalization

ii) Invoices of the expenses related to the hospitalization

iii) Medical documents to establish the diagnosis of the specific ailment

iv) Any other relevant document as required for the assessment of the claim

VI. Repudiations

The power to repudiate claims is vested in the corporate office to ensure transparency and standardization across the country.

For Reimbursement Claims:

If original bills, receipts, prescriptions, reports and other documents are submitted to the Company and Insured Person requires same for claiming amount from other organization/provider (which is otherwise not payable under our policy), then on request from the Insured Person, We will provide attested copies of the bills and other documents submitted by the Insured Person.

In the event of the original documents being provided to any other Insurance Company/Reimbursement provider, The Company shall accept verified photocopies of such documents attested along with the settlement letter by such other Insurance Company/ reimbursement provider.