ICICI LOMBARD MASHAK (MOSQUITO) RAKSHAK
POLICY WORDINGS

1. PREAMBLE

This Policy is a contract of insurance issued by ICICI Lombard GIC Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on thestatements and declaration provided in the Proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period the Insured Person is diagnosed (through laboratory examination and confirmed by the medical practitioner) with any Vector Borne Disease covered in this policy and hospitalized for a minimum period of seventy-two (72) consecutive hours at a Hospital following Medical Advice of a duly qualified Medical Practitioner, the Company shall pay the agreed sum insured as mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage, exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during the Policy Period shall be the Sum Insured (Individual or Floater) opted and specified in the Schedule.

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female, other genders and references to any statutory enactment includes subsequent changes to the same.

3.1. Age means age of the Insured person on last birthday as on date of commencement of the Policy.

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

3.3. 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.

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

3.5 "**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.

3.6 "**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.

3.7 "**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.

3.8 "**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.

3.9 Condition Precedent means a Policy term or condition upon which the Company's liability underthe Policy is conditional upon.

3.10 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 twenty-four hours because of technological advancement, and

b. which would have otherwise required a hospitalization of more than twenty four hours.

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

3.11 Disclosure to information norm: The policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of anymaterial fact by the policyholder.

3.12 Family means, the Family that consists of the proposer and any one or more of the family membersas mentioned below:

a. Legally wedded spouse

b. Parents and Parents-in-law

c. Dependent Children (i.e. natural or legally adopted) between the day 1 of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage.

3.13 Hospital means any institution established for in-patient care and day care treatment of disease/ 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 Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

has qualified nursing staff under its employment round the clock;
has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
has qualified medical practitioner (s) in charge round the clock;
has a fully equipped operation theatre of its own where surgical procedures are carried out
maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
'Hospital' includes AYUSH hospital.

3.14 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.

3.15 Hospitalization means admission in a hospital for a minimum period of seventy two (72) consecutive hours of 'In-patient care', provided it will not include procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

3.16 In-Patient Care means treatment for which the insured person has to stay in a hospital for morethan 72hours for a covered event.

3.17 Insured Person means person(s) named in the schedule of the Policy.

3.18 Medical Advice means any consultation or advice from a Medical Practitioner including the issueof any prescription or follow up prescription.

3.19 Medical Practitioner means a person who holds a valid registration from the Medical Council ofany 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 the licence.

3.20 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 illness or 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 practiceor by the medical community in India.

3.21 Nominee means the person nominated by the insured to receive the insurance benefits under this policy payable on the death of the insured.

3.22 Notification of Claim means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

3.23 Out-Patient (OPD) Treatment means treatment 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 medicalpractitioner. The insured is not admitted as a day care or in-patient.

3.24 Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

3.25 Policy period means period of one policy year as mentioned in the schedule for which the Policy is issued.

3.26 Policy Schedule means the Policy Schedule attached to and forming part of Policy.

3.27 Renewal means the terms on which the contract of insurance can be renewed on mutual consentwith 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.

3.28 Sum Insured means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum and total liability for any claim made under the Policy, in respect of that InsuredPerson (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Period.

3.29 Third Party Administrator (TPA) means a Company registered with the Authority, and engagedby an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

3.30 Unproven/Experimental treatment means the treatment including drug experimental therapywhich is not based on established medical practice in India.

3.31 Waiting Period means a period from the inception of this Policy during which specified vectorborne disease (s) is/are not covered.

4 SCOPE OF COVER:

The cover listed below is in-built Policy benefit and shall be available to all Insured Persons as mentioned in policy schedule and in accordance with the procedures set out in this Policy.

4.1 Hospitalization Benefit:

Lump sum benefit up to 100% of the Sum Insured (excluding the amount paid under diagnosis cover referred at clause 4.2, if any) shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of any of the following vector borne disease (s) if insured ishospitalized for a minimum period of seventy-two (72) consecutive hours.

i. Dengue fever
ii. Malaria
iii. Filaria (Lymphatic Filariasis)
iv. Kala-azar
v. Chikungunya
vi. Japanese Encephalitis
vii. Zika Virus

4.2 Diagnosis Cover:

2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under “diagnosis cover” for each disease only once in each of the policy year.

Note:

i. The total amount payable in respect of Covers 4.1 and 4.2 shall not exceed 100% of the Sum Insured during a policy period.
ii. Any laboratory test not recognized/ approved in India for diagnosis of the covered vector borne diseases is not covered.
iii. On payment of 100% of sum insured, the policy shall be terminated for the policy year. In case where a policy is issued to a family with individual sum insured for each member, policy will continue for the rest of the insured members.
iv. Once the Sum Insured is paid under the policy for any Insured Beneficiary for Filaria (Lymphatic Filariasis), notwithstanding the terms and conditions, no other claim for this particular condition shall be paid to the Named Insured Beneficiary in his/her entire lifetime.

5 Waiting Period:

5.1 First fifteen-days waiting period

The Company shall not be liable to make any payment under the policy if the covered vector

borne disease is diagnosed or hospitalization takes place during first fifteen days (15 days) from the commencement date of this Policy unless insured person is covered under this Policy continuously andwithout any break in the previous Policy Year.

5.2 Cooling Off Period:

If the Policy is renewed within 30 days from the date of discharge of the previously paid claim for the named insured a 30 days cooling off period shall apply for the same ailment in the renewed Policy. However, there would be no waiting period for other listed vector borne diseases.

6 EXCLUSIONS

6.1 General Exclusions:

The Company shall not be liable to make any payment under the policy in respect of:

i. Claim for any illness/disease other than for vector borne diseases covered under the policy
ii. Diagnosis / Treatment outside the geographical limits of India
iii. Any laboratory test not recognized / approved by the state or central government
iv. Unproven Treatments: Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

6.2 Exclusions specific to Section 4.1:

i. **Domiciliary Hospitalization**, Day care OPD treatment.

ii. Investigation & Evaluation

a. Expenses related to any admission primarily for diagnostics and evaluation purposes
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

iii. Rest Cure, rehabilitation and respite care

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

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons
b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs

iv. Excluded Providers

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations expenses up to the stage of stabilization are payable but not the complete claim.

i. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
ii. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.
iii. Hospitalization for less than a minimum period of seventy-two (72) consecutive hours.

7 CLAIM PROCEDURE

7.1 Notification of claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

7.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable) / Company within the prescribed time limit as specified hereunder.

Sl No	Type of Claim	Prescribed Time limit
1.	Hospitalization Benefit	Within thirty days (30 days) from date of discharge from hospital following positive diagnosis of covered vector borne Disease
2.	Diagnosis Cover	Within Fifteen days (15 days) of Diagnosis of the coveredvector borne disease

7.3 Documents to be submitted:

The claim is to be supported with the following documents and submitted within the prescribed timelimit.

Benefits	Claims Documents Required
1. Hospitalization Benefit	Duly filled and signed Claim Form Photo Identity proof of the patient Medical practitioner's prescription advising admission iv. Discharge summary including complete medical history of the patientalong with other details. Laboratory report(s) confirming the diagnosis vi. OT notes or Surgeon's certificate giving details of the operation performed, whereve applicable vii. NEFT Details (to enable direc credit of claim amount in banl account) and cancelled cheque. viii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs one (1 Lakh or as per extant AML Guidelines. Legal heir/succession certificate wherever applicable i. Any other relevant documen required by Company/TPA fo assessment of the claim.
2. Diagnosis Cover	Duly filled and signed Claim Form Photo Identity proof of the patient Laboratory report(s) confirming the diagnosis Payment receipt (s) v. NEFT Details (to enable direc credit of claim amount in banl account) and cancelled cheque Legal heir/succession certificate wherever applicable Any other relevant documen required by Company/TPA fo assessment of the claim.

Note:

1. The company shall only accept medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submittedto any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company

3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

7.4 Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim assessment, under this Policy by way of processing of claims, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

7.5 Payment of Claim

All claims under the policy shall be payable in Indian currency only.

8. GENERAL TERMS & CONDITIONS

8.1 Disclosure of Information

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

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

8.2 Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to makeany payment for claim(s) arising under the policy.

8.3 Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

8.4 Records to be maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

8.5 Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

8.6 Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any otherelectronic mode mentioned in the schedule.

8.7 Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

8.8 Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the

insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and d) any such act or omission as the law specially declaresto be fraudulent

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

8.9 Cancellation

i. The policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Refund of Premium (basis Policy Period)	
Risk Period (Policy in force)	**Refund %**
Up to 30 days*	77.5%
31 to 90 days	62.5%
3 to 6 months	42.5%
6 to 12 months	0%

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

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non- disclosure of material facts,established fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non- disclosure of material facts or fraud.

8.10 Renewal of Policy

A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium conditions as provided in the policy. .

i. Renewal shall not be denied on the ground that the insured person had made a claim or claimsin the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before theend of the policy period.

iii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

v. If the Policy is renewed within 30 days from the date of discharge of the previously paid claim for the named insured a 30 days cooling off period shall apply for the same ailment in the renewed Policy. However, there would be no waiting period for other listed vector borne diseases.

8.11 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 period as per IRDAI guidelines, provided the policy has been maintained without a break.

8.12 Automatic change in Coverage under the policy is permitted:

i. In the case of Insured Person's demise. However, the cover shall continue for the remaining Insured Person (s) till the end of Policy Period. The other insured person (s) may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of natural guardian or guardian appointed by court for the minor insured person. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the insured person, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

ii. Upon exhaustion of sum insured for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

8.13 Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

8.14 Arbitration

i. If any dispute or difference shall arise as to the quantum to be paid by the 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 here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

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

iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

Possibility of Revision of Terms of the Policy Including the Premium Rates The Company, , may revise or modify the terms of the policy including the premium rates..

8.15 Free look period

i. 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;

8.16 Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

ii. The policyholder may be changed during the Policy Period only in case of his/her demise or him/hermoving out of India. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any).

8.17 Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subjectto underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

8.18 Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

8.19 Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and incase there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

8.20 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 insurer 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.

8.21 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.

8.22 REDRESSAL OF GRIEVANCE

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"

TABLE OF BENEFITS

Name	ICICI Lombard Mashak (Mosquito) Rakshak
Product Type	Individual/ Floater
Category of Cover	Benefit
Sum insured	Rs 10,000/- (Ten Thousand) to 2,00,000/- (Two Lakh) (in the multiples of tenthousand) On Individual basis– SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Policy Period	Standard Product shall be offered with a policy tenure of one year (12 Months).
Eligibility	Minimum entry age shall be 18 years for principal insured and maximum age atentry shall not be less than 65 years for all the insured members including principal insured Policy can be availed for Self and the following family members legally wedded spouse. Parents and Parents-in-law. iii. Dependent Children (i.e. natural or legally adopted) between the day 1 of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible.
Hospitalization Benefit	Lump sum benefit equal to 100% of the Sum Insured (excluding the amount paid under diagnosis cover, if any) shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of any of the following vector borne disease (s) if insured is hospitalized for aminimum period of seventy-two

	(72) consecutive hours
Diagnosis Cover	2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under "diagnosis cover" for each disease only once in each of the policy years.
Sub-limits Diagnosis cover	2% of sum insured

Anexure-A The contact details of **the Insurance Ombudsman** offices are as below-

Office of the Insurance Ombudsman	Area 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 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, 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 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI 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 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	Maharashtra, Areas of 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.