PRADHAN MANTRI SURAKSHA BIMA YOJANA

PART I OF POLICY: POLICY SCHEDULE

Insured Details

Policy Number:
Issued At:
Name of the Insured:
Mailing Address of the Insured:
Contact Number:
ABHA ID*

Do you agree to share your medical records with ICICI Lombard GIC Ltd / TPA through ABHA :
Yes ____ No____

Nominee Details	
Nominee Name	
Nominee DOB	
Age	
Nominee Mobile No.	
Relationship with Proposer	
%	

Appointee Details (IF NOMINEE MINOR) NOTE: The appointee table should not be display if the age of the nominee is greater than 18 years):

Appointee Name	
Appointee DOB	
Relationship with Proposer	

Policy Details

Period of Insurance:

- From : 00:00 Hours of dd/mm/yyyy
- To: Midnight of dd/mm/yyyy

Total Lives Insured:
Sum Insured:
Details of Person Insured: As per Annexure

Premium Computation
Basic Premium:
Service Tax:
Education Cess on Service Tax:Higher Education Cess:

Total Premium:

Coverages

- ……
- ……
- ……

Exclusions

- ……
- ……
- ……
-

Other Conditions:

- ……
- ……
- ……
-

PART II OF POLICY

i. DEFINITIONS

A. Standard Definitions

a. **Accident**: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means

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

c. **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.

d. **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.

e. "**Break in policy**" means the 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.

f. "**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.

g. "**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.

h. "**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.

i. "**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.

j. **Injury** : 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.

k. **Notification of claims**: Notification of claim means the process of intimating a claim to the insurer or TPAthrough any of the recognized modes of communication.

B. Specific Definitions

The Company (ICICI Lombard General Insurance Company Limited) use certain words in this policy and Schedule, which have a specific meaning and are shown under the heading of Definitions in the policy. They have this meaning wherever they appear in the policy, including any endorsements, or Schedule. Where the context so permits, references to the singular shall also include references to the plural and references to the male gender shall also include references to the female gender, and vice versa in both cases.

Age - means the completed years of the Insured Person on his/her last birthday as per the English calendar.

Claim - means a demand made by You or on Your behalf for payment of benefits, as covered under the Policy.

Company – means ICICI Lombard General Insurance Company Limited.

Cover Year - means duration of twelve months beginning from the Cover Period Start Date as specified in the Policy Schedule, and for subsequent Cover Years, it will include any successive durations of twelve months, till the Cover Period End Date, as specified in the Policy Schedule.

Day - means a period of 24 consecutive hours.

Injury - Means any 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.

Permanent Disablement: The bodily injury that results in total and irrevocable loss of a body part or sensoryorgan specified under the table of benefit.

Insured Event - means any event specifically mentioned as covered under this policy.

Insured Person(s) - means the individuals (s) covered under the Policy whose name(s) is/are specifically appearing as such in the Policy Schedule and is/are hereinafter referred as "You"/"Your"/ "Yours"/ "Yourself"

Nominee - means the person(s) nominated by You to receive the benefits under this Policy payable on Yourdeath caused by an Accident. For the purpose of avoidance of doubt it is clarified that if You are a minor,
Your legal guardian shall appoint the Nominee

Period of Insurance means the period as specifically appearing in the Policy Schedule and commencing fromthe Policy Period Start Date of the first Policy taken by the insured from the company and then, running concurrent to the current Policy subject to the Insured's continuous renewal of such Policy with the company concurrent to the current Policy subject to the Insured's continuous renewal of such Policy with the company concurrent to the current Policy subject to the Insured's continuous renewal of such Policy with thecompany concurrent to the current Policy subject to the Insured's continuous renewal of such Policy with thecompany

Physical Separation - means with respect to the hand, severance of limb at or above the wrists, and

with respect to the foot, severance of limb at or above the ankle.

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, what is excluded from the cover and the terms & conditions on which the Policy is issued to the insured person.

Policy Holder means the person(s) or the entity named in the Policy Schedule who executed the Policy Schedule and is (are) responsible for payment of premium(s).

Policy Period means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule.

Policy Year means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve- month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.

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

Proposal and Declaration Form - means any initial or subsequent declaration made by the policyholder andis deemed to be attached and which forms a part of this Policy.

Sum Insured - means and denotes the maximum amount of cover available to the Insured Person under each section and extension (s) therein as detailed in Part I of the Policy to this Policy, subject to the terms and conditions of this Policy, which represents the Company's maximum liability for all claims in aggregate payable to such Insured Person by the Company under each of the respective section(s) and extension (s) therein.

You / Your / Yours / Yourself - means the person(s) that We insure and is/are specifically named as Insured Person(s) in the Policy Schedule.

We/ Our / Ours / Us - means the ICICI Lombard General Insurance Company Limited

ii. Benefits Covered Under the Policy

1. Scope -The Company hereby agrees, subject to the terms, exclusions and conditions herein contained or otherwise expressed hereon, to pay to the Insured Person (or his Nominee/ legal heir, as the case may be) a sumas compensation on occurrence of any Insured Event, as specifically described hereunder, under different Benefit(s) arising due to an Injury sustained by the Insured Person during the Policy Period but not exceeding theSum Insured as specified under the respective Benefits under Policy Schedule.

2. Eligibility Criteria:

The savings bank account holders of the participating banks aged between 18 years (completed) and 70 years (age nearer birthday) who give their consent to join / enable auto-debit, as per the above modality, will be enrolled intothe scheme.

In case of multiple saving bank accounts held by an individual in one or different banks, the person would be eligibleto join the scheme through one savings bank account only.

For the joint savings bank account holders all the account holders can take the benefit by filling one form for each member, separate premium would be charged for each member.

3. Benefit Covers

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section 2 and the terms, conditions, general exclusions stated in the Policy, to pay such Sum Insured as mentioned against benefit table as below under the Schedule to this Policy, on the occurrence of Accidental death or occurrence of the following permanent disablement of the Insured Person, provided such death or permanent disablement results solely and directly from an Injury, within twelve months from the date of Accident resulting in such Injury, provided that the date of occurrence of the Accident falls within the Policy Period/Policy year or as prescribed by the government.

	Table of Benefits	Sum Insured
a.	Accidental Death	Rs 2 Lakh
b.	Total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sight of one eye and loss of use of hand or foot	Rs 2 Lakh
c.	Total and irrecoverable loss of sight of one eye or loss of use of one hand or foot	Rs 1 Lakh

IV Exclusions:

4. Specific Exclusions:

The Company shall not be liable under this policy for:

i. Compensation under more than one of the categories specified in the Benefit covers in respect of the same period of disablement of the Insured Person.

ii. In case a member is covered through more than one account and premium is received by the Insurance Company inadvertently, insurance cover will be restricted to one only and the premium shall be liable to be forfeited.

iii. Any payment in case of more than one claim in respect of such Insured Person, under this policy during any one period of insurance by which the sum payable as per the Benefit covers of this policy to such Insured Person exceeds the maximum liability of the Company specified in Part I of the Policy applicable to such Insured Person.

iv. Payment of compensation in respect of death, injury or disablement of Insured Person (a) from intentional self-injury, suicide or attempted suicide;

viii. Payment of compensation in respect of Death or disablement resulting directly or indirectly caused by contributed to or aggravated or prolonged by childbirth or pregnancy or in consequence thereof.

Special Condition applicable to all the Exclusion:

If the Company alleges that by reason of any of the above Exclusion
i.e. any loss, damage, cost or expenses is not covered by this insurance, the onus of proving the contrary shall be upon the Insured person/nominee.

5. The procedure of lodging the claim shall be as under:

1. Immediately after the occurrence of an accident which may give rise to a claim under the policy, the insured or the nominee (in case of death of the insured) shall contact the bank branch where the insured person held the underlying Bank Account from which the premium for the policy was auto debited and submit a duly completedclaim form.

2. The claim form may be obtained from the above bank branch or any other designated source like insurance company branches, hospitals, Primary Health Centres (PHCs), Business Corespondents (BCs), insurance agents etc., including from designated websites. The Company concerned shall ensure wide availability of forms at allsuch locations

3. The Claim form shall be completed by the insured or, as the case may be, by the nominee and submitted to the bank branch preferably within 15days of the occurrence of the accident giving rise to the claim under the policy.

4. The Claim form shall be supported, in case of death of the insured, by the Original FIR/ Panchnama, Post Mortem Report and Death Certificate and in case of permanent disablement, by Original FIR/ Panchnama and a Disability Certificate issued by a Civil Surgeon. A discharge certificate in the format prescribed by government shall also be submitted by the claimant / nominee.

5. The authorised official of the Bank shall check the account / auto-debit particulars and verify the account details, nomination, debiting of premium / remittance to insurer and certify the correctness of the information given in the claim form, and forward the case to the insurance company concerned within 15days of the submission of the claim.

6. Insurer will verify and confirm that premium has been remitted for the insured and the

insured is included in the list of insured persons in the master policy.

7. Claim shall be processed by the Company within 15 days of its receipt from the Bank.

8. The admissible Claim amount will be remitted to the Bank Account of the insured or the nominee, as the case may be.

9. In case of death of an insured who has not named his/ her nominee the admissible claim amount shall be paid to the legal heirs of the insured on production of Succession Certificate/ Legal Heir certificate from the Competent Court/ authority.

10. Maximum time limit for Bank to forward duly completed claim form to Insurance Company is thirty days and maximum time limit for Insurance Company to approve claim and disburse money thereafter is thirty days

6. Claim Documents:

A) Mandatory Documents:

a) Accidental Death:

i) Completely filled PA claim Form with Signature of Authorised Official of the Bank.
ii) Original FIR / Panchnama.
iii) PM Report.
iv) Death Certificate.
V) Discharge Voucher

b) Disablement:

i) Completely filled PA claim Form with Signature of Authorised Official of the Bank.
ii) Original FIR/Panchnama.
iii) Disability Certificate issued by a Civil Surgeon.
iv) Discharge Voucher

B) Additional Documents required for Payment of Claims:

a) If payable to injured, following additional documents are required for all claims other than death
   i. Account details for Electronic Funds Transfer (EFT mandate form and cancelled cheque)
   ii. Anti Money Laundering AML documents (PAN card/Photo ID, Address proof, and 2 colour photographs) in case of claim amount is more than Rs. 100,000.

b) If payable to nominee, following additional documents for Death claims
   i. Payee name of the nominee
   ii. Account details for Electronic funds transfer (EFT mandate form and cancelled cheque)
   iii. Anti Money Laundering AML documents (PAN card/Photo ID, Address proof, Relationship proof and 2 colour photographs) in case of payment to Nominee/Legal heir.

In addition to above mentioned documents, additional supporting documents may be asked by the company or Thirdparty administrator (TPA), on behalf of the Company, to investigate the Claim or the Company's obligation to makepayment for it.

(a) Condition Precedent to Admission of Liability- The terms and conditions of the policy must be fulfilled by theinsured person for the Company to make any payment for claim(s) arising under the policy

7. Limitation period

In no case whatsoever shall the company be liable, for payment of any benefit for claim filed after the expiry of 30 days from the date of completion of treatment, or occurrence of the accident giving rise to the claim unless the claim is the subject of pending action or arbitration; If the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of disclaimer have been made the subject matterof a suit in court of law then the claim for all such purposes will be deemed to have been abandoned and shall not thereafter be recoverable hereunder.
*This will however be governed by the terms prescribed by the Government of India from time to time.

8. Policy Related Terms and Conditions

(i) Upon the happening of any event, which may give rise to a claim under this Policy, written notice with full particulars must be given to the Company immediately. In case of death, written notice must be given within one calendar month after the death preferably, unless reasonable cause is

shown for delay in intimation. In the event ofloss of sight or amputation of limbs, written notice thereof must be given within one calendar month after such lossof sight or amputation.
(ii) Satisfactory proof shall be furnished to the Company of all matters upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the insured Person(s) on the occasion of any alleged injuryor disablement when and so often as the same may reasonably be required on behalf of the Company and in the event of death to make a post-mortem examination of the body of the Insured Person. Such evidence as the Company mayfrom time to time require shall be furnished and a post-mortem examination report, be furnished within a period of thirty days.

(iii) In the event of a claim in respect of loss of sight, the Insured Person(s) shall undergo at the Insured's expense such operation or treatment as the may reasonably deem desirable. In the event the sight is not regained after suchoperation or treatment, and such loss of sight is of a permanent nature, compensation shall be payable as specified in the Benefit covers in Part II of the Policy of this Policy.

(iv) Position after a claim:

a. In case of death or total and irrecoverable loss of both eyes or loss of use of both hands or feet or loss of sightof one eye and loss of use of hand or foot of the Insured (as specified in Benefit covers) the Company shall delete the name of the Insured Person in respect of whom such sums shall become payable from the Part I of the Policy without any refund of the premium

b. In case of total and irrecoverable loss of sight of one eye or loss of use of one hand or foot (as specified in Benefit covers) the Company shall reduce the sum insured in respect of person to whom such sum shall becomepayable, by the amount admissible under the claim

9. Terms of Renewal

- The Policy can be renewed as a separate contract under the then prevailing Pradhan Mantri Suraksha Bima Yojana or its nearest substitute (in case the product Pradhan Mantri Suraksha Bima Yojana is withdrawn by the Company)
- The policy shall ordinarily be renewable except on grounds of Established fraud, or misrepresentation or non- cooperation by the insured.
- Subscribers who wish to continue beyond the first year will be expected to give their consent for auto-debit before each successive May 31st for successive years. Delayed renewal subsequent to this date may be possible on payment of full annual premium, subject to conditions that may be laid down by the Company.

Part III of Policy

V. General Terms and Clauses

A. Specific terms and Clauses applicable

1. Incontestability and 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 on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or devices being used by the Insured or any one acting on his behalf to obtain any benefit under this policy.

2. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsement of this policy in so far as they relate to anything to be done or complied with by the Insured, shall be a condition precedent to any liability of the Company to make any payment under this policy.

3. No constructive Notice

Any of the circumstances in relation to these conditions coming to the knowledge of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

4. Notice of charge etc.

The Company shall not be bound to notice or be affected by any notice of any trust, charge, lien, assignment or otherdealing with or relating to this policy but the receipt of the Insured or his legal personal representative shall in all cases be an effectual discharge to the company.

5. Special Provisions

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

6. Overriding effect of Part II of the Policy

The terms and conditions contained herein and in Part II of the Policy shall be deemed to form part of the policy andshall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Policy, then the term(s) and condition(s) contained herein shall be read *mutatis mutandis* with the scope of cover/terms and conditions contained in Part II of the Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable. In case of any inconsistency in terms and conditions mentioned in Part II of the Policy with Part I of the Policy then terms and conditions contained in Part I of the Policy will prevail over Part II of the Policy.

7. Electronic Transactions

The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, shall constitute legally bindingand 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. The Insured agrees that the Company may exchange, share or part with any information to or with other ICICI Group Companies or any other person in connection with the Policy, as may be determined by the Company and shall not hold the Company liable for such use/application.

8. Fraudulent/Rejected claims

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 shall be forfeited.

Any amount already paid against claims made under the policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s) who has made a 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 declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove thatthe misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

9. Termination of cover:

The accident cover for the member shall terminate on any of the following events and no benefit will be payablethere under:

1) On attaining age 70 years (age nearest birth day).

2) Closure of account with the Bank or insufficiency of balance to keep the insurance in force.

3) In case a member is covered through more than one account and premium is received by the Insurance Company inadvertently, insurance cover will be restricted to one only and the premium shall be liable to be forfeited.

4) If the insurance cover is ceased due to any technical reasons such as insufficient balance on due date or due to any administrative issues, the same can be reinstated on receipt of full annual premium, subject to conditions that may be laid down. During this period, the risk cover will be suspended and reinstatement of risk cover will be at the sole discretion of Insurance Company.

5) Individuals who exits the scheme at any point during the policy period.

10. 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, provided the policy has been maintained without a break.

11. 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.

12. Currency for payment

All claims shall be payable in Indian Rupees only.

13. Governing Law

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions containedherein is understood and agreed to by both the Insured and the Company to be subject to Indian Law.

14. Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under 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 to or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/ difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of The Arbitration and Conciliation Act, 1996.

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

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

15 Renewal notice

a. The Company shall ordinarily renew the policy except on grounds of

misrepresentation or established fraud or non cooperation by the Insured.. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to Insured that may result to enhanceCompany's risk under the guarantee hereby given. Any change in the risk will be intimated by Insured to the Company.

b. Insurer is required to send the insured renewal notice atleast 30 days prior to the due date.
c. The policy can be renewed as per relevant regulatory prescriptions and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the previous year policy.
d. Subscribers who wish to continue beyond the first year will be expected to give their consent for auto-debit before each successive May 31st for successive years. Delayed renewal subsequent to this date may be possible on payment of full annual premium, subject to conditions that may be laid down

***** This shall be subject to changes as per the guidelines prescribed by the Government of India.

16. Notices

Any notice, direction or instruction given under this policy shall be in writing to:

- In case of the Insured, at the address specified in Part I of the Policy.
- In case of the Company: ICICI Lombard General Insurance Company Limited ICICI Lombard House 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case ofhand delivery or e-mail.

17. Customer Service

If at any time the Insured requires any clarification or assistance, the Insured may contact the offices of the Company at the address specified, during normal business hours.

18. Grievances

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

The details of Insurance Ombudsman are available 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, Bulandsheha r, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnaga r, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpu r, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramna gar, 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.

For updated list of ombudsman details kindly visit https://www.cioins.co.in/Ombudsman

The updated details of Insurance Ombudsman are available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: - *www.gbic.co.in*, website of the company www.icicilombard.com or can be obtained from any of the offices of the Company.

Statutory Warning:
(Under Section 41 of Insurance Act, 1938)
(1)No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to [take out or renew or continue] an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing [or continuing] a policy

accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

[Provided that acceptance by an insurance agent of commission in connection with a policy of any class of insurance business taken out by himself in relation to risks associated with his own life, health or property shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.]

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.]