RASHTRIYA SWASTHYA BIMA YOJANA (Indicative Policy Wordings)

PART I OF THE POLICY - SCHEDULE

Policy No.		**Issued at**	
Name of the Policy Holder		**Contact Details of the Policy Holder**	
Policy Period	1 Year	**From** **Time To Midnight of**	Date in MM/DD/YYYY Date in MM/DD/YYYY'
Cover Period	Upto One Year (as per enrollment date)	**Total number of families to be insured**	
Sum insured per Family	Rs.	**Number of lives covered in a Family**	

Premium:

Basic Premium	Net Premium	Total Premium

1. Per family premium excluding service tax: Rs.__
2. Total amount excluding service tax: (Rs.) _____
3. Geographical location under coverage: _____
4. Coverage Conditions
   - .....
   - .....
   - .....

Company Contact Information:

- **Toll-free number: 1800-2-666**
- **Postal Address:**
  ICICI Lombard General Insurance Company LimitedICICI Lombard House,
  414, Veer Savarkar Marg, Near Siddhi Vinayak Temple,
  Prabhadevi, Mumb**ai 400025**
- **E-mail:** customersupport@icicilombard.com

Signed for and on behalf of the ICICI Lombard General Insurance Company Limited, at_____on this date

Authorised Signatory

PART II OF THE POLICY

I. PREAMBLE

ICICI Lombard General Insurance Company Limited ("the Company"), having received a Proposal and the premium from the Policy Holder named in the Schedule referred to herein below, and the said Proposal and Declaration together with any statement, report or other document leading to the issue of this Policy and referred to therein having been accepted and agreed to by the Company and the Proposer as the basis of this contract do, by this Policy agree, in consideration of and subject to the due receipt of the subsequent premiums, as set out in the Schedule with all its Parts, and further, subject to the terms and conditions contained in this Policy, as set out in the Schedule with all its Parts that on proof to the satisfaction of the Company of the compensation having become payable as setout in Schedule to the title of the said person or persons claiming payment or upon the happening of an event upon which one or more benefits become payable under this Policy, the sum insured/ appropriate benefit will be paid by the Company.

II. General Definitions

A. Standard Definitions

"Accident" An 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.

"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.

"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:

a. 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.

"Any one illness": Any one illness means continuous period of illness and includes relapse within 45 days from the dateof last consultation with the Hospital/Nursing Home where treatment was taken.

"Cashless facility": Cashless facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in

accordance with the policy terms and conditions, aredirectly made to the network provider by the insurer to the extent pre-authorization is approved.

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

"Congenital Anomaly": Congenital Anomaly means a condition which is present since birth, and which is abnormal withreference 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": Co-payment means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

"Cumulative Bonus": Cumulative Bonus means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

"Day Care Centre": A day care centre means any institution established for day care treatment of illness and/or injuries ora medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –

i) has qualified nursing staff under its employment;

ii) has qualified medical practitioner/s in charge;

iii) has fully equipped operation theatre of its own where surgical procedures are carried out;

iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

'Day care centre' includes AYUSH day care centre.

"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.

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

i. undertaken under General or Local Anesthesia in a *hospital/day care centre* in less than 24 hrsbecause of technological advancement, and

ii. which would have otherwise required hospitalization of more than 24 hours.

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

"Deductible": Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payableby the insurer. A deductible does not

reduce the Sum Insured.

"Dental Treatment": Dental treatment means a treatment related to teeth or structures supporting teeth includingexaminations, fillings (where appropriate), crowns, extractions and surgery.

"Disclosure to information norm" The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

"Domiciliary Hospitalization: Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normalcourse would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:

i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii) the patient takes treatment at home on account of non-availability of room in a hospital.

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

"Hospital": A hospital means any institution established for *in-patient care* and *day care treatment* of illness and/orinjuries 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) of the said act Or complies with all minimum criteria as under:

i) has qualified nursing staff under its employment round the clock;
ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15in-patient beds in all other places;
iii) has qualified medical practitioner(s) in charge round the clock;
iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company'sauthorized 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.

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

"Illness": Illness means a sickness or a disease or pathological condition leading to the impairment of normalphysiological function and requires medical treatment.

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to

respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /ortests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

"Injury": Injury means accidental physical bodily harm excluding illness or disease solely and directly caused byexternal, violent, visible and evident means which is verified and certified by a Medical Practitioner.

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

"Intensive Care Unit": Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

"ICU Charges": ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

"Maternity expenses": 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": Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

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

"Medical Practitioner": Medical Practitioner means a person who holds a valid registration from the Medical Council of anyState 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.
(Insurance companies may specify additional or restrictive criteria to the above e.g. that the registeredpractitioner should not be the insured or close member of the family. Insurance Companies may also specify definition suitable to overseas jurisdictions where Indian policyholders are getting treatment outside India as per the terms and conditions of a health insurance policy issued in India)

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

i) is required for the medical management of the illness or injury suffered by the insured;

ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

iii) must have been prescribed by a *medical*

practitioner;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"Network Provider": Network Provider means hospitals or health care providers *enlisted* by an insurer, TPA or jointly by anInsurer and TPA to provide medical services to an insured by a cashless facility.

"New Born Baby": Newborn baby means baby born during the Policy Period and is aged upto90 days.

"Non- Network Provider": Non-Network means any hospital, day care centre or other provider that is not part of the network.

"Notification of Claim": Notification of claim means the process of intimating a claim to the insurer or TPA through any of therecognized modes of communication.

"OPD treatment": OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like aconsultation 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.

"Pre-hospitalization Medical Expenses": Pre-hospitalization Medical Expenses means medical expenses incurred during pre-defined number ofdays preceding the hospitalization of the Insured Person, provided that:

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

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

"Post-hospitalization Medical Expenses": Post-hospitalization Medical Expenses means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalizationwas required, and

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

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

"Renewal": Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre- existing diseases, time-bound exclusions and for all waiting periods.

"Room Rent": Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses**.**

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

"Unproven/Experimental treatment": 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.

B. Specific Definitions:

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Extensions:

Where the context so requires, references to the singular shall also include references to the plural and referencesto any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

1. "**Company"** means ICICI Lombard General Insurance Company Limited.

2. **"Cover Period"** means the period for which the Insured is covered under the Policy and which shall fall within the Policy Period.

3. **"Empanelled Provider"** shall mean the Hospital ,Nursing Home, day care center or such other medical aid provider as has been empanelled by the Company to provide health care services The provider may be from government or private sector

4. **"Family"** shall mean and include the household head and up to four dependents.

5. **"Insured"** means the Individual(s) whose name(s) are specifically appearing as such in Part I of the Policy. For the purpose of avoidance of doubt it is clarified that the heirs, executors, administrators, successors or legal representatives of the Insured may present a claim on behalf of the Insured to the Company.

6. **"Package Charges"** means the fixed maximum permissible claim amount for a specific ailment / proceduresas agreed upon by the Policy Holder and the Company before Policy inception and as specifically stated in the Annexure I to the Policy.

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

8. **"Policy Period"** means the period of time stated in the Schedule of the Policy for which the Policy is valid.

9. **"Proposal"** means any initial or subsequent declaration made by the Policy Holder in form of a form, letteror written statement supplied to the Company and forms the basis of the Policy.

10. **"Schedule"** means the schedule as mentioned in Part I of the Policy, and any annexure to it, attached to and forming part of this Policy.

11. **"Smart card"** means an identity card issued to the Insured by the Company, for the purpose of identification of beneficiaries under the scope of this Policy

12. **"Surgical Operation"** means any manual and/or operative procedure (s) required for treatment of Illness/Injury, correction of deformities and defects, repair of Injuries, diagnosis and cure of diseases, relief of suffering and prolongation of life performed in a Hospital or day care centre by a Medical Practitioner.

III. Benefits Covered under the policy

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed herein, that, if during the Cover Period stated in Schedule, any Insured shall contract any disease or suffer from Illness or sustain any bodily Injury through Accident, and if such Illness or Injury shall require any such Insured, upon the advice of a Medical Practitioner to incur Medical Expenses upon Hospitalisation, the Company will pay to the Insured, the amount of such expenses as are reasonably and necessarily incurred thereof, by or on behalf of such Insured but not exceeding the aggregate sum insured for

a particular Insured as mentioned in the Schedule hereto. In addition, the following benefits would also be a part of cover under the Policy:

Pre-existing Diseases: The Company shall cover the Pre-Existing Diseases of the Insured from the day one ofPolicy issuance. Subject otherwise to the terms, conditions and exclusions of the Policy as defined in the relevant government scheme/tender document/relevant regulatory prescriptions.

1. **Maternity Expenses**: The Company shall indemnify the Insured against the Medical Expenses incurred, subject to a maximum of Rs.2500 for normal delivery and Rs.4500 for caesarian section / complicated delivery during the Cover Period which, on the advice of a Medical Practitioner requires Hospitalization, provided the minimum period of Hospitalisation is more than 48 hours post delivery. Expenses related to voluntary termination of pregnancy and pre-natal expenses will be excluded from the scope of this cover. Claims with respect to only first 2 living children would be covered under the Policy.

2. **Transportation / Ambulance charges:** The Company shall compensate the Insured, for the amounts incurred for necessary transportation up to a maximum of Rs. 100/- per Hospitalisation, subject to a maximum of Rs.1000/- during the entire Cover Period, for transportation of the Insured to the nearest hospital in case of lifethreatening emergency conditions or Accident, subject to certification by the Medical Practitioner of such life threatening emergency.

3. **New Born Baby cover:** The Company shall reimburse the Medical Expenses incurred by the Insured on Hospitalization of a "New born Baby" as an inpatient during the Cover Period subject to the Sum Insured.

   "New born Baby" means the baby born to Insured or his spouse during the Policy Period, aged between 1 dayand 90 days.

4. **Pre/Post hospitalization cover:** Notwithstanding anything contrary contained in the Policy, on the payment of additional premium, it is hereby agreed that 01 days Pre-hospitalization and 05 days Post-hospitalization expenses will be covered under this Policy.

5. **Floater Benefit:** Floater benefit means that the aggregate sum insured, as specified in the Schedule, is available to the Insured or Insured's Family members, as covered under this Policy, for any and all claims made in aggregate during the Cover Period.

   The Company will reimburse the expenses incurred by the Insured or Insured's Family members as covered under this Policy, for any and all claims subject to the sum Insured, made in aggregate by the Insured or Insured's members under the Floater Benefit, provided such claim is admissible under the Policy.

Subject otherwise to the terms, conditions and exclusions of the Policy

IV . Exclusions

A. **Specific Exclusions**:

The Company shall not be liable to make any payment under this Policy in connection with or in respect of any expenses whatsoever incurred by any Insured in connection with or in respect of:

1. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power

2. Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials

3. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident

4. Vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery unless necessary for treatment of an Illness or Injury not excluded by the terms of the Policy or as maybe necessitated due to treatment of an Accident.

5. Dental treatment or surgery of any kind unless requiring Hospitalisation.
6. Convalescence, general debility, run-down condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-Injury (whether arising from an attempt to suicide or otherwise) and use of intoxicating drugs and/or alcohol.

7. Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-Ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury whether or not requiring Hospitalisation.

8. Expenses on vitamins and tonics unless forming part of treatment for Injury or Illness as certified by the attending Medical Practitioner.

9. Experimental, unproven or non-standard treatment which is not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury.

10. Condition that do not require Hospitalization and can be treated under Out Patient Diagnostic (OPD) medical & surgical procedures or treatment unless necessary for treatment of a disease covered under day care procedures.

4. Claims Procedure

The Claims Settlement is done on a cashless basis through the Empanelled Provider as per process defined in the relevant government scheme/tender document/relevant regulatory prescriptions.

The fulfillment of the terms and conditions of this Policy insofar as they relate to anything to be done or compliedwith by the Policy Holder shall be conditions precedent to admission of liability under this Policy.

Further, upon the discovery or happening of any Illness or Injury that may give rise to a claim under this Policy, thenas a condition precedent to the admission of liability, the Insured shall undertake the following:

Cashless access in case Package Charges are fixed

1. The Insured contacts the Empanelled Provider. Cashless settlement is only available through an EmpanelledProvider.
2. The Insured provides the Empanelled Provider with the Smart Card.
3. The Empanelled Provider checks the identity of the Insured by using the finger prints and smart card details ofthe Insured. The Empanelled Provider also check the available sum insured of the Insured.
4. After these preliminary checks, Empanelled Provider passes a provisional entry to block the claim amount in the Smart Card of the Insured.
5. After the provisional entry is made on the Insured's Smart Card, the Insured avails the treatment.
6. At the time of discharge from the Hospital, the Empanelled Provider passes the final entry on the Insured's Smart Card after verification of the Insured's finger prints (any other enrolled Family member in case of death)to complete the transaction.
7. Thereafter the Empanelled Provider electronically transmits this data to the Company
8. The Company settles the claim electronically with the Empanelled Provider.

Pre-authorisation for cashless access in case no Package Charges are fixed

1. The Insured contacts the Empanelled Provider. Cashless settlement is only

available through an Empanelled Provider.

2. The Insured provides the Empanelled Provider with the Smart Card.
3. The Empanelled Provider checks the identity of the Insured by using the finger prints and smart card details ofthe Insured. The Empanelled Provider also check the available sum insured of the Insured.
4. The Empanelled Provider forwards the Hospitalisation request of the Insured to the Company after taking the disease / ailment details from the treating Medical Practitioner
5. Such request has to be forwarded to the Company within 6 hours of admission in case of an emergency and within 7 days prior to the expected date of admission in case of a planned Hospitalisation.
6. On receipt of such request, the Company forwards the authorisation letter to guarantee payment in case the claim is considered to be admissible by the Company. In case of denial of such request, the Company will provide clarification to the Policy Holder.
7. The Empanelled Provider passes an entry in the Smart Card of the Insured for the authorised amount by the Company.
8. The Company will not be liable for any claim payment in case the information as provided in authorization letter or any other document during the course of authorization is found incorrect or not disclosed

In case the balance Sum Insured available is less than the Package Charge, the settlement shall be made bythe Company upon receipt of original medical bills and documents for the balance amount.

In case a claim is repudiated by the Company, the Company shall communicate the same along with anexplanation for the repudiation to the Policy Holder.

5. Policy Related Terms and Conditions

1. Any Medical Practitioner authorised by the Company shall be allowed to examine the Insured in case of any alleged diseases, Illness, Accident or Injuries requiring Hospitalisation when and as often as the same may reasonably be required on behalf of the Company. The cost of any such further examination required by the Company will be borne by the Company.

2. If at the time when any claim arises under this policy, there is in existence any other insurance policy whether it be effected by or on behalf of any insured in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses, the Company shall not be liable to pay or contribute more thanits rateable proportion of any loss, liability, compensation, costs or expenses.

3. All medical/surgical treatment under this policy shall have to be taken in India and admissible claims thereofshall be payable in Indian currency

6. Terms of Renewal

- The Policy can be renewed under the then prevailing Rashtriya Swasthya Bima Yojana product or its nearest substitute (in case the product Rashtriya Swasthya Bima Yojana is withdrawn by the Company)
  - A health insurance policy shall ordinarily be renewable except on grounds of established fraud, or misrepresentation or non-cooperation by the insured
  - **Renewal Premium** - Premium payable on renewal and on subsequent continuation of cover are subject to change.
  - **Maximum Renewal Age** – Any person in the age group of 91 days – 100 years of age can be covered under thisPolicy with no restriction on the renewal age
  - On renewal of the policy, the benefit provided under the policy and/or terms and condition of the policy including premium may be subject to change.

PART III OF THE POLICY

V. General Terms and Clauses

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. Reasonable Care

The Insured shall take all reasonable steps to safeguard the interests of the Insured against Accidental loss or damage that may give rise to the Claim.

3. 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.

4. Material change

The Insured shall immediately notify the Company in writing of any material change in the risk and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

5. Records to be maintained

The Insured shall keep an accurate record containing all relevant medical records and shall allow the Company to inspect such record. The Insured shall also exercise necessary co-operation in obtaining the medical records from the hospital, as may be required in relation to the claim within such reasonable time limit.

6. No constructive Notice

Any knowledge or information of any circumstances or condition in connection with the Insured in possession of anyofficial 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.

7. Notice of charge etc.

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment orother dealing with or relating to this Policy, but the payment by the Company to the Insured or his legal representative of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

8. 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 and shall 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.

9. Duties of the Insured on occurrence of loss

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

(i) Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in PartII of the Policy.

(ii) Assist and not hinder or prevent the Company or any of its agents from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

If the Insured does not comply with the provisions of this Clause or other obligations cast upon the Insured under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents,all benefits under the Policy shall be forfeited, at the option of the Company.

10. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured's rights or recovery thereof against any person or organisation, and the Insured shall execute and deliver instruments and papers necessary to secure such rights.

The Insured and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required

by the Company, before or after Insured's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. However, this condition shall not be applicable for all the Benefit based covers under the Policy, as applicable.

11. Fraudulent 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 which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment. For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a 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.

12. Cancellation/ termination Cancellation of the Policy may be-

a. By the Government, at any time, in the event of material breach of the terms of the agreement,committed by the Company, by giving due notice to the Company.

b. By either of the parties that are the Government or the Company, provided they give the other party atleast 7 days prior written notice as per process defined in the relevant government scheme/tender document/relevant regulatory prescriptions..

c. In case of automatic renewal of the contract, it will be done only if both parties that are the Governmentand the Company agree for it.

In case of cancellation by either party, the unutilized amount of premium shall be refunded by the Company.

13. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Part I to the Policy or Extensions to this Policy. All claims payable in India shall be in Indian Rupees only.

Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both the Insured and the Company to be adjudicated or interpreted in accordance withthe Laws of India and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

14. Arbitration clause

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 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. 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 referable to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

15. **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.

16. **Renewal notice**

a) The Company shall ordinarily renew the policy except on grounds of misrepresentation or established fraud or non cooperation by the InsuredEvery 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 the Insured that may result to enhance the risk under the guarantee hereby given. Any change in the risk will be intimated by Insured to the Company. Nothing herein or otherwise shall affect our right to impose any additional terms and conditions on renewal or restrict any renewal terms as to premium or otherwise.

(b) The Policy may be renewed as per the relevant regulatory prescriptions and terms of the government schemeand in such event the renewal premium shall be paid to the Company on or before the date of expiry of the Policy and in no case later than Grace Period of 30 days from the expiry of the Policy.

17. **Notices**

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimileto:

In case of the Policy Holder, at the address specified in the Schedule. In case of the Company:

ICICI Lombard General Insurance Company LimitedICICI Lombard House,
414, Veer Savarkar Marg, Near Siddhi Viniyak Temple,Prabhadevi, Mumbai 400025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of handdelivery, facsimile or e-mail.

18. **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.

19. **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

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:	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).

bimalokpal.chennai@cioins.co.in	
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, Pratapgar

	h, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, 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.

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

The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org and on thewebsite of General Insurance Council:

www.generalinsurancecouncil.org also on website of the company www.icicilombard.com or from any of the officesof the Company.

Statutory Warning:

PROHIBITION OF REBATES.

(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.]