Saral Suraksha Bima, Acko

Policy wordings

1. PREAMBLE

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

2. OPERATIVE CLAUSE

Any amount payable under the policy shall be subject to the terms of coverage, exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured and Cumulative Bonus (if any) specified in the Schedule.

3. DEFINITIONS

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

Standard definitions

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

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

2.3. Cashless Facility means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

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

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

2.6. 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 hrs because 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.

2.7. 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.

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

2.9. Family: Family consists of the proposer and any one or more of the family members as mentioned below:

(iv) legally wedded spouse.

(v) Parents and Parents-in-law.

(vi) dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

2.10. **Hospital** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;

ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;

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 shall make these accessible to the Company's authorized personnel.

2.11. **Hospitalisation** means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

2.12. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

2.13. **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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

2.15. **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.

2.16. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.

2.17. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

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

2.19. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the licence.

2.20. **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 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.

2.21. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

2.22. **Non- Network Provider** means any hospital that is not part of the network.

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

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

2.25. **Policy** period means period of one policy year for which the Policy is issued.

2.26. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy

2.27. **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

b) 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.

2.28. **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.

2.29. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

2.30. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person.

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

2.32. **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.

2.32 **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

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.

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

4. COVERAGE:

a. **Base Covers:** The covers listed below are in-built Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

a) Death: The company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, on death of the insured person, due to an Injury sustained in an Accident during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of the Accident. Where claim payment has been made owing to disappearance of insured person following an accident, if after the payment of accidental death claim, it is found that the insured person has survived the accident, then the policyholder has to refund the payment back to the company in consideration of the obligatory guarantee as provided during the claim.

b) Permanent Total Disablement: The company shall pay the benefit equal to 100% of Sum Insured, specified in the policy schedule, if an insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident during the Policy Period, provided that the Permanent Total Disablement occurs within 12 months from the date of the Accident:

a) Total and irrecoverable loss of sight of both eyes or

b) Physical separation or loss of use of both hands or feet or

c) Physical separation or loss of use of one hand and one foot or

d) loss of sight of one eye and Physical separation or loss of use of hand or foot

e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever.

c) Permanent Partial Disablement:

The company shall pay the following percentage of Sum Insured, specified in the policy schedule, if the Insured Person suffers Permanent Partial Disablement of the nature specified below solely and directly due to an Accident during the Policy Period provided that the Permanent Partial Disablement shall occur within 12 months of the date of the Accident.

	Loss Covered	Percentage of Sum Insured
1.	Loss of Use/ Physical Separation:	
	One entire hand	50%
	One entire foot	50%
	Loss of Sight of one eye	50%
	Loss of toes – all	20%

	Great both phalanges	5%
	Great – one phalanx	2%
	Other than great if more than one toe lost	1%
2.	Loss of Use of both ears	50%
3.	Loss of Use of one ear	20%
4.	Loss of four fingers and thumb of one hand	40%
5.	Loss of four fingers	35%
6.	Loss of thumb	
	- both phalanges	25%
	- one phalanx	10%
7.	Loss of Index finger	
	- three phalanges	10%
	- two phalanges	8%
	- one phalanx	4%
8.	Loss of middle finger –	
	three phalanges	6%
	two phalanges	4%
	one phalanx	2%
9.	Loss of ring finger –	
	three phalanges	5%
	two phalanges	4%
	one phalanx	2%
10.	Loss of little finger –	
	three phalanges	4%
	two phalanges	3%
	one phalanx	2%
11.	Loss of metacarpus -	
	first or second (additional)	3%
	third, fourth or fifth (additional)	2%
12.	Any other permanent partial disablement	Percentage as assessed by the independent Medical Practitioner

Maximum amount payable in respect of multiple nature of disablements shall be restricted to sum insured chosen by the policyholder.

Note:

a) The base sum insured chosen and cumulative bonus, if any, is applicable cumulatively for all the three covers specified under 4.1(a),4.1(b) and 4.1(c) above i.e, there is a single sum insured for all the three covers namely, Accidental death, Permanent total disability and Permanent Partial Disability.

b) If the accident occurs during the policy period, benefits covered under 4.1(a),4.1(b) and 4.1(c) above are payable, even if death or Permanent Total Disablement or Permanent Partial Disablement or any combination thereof occurs after the completion of policy period, but within 12 months from the date of accident.

b. **Optional Covers:** The covers listed below are optional benefits and shall be available to Insured Persons in accordance with the terms set out in the Policy, if the listed cover is opted.

a) Temporary Total Disablement:

If the Insured Person sustains an Injury in an Accident during the Policy Period and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable of performing at the time of the Accident (Temporary Total Disablement), the company shall pay the benefit as specified in the policy schedule, till the time the insured person is able to return to work, provided that:

(i) The period of temporary total disablement shall exceed four consecutive weeks from the date of accident, however, the benefit shall be reckoned from the date of accident and shall be payable for the entire duration of disablement.

(ii) the compensation payable under this benefit mentioned under Section 4.2(a) shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the Sum Insured.

(iii) The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident.

(iv) The compensation shall be paid by the company at quarterly intervals, after ascertaining the amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period

(v) During the course of payment under this benefit, the company shall have right to call for a certification from an independent medical practitioner with regard to the continuity of temporary total disability specified under this section.

(vi) The insured shall notify the company immediately on resuming to his occupation/employment. Where it is found that the insured resumed to his occupation/employment without notifying to the company and received the compensation under this cover, the company shall have right to claim the recovery of such benefit paid.

Note: For the purpose of this benefit, “week” is a period of seven consecutive calendar days.

b) Hospitalisation Expenses due to Accident: The Company shall indemnify medical expenses incurred for hospitalisation arising due to accident during the policy period, up to the limit of 10% of the base sum insured, specified in the policy schedule.

The hospitalisation expenses shall cover the following:

i. Room, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home,

ii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.

iii. Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities, and such other similar expenses.

(Expenses on Hospitalisation for a minimum period of 24 hours are admissible. However, this time limit of 24 hours shall not apply when the treatment does not require hospitalisation as specified in the terms and conditions of policy contract, where the treatment is taken in the Hospital and the Insured is discharged on the same day.)

iv. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses

v. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure carried out to treat the accidental injury covered under the policy

vi. Expenses incurred on hospitalization due to accident, under AYUSH (as defined in IRDAI (Health Insurance) Regulations, 2016) systems of medicine shall be covered without any sub-limits.

The following other expenses necessitated due to injury shall also be covered under the optional cover specified under Section 4.2(b):

i. Dental treatment.

ii. Plastic surgery.

iii. All the day care treatments.

iv. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalization.

Note: The expenses that are not covered under the section 4.2(b) are placed under List-I of Annexure-B. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-B respectively.

c) Education Grant:

Following an admissible claim of the insured person under the policy towards Death or Permanent Total Disability of the insured person, the company shall pay a one-time educational grant of 10% of the Base Sum insured (specified in the policy schedule), per child to all dependent children of the Insured provided that:

a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.

b. Age of the child or children as the case shall not be more than 25 completed years.

Note:

i. The benefits payable under each of the optional covers 4.2(a), 4.2(b) and 4.2(c) are independent and over and above the base sum insured.

ii. Claim admissibility under the optional covers “Temporary total disablement” and “hospitalization due to accident” is independent of claim admissibility under the base covers.

d) Cumulative bonus:

Sum insured (excluding cumulative bonus) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured. If a claim is made in any particular year, the cumulative bonus accrued may be reduced at the same rate at which it has accrued.

Notes:

i. The cumulative bonus is applicable only in respect of base covers referred at Section 4.1(a),4.1(b) and 4.1(c). Addition or reduction of cumulative bonus will be done only if claim made under base covers

ii. The CB shall be added and available individually to the insured persons under the policy, if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person.

iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal

premium any awarded CB shall be withdrawn

5. EXCLUSIONS (applicable to all sections of the policy)

Standard Exclusions

The Company shall not be liable to make any payments under this policy in respect of:

(i) Any claim for death or disablement (whether of a permanent nature or of a temporary nature), hospitalisation of the insured person, directly or indirectly due to War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

(ii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person

a. from intentional self-injury unless in self-defense or to save life, suicide or attempted suicide;

b. whilst under the influence of intoxicating liquor or drugs or other intoxicants except where the insured is not directly responsible for the injury / accident though under influence of intoxication.

c. whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or travelling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world. [Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a regular airline or whether such an aircraft has a single engine or multiengine;]

d. arising or resulting from the Insured Person committing any breach of law with criminal intent.

(iii) Any claim for death, disablement (whether of a permanent nature or of a temporary nature), hospitalization of Insured Person due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

(iv) Any claim resulting or arising from or any consequential loss directly or indirectly caused by or contributed to or arising from:

A. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel or from any nuclear waste from combustion (including any self-sustaining process of nuclear fission) of nuclear fuel.

B. Nuclear weapons material

C. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

D. Nuclear, chemical and biological terrorism

(v) Any loss arising out of the Insured Person's actual or attempted commission of or willful participation in an illegal act or any violation or attempted violation of the law.

(ii) Exclusions specific to section 4.2(b) "Hospitalisation Expenses due to Accident"

The Company shall not be liable to make any payments under this policy in respect of any expenses incurred by the insured person in connection with or in respect of:

i. Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment.

ii. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code- Excl14)

iii. Expenses incurred for treatment of accidental injuries which does not warrant hospitalization.

iv. Any expenses incurred on Domiciliary Hospitalization and OPD treatment.

v. Treatment taken outside the geographical limits of India.

vi. All expenses listed in Annexure-B (List I) of the Policy.

e) CLAIM PROCEDURE

(i) Notification of claim:

i. Intimation about an event or occurrence that may give rise to a claim under this policy must be given within 30 days of its happening.

ii. Claims for insurance benefits must be submitted to the Company not later than one (1) month after the completion of the treatment or after transportation of the mortal remains/ burial in the event of Death.

iii. If any treatment for which a claim may be made is to be taken and that treatment requires Hospitalisation in an Emergency, the company shall be informed within 24 hours of the admission of the insured person in Hospital.

Note: The Company will examine and relax the time limit mentioned herein above depending upon the merits of the case.

(ii) Documents to be submitted:

7.2.1 Basic documents required for All claims

i. Duly completed claim form

ii. Photo Identity Proof of the insured person

iii. Copy of FIR/ Panchnama /Police Inquest Report (wherever these reports are required as per the circumstance of the Accident) duly attested by the concerned Police Station

iv. Copy of Medico Legal Certificate (wherever it is required as per the circumstance of the Accident) duly attested by the concerned Hospital

v. Any other relevant document required by the Company for assessment of the claim

7.2.2 Documents required in case of Death covered under Section 4.1(a)

i. Death certificate;

ii. Post Mortem Report (if conducted);

iii. Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any

other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.

7.2.3 Documents required in case of Permanent Total Disablement (PTD) / Permanent Partial Disablement (PPD), covered under Sections 4.1(b) and 4.1(c)

i. Original treating Medical Practitioner's certificate describing the disablement

ii. Original Discharge summary from the Hospital

iii. Disability certificate issued by treating Medical Practitioner

iv. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable.

7.2.4 Documents required in case of Temporary Total Disablement (TTD), covered under Section 4.2(a)

i. Original treating Medical Practitioner's certificate confirming the disability

ii. Original Discharge summary from the Hospital

iii. Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

iv. Leave/Absence Certificate from Employer (If Employed)

v. Medical Practitioner's certificate confirming the Injury and advising rest/ unfit to work for specified number of days

vi. Fitness Certificate issued by the treating doctor.

7.2.5 Documents required for coverage under Section 4.2(b)- Hospitalisation Expenses due to Accident:

i. Discharge Summary from The Hospital

ii. Medical & Investigation reports

iii. Prescriptions, and consultation papers of the treatment

iv. Any other medical, investigation reports, as applicable

7.2.6 Documents required for coverage under Section 4.2(b)- Education Grant:

i. Proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate.

ii. Photo Identity Proof of Child

iii. Age proof of Child

iv. Bonafide Certificate issued by the educational institution confirming that he/she is a full time student of the institution

(iii) Claim Settlement

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.

ii. In case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 15 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 15 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: “Bank rate” shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the Financial Year in which claim has fallen due)

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

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre- authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy. The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

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

(v) Payment of Claim

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

f) General Terms and Conditions

(i) Disclosure of Information

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 by the policyholder.

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

(ii) Condition Precedent to Admission of Liability

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

(iii) Material Change

The Insured Person shall immediately notify the Company in writing of any change in his business or occupation or physical defect or infirmity with which he has become affected since the payment of last preceding premium.

(iv) Automatic Termination of Insurance

This policy shall automatically terminate upon the Insured Person's death or payment of 100% Sum Insured.

However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

(v) Complete Discharge

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

(vi) Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

(vii) Territorial Limit

The coverage is worldwide except for the optional cover “Hospitalization expenses due to accident”.

The coverage of optional cover “Hospitalization expenses due to accident”, is limited to medical treatment taken in India only.

(viii) Multiple policies (Applicable to covers which offer fixed benefits)

In case of multiple policies which provide fixed benefits, on the occurrence of the Insured event in accordance with the terms and conditions of the policies, the insurer shall make the claim payments independent of payments received under other similar policies.

(ix) Multiple policies (Applicable for Section 4.2(b)- Hospitalisation Expenses due to Accident)

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

b. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

c. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

d. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only have indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

(x) Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy 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 that the 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.

(xi) Cancellation

i. The Insured may cancel this Policy by giving 7 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund of Premium on Cancellation

Cancellation Period	% of Premium
Within 25% of the Coverage Period	**60%**
25%-50% of the Coverage Period	**40%**
50%-75% of the Coverage Period	**20%**
Exceeding 75% of the Coverage Period	**0%**

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

ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non- disclosure of

material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

(xii) Nomination:

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

(xiii) Renewal of the Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

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

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

v. The cover for the Insured shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under Coverage Death or Permanent Total Disability and no Renewal of contract will be permissible.

vi. The insured may also avail an optional cover or opt out of the optional cover at the time of renewal.

(xiv) Possibility of revision of the premium rates:

The company, with prior approval of IRDAI, may revise or modify the premium rates.

(xv) Policy Disputes:

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

(xvi) Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 30 days (15 days in case of monthly instalments) would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. No interest will be charged If the instalment premium is not paid on due date.

iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.

v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vi. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

(xvii) Free look period

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If you are not satisfied with any of the terms and conditions, you have the option to cancel your policy. This option is available in case of policies with a term of one year or more.

If you have not made any claim during the Free Look Period, the you shall be entitled to:
1. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
2. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
3. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

g) Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, insured person may contact the company through:

i. Website: www.acko.com/gi

ii. Toll Free : 1800 266 2256

iii. E-mail: hello@acko.com

h) Grievances

For resolution of any query or grievance, insured may contact the company on our helpline number **1800 266 2256** or toll free number **1860 266 2256** or may write an e-mail at hello@acko.com.

If there is lack of response or if the response provided does not meet your expectation, you can write to grievance@acko.com. Your complaint will be acknowledged by us within 24 working hours.

If in case you are dissatisfied with the decision/resolution provided through details indicated above on your Complaint or have not received any response within 15 working days, you may write or email to,

Chief Grievance Officer

Acko General Insurance Limited 36/5 Hustlehub One East, Somasandrapalya, 27th Main Road Sector 2, HSR Layout, Karnataka Bangalore – 560102

Phone: 1800 266 2256 (Toll-Free) or 1860 266 2256 Email: gro@acko.com

If your issue remains unresolved within 30 days of lodging a complaint with us and you wish to pursue other avenues for redressal of grievances, you may approach IRDAI by calling on the Toll-Free no. 155255 or you can register an online complaint on the website Bima Bharosa

Insurance Ombudsman for Redressal, whose details are given below:

General Manager Consumer Affairs Department- Grievance Redressal Cell

Website: https://cioins.co.in/Ombudsman

In the event of an unsatisfactory response from the Grievance Officer, he/she may register a complaint in the Integrated Grievance Management System (IGMS) of the IRDAI.

Where the grievance is not resolved, the insured may, subject to vested jurisdiction, approach the Insurance Ombudsman for the redressal of grievance. The details of the Insurance Ombudsman are available in Annexure A:

i) TABLE OF BENEFITS

Name	Standard Personal Accident Insurance policy by Acko General Insurance Limited
Product Type	Individual
Category of Cover	All the covers are benefit based except the optional cover “Hospitalisation Expenses due to Accident” which is indemnity based.
Sum insured	On Individual basis – SI shall apply to each individual family member
Policy Period	1 year
Base covers	i. Death ii. Permanent total disablement iii. Permanent partial disablement
Optional covers	i. Temporary total disablement ii. Hospitalisation Expenses due to Accident iii. Education grant
Cumulative bonus	Sum insured (excluding CB) shall be increased by 5% in respect of each claim free policy year, provided the policy is renewed without a break subject to maximum of 50% of the sum insured.

ANNEXURE-A

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

AHMEDABAD - Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Near S.V College, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/ Email: bimalokpal.ahmedabad@cioins.co.in

BENGALURU - 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

BHOPAL - Office of the Insurance Ombudsman, LIC of India Zona! Office Bldg.. 1st Floor, South Wing,Jeevan Shikha, opp. Gayatri Mandir, Hoshangabad Road, Bhopal-462011. Tel.: - 0755-2769201/02/03, Email: bimalokpal.bhopal@cioins.co.in

BHUBANESHWAR - Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar-751 009. Tel.:- 0674- 2596461/55/29/03 Email: bimalokpal.bhubaneswar@cioins.co.in

CHANDIGARH - Office of the Insurance Ombudsman, Jeevan Deep Ground Floor, LIC of India Bldg**.,** SCO 20-27, Sector 17-A, Chandigarh -160017, Tel: 0172-2706468/7468, Email: bimalokpal.chandigarh@cioins.co.in

CHENNAI - Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453(Old 312), Anna Salai, Teynampet, CHENNAI-600018. Tel.: - 044-24333668/78 Email: bimalokpal.chennai@cioins.co.in

DELHI - Office of the Insurance Ombudsman, 2/2 A,1st Floor Universal Insurance Building, Asaf Ali Road, New Delhi-110 002. Tel.: - 011- 23232481/23213504/46013992 Email: bimalokpal.delhi@cioins.co.in

GUWAHATI - Office of the Insurance Ombudsman, Jeevan Nivesh Bldg, 5th Floor, S.S. Road, Guwahati-781001 (ASSAM) Tel: 0361- 2632204 / 2632205/ 2631307 Email: bimalokpal.guwahati@cioins.co.in

HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st Floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel: 040 – 23312122/ 223376991/23376599/23328709/23325325 Email: bimalokpal.hyderabad@cioins.co.in

JAIPUR - Office of the Insurance Ombudsman, Jeevan Nidhi – II, Ground Floor, Bhawani Singh Road, Ambedkar Circle, Jaipur – 302 005 Tel: 0141-2740363 Email: bimalokpal.jaipur@cioins.co.in

KOCHI - Office of the Insurance Ombudsman, 10th Floor, LIC Bldg, Jeevan Prakash, Opp to Maharaja College Ground M.G Road, Ernakulam, Kochi-682011 Tel: 0484-2358759 Email: bimalokpal.ernakulam@cioins.co.in

KOLKATA - Office of the Insurance Ombudsman, Hindustan Building. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA 700072. Tel.: 033-22124339/22124341 Email: bimalokpal.kolkata@cioins.co.in

LUCKNOW - Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226001. Tel.: 0522-4002082/3500613 Email: bimalokpal.lucknow@cioins.co.in

MUMBAI - Office of the Insurance Ombudsman, IIIrd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz west, Mumbai – 400054. Tel:69038800/33, Email: bimalokpal.mumbai@cioins.co.in

NOIDA - 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

PATNA - Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800001. Tel.: 0612- 2547068 Email: bimalokpal.patna@cioins.co.in

PUNE - Office of the Insurance Ombudsman, Jeevan Darshan LIC of India Bldg., 3rd Floor, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in

The updated details of Insurance Ombudsman offices are also available at the IRDAI website www.irda.gov.in, or on the website of Governing Body of Insurance Council www.ecoi.co.in or on the Company's website at www.acko.com/gi.

ANNEXURE-B

List I - Items for which coverage is not available in the policy

SL NO	ITEM
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES

30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS

62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

SR NO	ITEM
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER

18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

SR NO.	ITEM
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (FOR SITE PREPARATIONS)

3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

SR NO.	ITEM
1	ADMISSION/REGISTRATION CHARGES

2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/ STERILLIUM
17	GLUCOMETER& STRIPS
18	URINE BAG

ANNEXURE-C: List of Network Hospitals

The complete list of network hospitals can be found on our website: www.acko.com/gi