Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
For more details, log on to: www.bajajallianz.com | E-mail: bagichelp@bajajallianz.co.in or
Call at: Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)
Issuing Office:

Health Guard (Group) – Silver Plan

Policy Wordings

SECTION A) PREAMBLE

Whereas the Policy Holder has made to Bajaj Allianz General Insurance Company Ltd (hereinafter called the "Company"), a proposal which is hereby agreed to be the basis of this Master Policy/Certificate of Insurance and has paid the premium specified in the Schedule, now the Company agrees, subject always to the following terms, conditions, exclusions and limitations, to indemnify the Insured Person and subject always up to the Sum Assured specified in the Certificate of Insurance.

SECTION B) DEFINITIONS - STANDARD DEFINITIONS

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

2. Any one illness
Any one illness means continuous Period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.

3. Cancer of Specified Severity

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

4. 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, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.

5. Co-Payment:
A 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 claim amount. A co-payment does not reduce the Sum Insured.

6. Condition Precedent:
Condition Precedent means a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

7. Congenital Anomaly:
Congenital Anomaly means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
a. Internal Congenital Anomaly- Congenital anomaly which is not in the visible and accessible parts of the body
b. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body

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

9. Day care centre:
A day care centre means any institution established for day care treatment of illness and / or injuries or a medical set -up with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-

i. has qualified nursing staff under its employment,
ii. has qualified medical practitioner(s) in charge,
iii. has a 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.

10. 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 a hospitalization of more than 24 hours.

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

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

12. 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.

13. Emergency Care:
Emergency care means management of an illness or 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.

14. Grace Period:
Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium
is received.

15. Hospital:
A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the 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 15 in-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's authorized personnel.

16. 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.

17. Illness
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

a. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
b. Chronic condition – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
ii. it needs ongoing or long-term control for relief of symptoms
iii. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
iv. it continues indefinitely
v. it recurs or is likely to recur.

18. Inpatient Care
Inpatient care means treatment for which the Insured has to stay in a hospital for more than 24 hours for a covered event.

19. Injury/Bodily Injury
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.

20. 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.

21. Kidney Failure Requiring Regular Dialysis :
End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a Specialist Medical Practitioner.

22. 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.

23. New Born Baby
Newborn baby means baby born during the Policy Period and is aged up to 90 days.

24. Medical Advice:
Medical advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.

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25. Medical expenses:
Medical Expenses means those expenses that an Insured 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 had not been Insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

26. Medical Practitioner/Doctor/ Physician:
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 or Ayurvedic and or such other authorities 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 .

27. 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.

28. Migration:
Migration means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

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

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

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

32. OPD treatment:
OPD treatment means one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

33. Portability:
Portability means the right accorded to an individual health insurance policyholder (including all members under family cover) to transfer the credit gained for pre-existing conditions and time-bound exclusions from one insurer to another.

34. Pre-Existing Disease:
Pre- existing disease means any condition, ailment or injury or disease

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement **Or**
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

35. Pre-hospitalization Medical Expenses:
Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

36. Post-hospitalization Medical Expenses:
Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the Insured Person is discharged from the hospital provided that:

a. Such Medical Expenses are for the same condition for which the Insured Person's hospitalization was required, and
b. The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.

37. 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.

38. 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 / injury involved.

39. 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.

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40. Room rent
Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

41. 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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

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

SECTION B) DEFINITIONS - SPECIFIC DEFINITIONS

1. Act of Terrorism:-

a. Whoever With intent to threaten the unity, integrity, security or sovereignty of India or to strike terror in the people or any section of the people does any act or thing by using bombs, dynamite or other explosive substances or inflammable substances or firearms or other lethal weapons or poisons or noxious gases or other chemicals or by any other substances (whether biological or otherwise) of a hazardous nature or by any other means whatsoever, in such a manner as to cause or likely to cause, death of or injuries
to any person or persons or loss of or damage to or destruction of property or disruption of any supplies or services essential to the life of the community or causes damage or destruction of any property or equipment used or intended to be used for the defense of India or in connection with any other purposes of the Government of India, any state government or any of their agencies or detains any person and threatens to kill or injure such person in order to compel the Government or any other person to do or abstain from doing any act

b. Whoever Is or continues to be a member of an association declared unlawful under the Unlawful Activities (Prevention) Act 1967, (37 of 1967), or voluntarily does an act aiding or promoting in any manner the objects of such association and in either case is in possession of any unlicensed firearms, ammunition, explosives or other instrument or substances capable of causing mass destruction and commits any act resulting in loss of human life or grievous injury to any person or causes significant damage to any property, commits a terrorist act.

2. Bajaj Allianz Network Hospitals / Network Hospitals
Bajaj Allianz Network Hospitals / Network Hospitals means the Hospitals which have been empanelled by Us as per the latest version of the schedule of Hospitals maintained by Us, which is available to You on request. For updated list please visit our website.

3. Bajaj Allianz Diagnostic Centre
Bajaj Allianz Diagnostic Centre means the diagnostic centers which have been empanelled by us as per the latest version of the schedule of diagnostic centers maintained by Us, which is available to You on request.

4. Certificate of Insurance means the document issued by the Company to the Insured Beneficiary as per these terms and conditions detailing the Cover Period, Insured Person name, address, age, coverage, sums insured, condition(s), exclusions and or endorsement(s). Provided however if there is any contradiction between what is stated in the wordings attached to Certificate of Insurance and these Policy Wordings, then these Policy Wordings shall prevail.

5. Family
For the purpose of Individual Sum Insured policy- includes the Insured; his/her lawfully wedded spouse and dependent children, parents, Sister, Brother, In laws, Aunt, Uncle, Grandchildren

For the purpose of Floater Sum Insured Policy- includes the insured; his/her lawfully wedded spouse and dependent children. Parents can be covered in as separate Policy

6. Group
The definition of a group as per the provisions of Insurance Regulatory and Development Authority of India (Health Insurance) Regulations, 2016, read with group guidelines issued by IRDAI vide circular 015/IRDA/Life/Circular/GI Guidelines/2005 dated 14th July 2005, as amended/modified/further guidelines issued, from time to time.

7. Group Policy or Master Policy This Policy Document, the Policy Schedule and the Proposal, declaration and applicable Endorsements under the Policy containing the terms and conditions of the insurance coverage and under which Certificates of Insurance shall be issued to the Insured Person with the details of the extent of cover available to the Insured Person, the Exclusions under the cover and the terms, conditions, warranties and limitations.

8. Insured mean the Policy Holder who has taken the Group Insurance Policy as Group Manager of a homogeneous group of person who assemble together for a community of purpose and there is a clarity evident relationship between the member of group and group manager for services other than insurance.

9. Insured Person or Insured Beneficiary or member of Group means the person(s) named in the Certificate of Insurance who shall be the beneficiary under the Policy.

10. Limit of Indemnity
Limit of Indemnity represents Our maximum liability to make payment for each and every claim per person and collectively for all persons mentioned in the Certificate of Insurance during the Policy Period and in the aggregate for the person(s) named in the Certificate of Insurance during the Policy Period, and means the amount stated in the Certificate of Insurance against each Cover.

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11. **Obesity** means abnormal or excessive fat accumulation that may impair health. Obesity is measured in Body Mass Index.
Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2).

The WHO definition is:
- BMI greater than or equal to 25 is overweight
- BMI greater than or equal to 30 is obesity

12. **Policy** means the proposal, the certificate of insurance, the Master Policy/Health Guard (Group) Policy Schedule, the Policy documents, these Terms and Conditions and any endorsements attaching to or forming part hereof either on the commencement date or during the Policy Period.

13. **Policy Holder/Proposer/Group Administered or "Insured"** is the Organization or Legal Entity which has taken the Policy on behalf of all Insured Beneficiaries.

14. **Policy Period:** means period for which the Insured Person/Insured Beneficiary is covered under the Certificate of Insurance.

15. **Master Policy Period:** means period for which the Master Policy is valid in the name of Insured.

16. **Policy Schedule** means the Group Policy schedule and any annexure to it read with respective Certificate of Insurance which are forming part of the policy.

17. **Schedule** means the Health Guard (Group) Policy schedule and any annexure to it read with respective Certificate of Insurance.

18. **Sum Assured** means the amount stated in the Certificate of Insurance against each relevant Section, which shall be the Company's maximum liability under this Policy.

19. **You, Your, Yourself, Your Family** the Insured Person/Insured Beneficiary, family members of Insured Person [in floater Policy] as set out in the Certificate of Insurance.

20. **We, Our, Ours, the Company** means the Bajaj Allianz General Insurance Company Limited.

SECTION C) COVERAGE

Eligibility
a. All members forming part of the Group can be covered with Individual Sum Insured for each Insured Person
b. All Families forming part of the Group can be covered with Floater Sum Insured for each family

Policy Period under Certificate of Insurance:
• 1 Year

Scope of cover:
The Company hereby agrees to pay the Insured Person reasonable and customary expenses in respect of an admissible claim, any or all of the following covers subject to the Sum Insured, limits, terms, conditions and definitions, exclusions contained or otherwise expressed in this Policy.

1. **In-patient Hospitalisation Treatment**
If You are hospitalized on the advice of a Doctor as defined under policy because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then We will pay You, Reasonable and Customary Medical Expenses incurred subject to

i. Room, Boarding and Nursing Expenses as provided by the Hospital/Nursing Home up to 1%of Sum Insured per day (Excluding Cumulative Bonus) or actual, whichever is lower.
ii. If admitted in ICU, we will pay up to actual expenses provided by Hospital.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.
iv. Anesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically necessary.

Note:
a. In case of admission to a room at rates exceeding the limits as mentioned under (i), the reimbursement of all other expenses incurred at the Hospital, with the exception of cost of Pharmacy/medicines, consumables, implants, medical devices & diagnostics, shall be payable in the same proportion as the admissible rate per day bears to the
actual rate per day of room rent charges
b. Proportionate deductions shall not apply in respect of the Hospitals which do not follow differential billings or for those expenses in respect of which differential billing is not adopted based on the room category.

Claim under this section shall be payable by Us only when:
i. Such life threatening emergency condition is certified by the Medical Practitioner, and
ii. We have accepted Your Claim under "In-patient Hospitalisation Treatment" or "Day Care Procedures" section of the Policy.

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

2. **Pre-Hospitalisation**
The Medical Expenses incurred during the 60 days immediately before you were Hospitalised, provided that: Such Medical Expenses were incurred for the same illness/injury for which subsequent Hospitalisation was required, and We have accepted an inpatient Hospitalisation claim under Inpatient Hospitalisation Treatment. (Section C1)

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3. Post-Hospitalisation
The Medical Expenses incurred during the 90 days immediately after You were discharged post Hospitalisation provided that: Such costs are incurred in respect of the same illness/injury for which the earlier Hospitalisation was required, and We have accepted an inpatient Hospitalisation claim under Inpatient Hospitalisation Treatment. (Section C1)

4. Road Ambulance
We will pay the reasonable cost to a maximum of Rs 20000/- per policy year incurred on an ambulance offered by a healthcare or ambulance service provider for transferring You to the nearest Hospital with adequate emergency facilities for the provision of health services following an Emergency.
We will also reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider for transferring You from the Hospital where you were admitted initially to another hospital with higher medical facilities.
Claim under this section shall be payable by Us only when:

i. Such life threatening emergency condition is certified by the Medical Practitioner, and
ii. We have accepted Your Claim under “In-patient Hospitalisation Treatment” or “Day Care Procedures” section of the Policy.

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

5. Day Care Procedures
We will pay you the medical expenses as listed above under Section C1 In-patient Hospitalisation Treatment for Day care procedures / Surgeries taken as an inpatient in a hospital or day care centre but not in the outpatient department. Indicative list of Day Care Procedures is given in the annexure I of Policy wordings.

6. Organ Donor Expenses:
We will pay expenses towards organ donor’s treatment for harvesting of the donated organ, provided that,

i. The organ donor is any person whose organ has been made available in accordance and in compliance with THE TRANSPLANTATION OF HUMAN ORGANS (AMENDMENT) BILL, 2011and the organ donated is for the use of the Insured Person, and
ii. We have accepted an inpatient Hospitalisation claim for the insured member under In Patient Hospitalisation Treatment (section C1).

7. Convalescence Benefit:
In the event of insured hospitalised for a disease/illness/injury for a continuous period exceeding 10 days, We will pay benefit amount of Rs. 5,000 per policy year.
This benefit will be triggered provided that the hospitalization claim is accepted under Section C1-In Patient Hospitalisation Treatment.

8. Daily Cash Benefit for Accompanying an Insured Child
We will pay Daily Cash Benefit of Rs. 500 per day maximum up to 10 days during each policy year for reasonable accommodation expenses in respect of one parent/ legal guardian, to stay with any minor Insured Person (under the Age of 12), provided the hospitalization claim is paid under Section C1 Inpatient Hospitalisation Treatment.

9. Sum Insured Reinstatement Benefit:
If Section C1 Inpatient Hospitalization Treatment Sum Insured and cumulative bonus (if any) is exhausted due to claims lodged during the Policy year, then it is agreed that 100% of the Sum Insured specified under Inpatient Hospitalization Treatment be reinstated for the particular Policy year provided that:

1. The reinstated Sum Insured will be triggered only after the Inpatient Hospitalization Treatment Sum Insured inclusive of the Cumulative Bonus(If applicable) has been completely exhausted during the policy year;
2. The reinstated Sum Insured can be used for claims made by the Insured Person in respect of the benefits stated in Inpatient Hospitalization Treatment.
3. If the claimed amount is higher than the Balance Sum Insured inclusive of the Cumulative Bonus(If applicable) under the policy, then this benefit will not be triggered for such claims
4. The reinstated Sum Insured would be triggered only for subsequent claims made by the Insured Person. In case of relapse within 45 days, this benefit will not trigger
5. This benefit is applicable only once during each policy year& will not be carried forward to the subsequent policy year/ renewals if the benefit is not utilized.
6. This benefit is applicable only once in life time of Insured Person covered under this policy for claims regarding CANCER OF SPECIFIED SEVERITY and KIDNEY FAILURE REQUIRING REGULAR DIALYSIS as defined under the policy.
7. Additional premium would not be charged for reinstatement of the Sum Insured.
8. Incase Family Floater policy, Reinstatement of Sum Insured will be available for all Insured Persons in the Policy.

10. Preventive Health Check Up
At the end of block of every continuous period of 3 years during which the Insured Person has held Our Health Guard (Group) policy, the Insured Person is eligible for a free Preventive Health checkup. The Company will reimburse the amount equal to 1% of the sum insured max up to Rs. 2000/- for each member in the Policy having Individual sum insured Policy during the block of 3 years. This benefit can be availed by proposer & spouse only under policy having sum insured on Floater basis.
The Insured Person may approach the Company for the arrangement of the Health Checkup. For the avoidance of doubt, the Company shall not be liable for any other ancillary or peripheral costs or expenses (including but not limited to those for transportation, accommodation or sustenance).
Contact Email id- healthcheck@bajajallianz.co.in
Note: Payment under this benefit will not reduce the base sum insured mentioned in policy Schedule.

11. Preventive and Wellness Benefits
A. Individual Sum Insured Policy
The Insured Person is eligible for preventive and wellness benefits which he/ she can earn as reward points known as Healthkarats by:

a. Registering in the Bajaj Allianz General Insurance Company Ltd’s (BAGIC) Preventive and Wellness Benefit Portal insurance wallet/pro-fit.bjaz.in and
b. Participating in any or all the activities mentioned in the Activity Chart shown below.

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Healthkarat Benefits-
The earned Healthkarats can be utilized in the following manner

I. Claim Free Policy Period
The Insured Person is eligible for increase in Sum Insured at the time of renewal by an amount equivalent to the value of the Healthkarats. The value of the Healthkarats will be computed in the following manner.

i. Each Healthkarat will be equivalent to INR 1.00
ii. The total healthkarats earned during the policy period shall be multiplied by INR 1.00 to arrive at the value of the Healthkarats by which the Sum Insured at the time of renewal shall be increased.
iii. Sum Insured at the time of renewal will be increased by the value of Healthkarats arrived at as per Point (ii) above.

II. Claim during the Policy Period
In the event of a claim during the policy period the Insured Person can utilize the earned Healthkarats up to the date of claim in the following manner.

i. For payment of Non-medical expenses or
ii. For payment of co-pay.

B. Floater Sum Insured Policies
The Insured Persons under floater policy are eligible for preventive and wellness benefits which he/ she can earn as reward points known as Healthkarats by:

a. Registering in the Bajaj Allianz General Insurance Company Ltd's (BAGIC) Preventive and Wellness Benefit Portal- insurance wallet/pro-fit.bjaz.in and
b. Participating in any or all the activities mentioned in the Activity Chart shown below.
c. Total sum of the Healthkarats of all the Insured Persons covered under the floater Policy (who have exceeded the threshold of 2000 Healthkarats) will be considered for utilization by any of the Insured Persons covered under the floater Policy

Healthkarat Benefits-
The earned Healthkarats can be utilized in the following manner

I. Claim Free Policy Period
The floater Sum Insured shall be increased at the time of renewal by an amount equivalent to the value of the Healthkarats. The value of the Healthkarats will be computed in the following manner.

i. Each Healthkarat will be equivalent to INR 1.00
ii. The total healthkarats earned during the policy period shall be multiplied by INR 1.00 to arrive at the value of the Healthkarats by which the Sum Insured at the time of renewal shall be increased.
iii. Sum Insured at the time of renewal will be increased by the value of Healthkarats arrived at as per Point (ii) above

II. Claim during the Policy Period
In the event of a claim during the floater policy period the Insured Person(s) can utilize the earned Healthkarats up to the date of claim in the following manner.

i. For payment of Non-medical expenses or
ii. For payment of co-pay.

The earned Healthkarats shall be computed in the following manner

i. Each Healthkarat will be equivalent to INR 0.50
ii. The total healthkarats earned up to the date of claim during the policy period shall be multiplied by INR 0.50 to arrive at the value of the Healthkarats.
iii. The value of the Healthkarat so arrived at can be utilized at the time of claim during the policy period either for the payment of Non-medical expenses or for the payment of co-pay.

The Insured Person can utilize the healthkarats anytime throughout a year subject to below conditions:

1. The Healthkarat Benefit Amount can be redeemed only if the health karats exceeds 2000 points.
2. The Healthkarat Benefit Amount can be redeemed in the event of a claim during the current Policy Period in which the health points are earned.
3. The cost of the health check-up (Basic, executive and comprehensive). Diabetes disease management, Hypertension/CVA disease management, Dyslipidaemia management, Obesity Management will have to be borne by the Insured Person. The tests can be done at any of the Company's Network Providers mentioned on the Company's website www.general.bajajallianz.com . Reward points will also be available in case the Insured Person undertakes the specified tests at other than our Network providers.
4. The Health Checkup done as a part of Coverage "Section C 10. Preventive Health Check Up" at the end of block of every continuous period of 3 years during which the Insured Person has held Our Health Guard (Group) will be considered for giving credit of the Healthkarat Benefit.
5. The annual subscription for fitness activities such as swimming/sports classes/gym/Yoga and meditation and participation in marathon will have to be borne by the Insured Person.

Validity of Reward points:

a. In case of renewal of a claim free policy, the Insured Person has to redeem the reward points within next 30 days from expiry date of the Policy. Please refer annexure IV for the details on healthkarats, its utilization and illustration.

Activity Chart:

The Activities Identified against which Healthkarat will be allotted are as follows:

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Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerawada, Pune - 411 006. Reg. No.: 113
For more details, log on to: www.bajajallianz.com | E-mail: bagichelp@bajajallianz.co.in or
Call at: Sales - 1800 209 0144 / Service - 1800 209 5858 (Toll Free No.)
Issuing Office:

Health Guard (Group) – Silver Plan

Activity Description	Reward Healthkarats	Maximum Healthkarats that can be earned in a year	Healthkarats breakup with Frequency
Registration and addition of your policy			
On signing up	250	250	One time activity
Addition of Health insurance policy Card/policy Details	25	100	25 Healthkarats per policy and a maximum of 100 Healthkarats can be accrued. Only one card can be added per login.
Health Risk Assessment			
Attempt	100		Frequency- once in 6 months
Completed in multiple sessions	50	250	Maximum only 2 times will be considered- one at the beginning of policy and 2nd one after the 6 months
Completed in single session (Attempt and Completed)	250		
Wellness score- 0-40	0	200(Maximum healthkarats that can be earned based on outcome if taken 2 times a year)	
Wellness score- 41-60	50		
Wellness score- 61-80	75		
Wellness score- Above 80	100		
Improvement by one slab	50		
Fall by one slab	-50		
Health Check-up**- Basic	250	500	Once in year - 250 and twice a year- 500
Health Check-up**- Executive	500	1000	Once in year - 500 and twice a year- 1000
Health Check-up**- Comprehensive	1000	2000	Once in year - 1000 and twice a year- 2000
HbA1c- For Diabetes	50	200	Can be done once in a quarter, max four times a year. Per investigation 50 Healthkarats, max 200 Healthkarats in a year
2D Echo	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
C TMT	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
Chest X ray/USG	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
PAP Smear/PSA for above 40yrs	200	200	Can be done once in a year, max once a year. Per investigation 200 Healthkarats, max 200 Healthkarats in a year
Mammography above 35yrs	200	200	Can be done once in a year, max once a year. Per investigation 200 Healthkarats, max 200 Healthkarats in a year

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Additional test suggested by Medical Expert that is not included in any of the health check-up packages	100	200	Can be done once in a half year, max two times a year. Per investigation 100 Healthkarats, max 200 Healthkarats in a year
Disease management program			
Diabetes Disease management having minimum below parameters	1000	1 000	Purchase-1000
HbA1c			
Blood Sugar- Fasting and PP			
Urine Analysis- Protein and Sugar			
Thyroid Function			
Diet plan			
Health Coach			
Hypertension/ CV Disease management having minimum below parameters			
ECG			
Blood Pressure Readings- three consecutive readings			
2D Echo			
Stress test			
Lipid Profile			
Kidney Profile			
Diet plan			
Health Coach			
Dyslipidaemia Management having minimum below parameters			
Lipid Profile			
ECG			
Diet plan			
Health Coach			
Obesity Management having minimum below parameters			
BMI			
Hip-waist ratio- 3 consecutive readings			
Diet plan			

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Health Coach			
Count your steps			
6000-8000 steps/day	5 per day		
8001-10000 steps/day	7.5 per day	3650	max 3650 in a Policy Period
above 10000	10 per day		
Health Challenges- at least 4 challenges in a year	10	40	10 Per Challenge, max 40 Healthkarats in a Policy Period
Fitness Subscription			
Annual subscription of Swimming/ Sports Classes/Gym/Yoga and Meditation, any other similar fitness activity	1000	1000	(Sign up-750+ Weekly log- 5 (5*50=250))
Marathon Participation	500	1000	500 Per participation, max 1000 Healthkarats in a Policy Period
** As per annexure attached			

Health Check-up

BASIC (Vital)- INR 850/-	EXECUTIVE (MALE/FEMALE)- INR 2500/-	COMPREHENSIVE(MALE/FEMALE)- INR 5000/-
CBC	CBC	CBC
FMR	ESR	ESR
Urine Routine	Blood Group	Blood Group
	Urine Routine	Urine Routine
	VIT D3	VIT D3
	VIT B12	VIT B12
	TSH	T3
		T4
		TSH
FBS	FBS	FBS
	PPBS	PPBS
		Fasting Insulin
HbA1c		HB1Ac
	BUN	BUN
S.Creatinine	S.Creatinine	S.Creatinine
	S. Electrolytes	S. Electrolytes
	S.Uric Acid	S. Calicum
		S.Uric Acid
	Billirubin	Billirubin
	Total Protein	Total Protein
	Albumin	Albumin

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	Globulin	Globulin
SGOT	SGOT	SGOT
SGPT	SGPT	SGPT
	Alkaline Phosphatase	Alkaline Phosphatase
GGTP	GGTP	GGTP
	Chest X-Ray	Chest X-Ray
		USG Abdomen & Pelvis
		BMD
		Mammography*
ECG	ECG	ECG
	Stress Test	Stress Test
		2D Echo
Total Cholesterol	Total Cholesterol	Total Cholesterol
Triglycerides	Triglycerides	Triglycerides
HDL	HDl	HDl
	LDL	LDL
	VLDL	VLDL
		Lipoprotein(Lp(a))
		Apolipoprotein A1
		Apolipoprotein B
		Apo A1/Apo B Ratio
Physician	Physician	Physician
	Ophthalmologist	Ophthalmologist
	Gynaecologist*	Gynaecologist*
	Dentist	Dentist
	ENT	ENT
		Dietician
	Pap Smear*	Pap Smear*
	PSA**	PSA**
		CEA
		CA - 125*
	Pulmonary Function Test	Pulmonary Fuction Test
	Audiometry	Audiometry
		HBsAg (ELISA)
		HIV I & II (ELISA)

*- Tests to be conducted only for female

**- Tests to be conducted only for Male

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SECTION D) EXCLUSIONS UNDER THE POLICY - STANDARD EXCLUSIONS

The Company will not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or attributable to any of the following:

I. Waiting Period

1. Pre-existing Diseases waiting period (Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Health Guard Group Policy with us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. Specified disease/procedure waiting period (Excl02)

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Health Guard Group Policy with Us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.
e. If the Insured is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures is as below

1. Any type gastrointestinal ulcers	2. Cataracts,
3. Any type of fistula	4. Macular Degeneration
5. Benign prostatic hypertrophy	6. Hernia of all types
7. All types of sinuses	8. Fissure in ano
9. Haemorrhoids, piles	10. Hydrocele
11. Dysfunctional uterine bleeding	12. Fibromyoma
13. Endometriosis	14. Hysterectomy
15. Uterine Prolapse	16. Stones in the urinary and biliary systems
17. Surgery on ears/tonsils/ adenoids/ paranasal sinuses	18. Surgery on all internal or external tumours/cysts/ nodules/polyps of any kind including breast lumps.
19. Mental Illness	20. Diseases of gall bladder including cholecystitis
21. Pancreatitis	22. All forms of Cirrhosis
23. Gout and rheumatism	24. Tonsilitis
25. Surgery for varicose veins and varicose ulcers	26. Chronic Kidney Disease
27. Alzheimer's Disease	

3. Any Medical Expenses incurred during the first three consecutive annual periods during which You have the benefit of a Health Guard Group Policy with Us in connection with:

a. Joint replacement surgery,
b. Surgery for vertebral column disorders (unless necessitated due to an accident)
c. Surgery to correct deviated nasal septum
d. Hypertrophied turbinate
e. Congenital internal diseases or anomalies
f. Treatment for correction of eye sight due to refractive error recommended by Ophthalmologist for medical reasons with refractive error greater or equal to 7.5
g. Bariatric Surgery
h. Parkinson's Disease
i. Genetic disorders

4. 30-day waiting period (Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b. This exclusion shall not, however apply if the Insured has Continuous Coverage for more than twelve months.
c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

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II. General Exclusion:

1. Investigation & Evaluation (Excl04)
a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

2. Rest Cure, rehabilitation and respite care- (Excl05)
Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address medical, physical, social, emotional and spiritual needs.

3. Obesity/Weight Control (Excl06)
Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
a) greater than or equal to 40 or
b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

4. Change-of-gender treatments (Excl07)
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. Cosmetic or plastic Surgery (Excl08)
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. Hazardous or Adventure Sports (Excl09)
Expenses related to any treatment necessitated 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.

7. Breach of law (Excl10)
Expenses for treatment directly arising from or consequent upon any Insure Person committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers (Excl11)
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

9. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Excl12)

10. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. (Excl13)

11. 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. (Excl14)

12. Refractive Error (Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

13. Unproven Treatments (Excl16)
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility (Excl17)
Expenses related to sterility and infertility. This includes:
a) Any type of contraception, sterilization
b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c) Gestational Surrogacy
d) Reversal of sterilization

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15. Maternity (Excl 18) :

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SECTION D) GENERAL EXCLUSIONS - SPECIFIC EXCLUSIONS

1. Any dental treatment that comprises of cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization
2. Medical expenses where Inpatient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock
3. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.
   Any Medical expenses incurred due to Act of Terrorism will be covered under the Policy.
4. External medical equipment of any kind used at home as post Hospitalization care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.
5. The cost of spectacles, contact lenses, hearing aids, crutches, dentures, artificial teeth and all other external appliances and/or devices whether for diagnosis or treatment except for Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents etc.
6. Congenital external diseases or defects or anomalies, growth hormone therapy, stem cell implantation or surgery except for Hematopoietic stem cells for bone marrow transplant for haematological conditions.
7. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)
8. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating Medical practitioner.
9. All non-medical Items as per Annexure II
10. Any treatment received outside India is not covered under this Policy.
11. Circumcision unless required for the treatment of Illness or Accidental bodily injury,
12. Treatment for any other system other than modern medicine (allopathy)

SECTION E) CONDITIONS - STANDARD GENERAL TERMS AND CLAUSES

1. 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)

2. Condition Precedent to Admission of Liability

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

3. Moratorium Period:

After completion of eight continuous years under this policy no look back would be applied. This period of eight years is called as moratorium period.
The moratorium would be applicable for the sums insured of the first policy and subsequently completion of eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract

4. Claim Settlement. (provision for Penal interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the 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 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 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)

5. Complete Discharge

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

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6. Fraud

i. If any claim made by the Insured beneficiary, 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 beneficiary or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

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

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

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

iv. The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured beneficiary / 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 misstatement of or suppression of material fact are within the knowledge of the insurer

7. Multiple Policies

i. 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.

ii. 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.

iii. 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.

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

8. Renewal of Policy

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

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

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

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

iv. 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.

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

9. Cancellation

The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Cancellation grid for premium received on annual basis or full premium received at policy inception are as under

PERIOD ON RISK	RATE OF PREMIUM REFUNDED
Within 15 days	As per Free Look condition
Within 3 Months	65% of annual rate
Exceeding 3 months but less than 6 months	45% of annual rate
Exceeding 6 months to 12 months	0.00%

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.

10. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. 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

ii. 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

iii. where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

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11. Portability

The Insured beneficiary will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed
Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

12. Possibility of Revision of Terms of the Policy Including the Premium Rates:

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

13. Migration

The Insured beneficiary will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured beneficiary will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.
For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/Circulars_List.aspx?mid=3.2.3

14. Withdrawal of Policy

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

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

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any) and 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.

16. Grievance Redressal Procedure

The company has always been known as a forward-looking customer centric organization. It takes immense pride in its approach of “Caringly Yours”. To provide you with top-notch service on all fronts, the company has provided with multiple platforms via which you can always reach out to us at below mentioned touch points

1. Our toll-free number 1-800-209- 5858 or 020-30305858, say Say “Hi” on WhatsApp on +91 7507245858
2. Branches for resolution of your grievances / complaints, the Branch details can be found on our website www.bajajallianz.com/branch-locator.html
3. Register your grievances / complaints on our website www.bajajallianz.com/about-us/customer-service.html
4. E-mail

a) Level 1: Write to bagichelp@bajajallianz.co.in and for senior citizens to seniorcitizen@bajajallianz.co.in
b) Level 2: In case you are not satisfied with the response given to you at Level 1 you may write to our Grievance Redressal Officer at ggro@bajajallianz.co.in
c) Level 3: If in case, your grievance is still not resolved, and you wish to talk to our care specialist, please give a missed call on +91 80809 45060 OR SMS To 575758 and our care specialist will call you back

5. If you are still not satisfied with the decision of the Insurance Company, you may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. Detailed process along with list of Ombudsman offices are available at www.cioins.co.in/ombudsman.html

The contact details of the Ombudsman offices are mentioned in **Annexure V:**

SECTION E) CONDITIONS - SPECIFIC TERMS AND CLAUSES

17. Insured

Only those persons named as the insured in the Schedule shall be covered under this Policy. Cover under this Policy shall be withdrawn from any insured member upon such insured member giving 14 days written notice to be received by Us.

18. Communications

Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for You will be sent by Us to Your address shown in the Schedule.

19. Paying a Claim

i. You agree that We need only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information.

ii. If the insurer, for any reasons decides to reject the claim under the policy the reasons regarding the rejection shall be communicated to the insured in writing within 30 days of the receipt of documents. The insured may take recourse to the Grievance Redressal procedure stated under policy.

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20. Basis of Claims Payment

i. If the Insured Person suffer a relapse within 45 days of the date when he/ she last obtained medical treatment or consulted a Medical Practitioner/Doctor and for which a claim has been made, then such relapse shall be deemed to be part of the same claim.

ii. If opted voluntarily by the Policyholder, the Insured Person, shall bear 10% / 20% of co-payment for each and every claim payable under the Inpatient Hospitalization
Treatment section and the Company's liability, if any, shall only be in excess of that sum.

iii. The day care procedures listed are subject to the exclusions, terms and conditions of the policy and will not be treated as independent coverage under the policy.

iv. The Company's obligation to make payment in respect of surgeries for cataracts (after the expiry of the 24 months period referred to in Exclusion D.I.2) above, shall be restricted to 20% of the Sum insured for each eye.

v. The Company shall make payment in Indian Rupees only.

vi. Our obligation to make payment in respect of illness/surgeries listed below shall be restricted to :

Coverages	Sub-limit
Cataract	20% of the Sum insured for each eye
Mental Illness	25% of Sum Insured or 2 Lac whichever is lower
Modern Treatment Methods and Advancement in Technologies (as per list in Annexure III)	50% of Sum Insured or 5 Lacs whichever is lower

21. Cumulative Bonus:

If the Insured Person's " Health Guard (Group)" with the Company is renewed without any break and there has been no claim in the preceding year, the Company will increase the Limit of Indemnity by 10% of base sum insured per annum, but:

i. The maximum cumulative increase in the Limit of Indemnity will be limited to 10 years and 100% of base sum insured of the Insured Person's first "Health Guard (Group) Policy" with the Company.

ii. This clause does not alter the annual character of this insurance

iii. If a claim is made in any year where a cumulative increase has been applied, then the increased Limit of Indemnity in the Policy Period of the subsequent "Health Guard (Group) Policy" shall be reduced by 10%, save that the limit of indemnity applicable to the Insured Person's first "Health Guard (Group) Policy" with the Company shall be preserved.

22. Entry Age and Renewal Age

Cover	Member	Eligible Entry Age	Renewal
"Health Guard (Group)"	Self, Spouse, Parents.	18 years to 65 years	lifetime renewals**
	Dependent Children	3 months to 30 years	35 Years*

* * Subject to policy is renewed annually with the Company within the Grace period of 30 days from date of Expiry

Eligibility:

- Indian nationals residing in India would be considered for this policy.
- Sum Insured for Self cannot be less than any of his/her family members.

23. Endorsements

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

24. Discounts:

i. Co-pay Discount:

If opted voluntarily and mentioned on the Master Policy Schedule read with Certificate of Insurance that a Co-payment is effective by the Group then Group and Insured Persons will be eligible of additional 10% or 20% discount respectively on the policy premium.
If a claim has been admitted under Section C 1) In-patient Hospitalisation Treatment then, the Insured Person shall bear 10% or 20% of the eligible claim amount payable under this section and the Company's liability, if any, shall only be in excess of that sum and would be subject to the Sum Insured.

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ii. Discount offered in lieu of Group size

Floater Policies	
Group Size Band	Implied Group Discount
7 to 100	8%
101 to 250	12%
251 to 500	13%
501 to 750	15%
751 to 1000	16%
1001 to 5000	17%
5001 and above	18%

Non-Floater Policies	
Group Size Band	Implied Group Discount
7 to 100	10%
101 to 250	14%
251 to 500	16%
501 to 750	17%
751 to 1000	18%
1001 to 5000	19%
5001 and above	20%

25. Premium payment Zone:

Zone A
"Following cities has been clubbed in Zone A:-
Delhi / NCR, Mumbai including (Navi Mumbai, Thane and Kalyan), Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara and Surat.

Zone B
Rest of India apart from Zone A cities are classified as Zone B.
Note:-

- Insured Person can avail treatment allover India without any co-payment if Zone A premium rates is paid
- Insured Person for whom premium rate of Zone B is paid and avail treatment in Zone A city will have to pay 20% co-payment on admissible claim amount. This Co – payment will not be applicable for Accidental Hospitalization cases."
- Insured Person residing in Zone B and for whom Zone A premium is paid can avail treatment all over India without any co-payment.

26. Sum Insured Enhancement:

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal. You can apply for enhancement of Sum Insured by submitting a fresh proposal form to the company.
ii. The acceptance of enhancement of Sum Insured would be at the discretion of the company, based on the health condition of the insured person& claim history of the policy.
iii. All waiting periods as defined in the Policy shall apply for this enhanced Sum Insured limit from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company

27. Addition /Deletion of Insured Person(s)

No person other than those persons named as the Insured Person(s) or those categories of the Insured specified in the Schedule shall be covered under this Policy unless and until his/her name or the category has been notified in writing to the Company, any additional premium due has been paid and the Company's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person or category of persons as an Insured Persons.

Cover under Certificate of Insurance shall be withdrawn from any Insured Person(s) named or any category of Insured Beneficiaries Insured immediately upon the Policyholder delivering written notice of the same to the Company.

28. Territorial Limits & Governing Law

i. The Company cover insured events arising during the Policy Period, as well as treatment availed, within India only. The Company's liability to make any payment shall be to make payment within India and in Indian Rupees only.
ii. The Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by an endorsement on the Schedule.
iii. The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

29. Arbitration and Reconciliation

i. If any dispute or difference shall arise as to the quantum to be paid under the Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to decision of a sole arbitrator in writing by the parties 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 the arbitrators comprising of two arbitrators, one appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996. The law of the arbitration will be Indian law, and the seat of the arbitration and venue for all hearings shall be within India.
ii. 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.
iii. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.
iv. If these arbitration provisions are held to be invalid, then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

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30. Special Conditions relating to Group Policy

All group policies are subject to the following conditions:

1. The insured will maintain sufficient deposit or provide a Bank Guarantee to strictly comply with the requirement of section 64VB.
2. New names can be added to the existing group policies by charging pro-rata premium for the unexpired Policy Period.
3. For deletion of names from Group Policies during the currency of the Policy, refund of pro- Rata premium can be allowed only if there is no claim in respect of the particular Insured Person at the expiry of the policy only.

SECTION E) CONDITIONS – OTHER TERMS AND CLAUSES

31. Claims Procedure

All Claims will be settled by In house claims settlement team of the company and no TPA is engaged.
If You meet with any Accidental Bodily Injury or suffer an Illness that may result in a claim, then as a condition precedent to Our liability, You must comply with the following:

A. Cashless Claims Procedure:

Cashless treatment is only available at Network Hospitals. In order to avail of cashless treatment, the following procedure must be followed by You:

i. For planned treatment or Hospitalization, prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, You or Your representative must intimate Us 48 hours before the planned Hospitalization and request pre-authorisation by way of the written form.
ii. After considering Your request and after obtaining any further information or documentation We have sought, We may, if satisfied, send You or the Network Hospital, an authorisation letter. The authorisation letter, the ID card issued to You along with this Policy and any other information or documentation that We have specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Your admission to the same.
iii. If the procedure above is followed, You will not be required to directly pay for the bill amount in the Network Hospital that We are liable under Section C1In-Patient Hospitalisation Treatment above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorisation
does not guarantee that all costs and expenses will be covered. We reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.
iv. In case any treatment or procedure is to be taken on an Emergency basis, You or Your representative must intimate Us in writing immediately within 24 hours of hospitalization.

B. Reimbursement Claims Procedure:

If Pre-authorisation as per Cashless Claims Procedure above is denied by Us or if treatment is taken in a Hospital other than a Network Hospital or if You do not wish to avail cashless facility, then:

i. You or someone claiming on Your behalf must inform Us in writing immediately within 48 hours of hospitalization in case of emergency hospitalization & 48 hours prior to hospitalization in case of planned hospitalization
ii. You must immediately consult a Doctor and follow the advice and treatment that he recommends.
iii. You must take reasonable steps or measures to minimize the quantum of any claim that may be made under this Policy.
iv. You must have Yourself examined by Our medical advisors if We ask for this, and as often as We consider this to be necessary at our cost.
v. You or someone claiming on Your behalf must promptly and in any event within 30 days of discharge from a Hospital give Us the documentation as listed out in greater detail below and other information We ask for to investigate the claim or Our obligation to make payment for it.
vi. In the event of the death of the insured person, someone claiming on his behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 30 days*
vii. If the original documents are submitted with the co-insurer, the Xerox copies attested by the co-insurer should be submitted
*Note: In case You are claiming for the same event under an indemnity based policy of another insurer and are required to submit the original documents related to Your treatment with that particular insurer, then You may provide Us with the attested Xerox copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

**Note: Waiver of conditions (i) and (vi) may be considered in extreme cases of hardship where it is proved to Our satisfaction that under the circumstances in
which You were placed, it was not possible for You or any other person to give notice or file claim within the prescribed time limit.
List of Claim documents:

- Claim form with NEFT details & cancelled cheque duly signed by Insured
- Original/Attested copies of Discharge Summary / Discharge Certificate / Death Summary with Surgical & anesthetics notes
- Attested copies of Indoor case papers
- Original/Attested copies Final Hospital Bill with break up of surgical charges, surgeon's fees, OT charges etc
- Original Paid Receipt against the final Hospital Bill.
- Original bills towards Investigations done / Laboratory Bills.
- Original/Attested copies of Investigation Reports against Investigations done.
- Original bills and receipts paid for the transportation from Registered Ambulance Service Provider. Treating Doctor certificate to transfer the Injured person to a higher
medical centre for further treatment (if Applicable).
- Cashless settlement letter or other company settlement letter
- First consultation letter for the current ailment.
- In case of implant surgery, invoice & sticker.

Please send the documents on below address
Bajaj Allianz General Insurance Company
2nd Floor, Bajaj Finserv Building,
Behind Weikfield IT park,
Off Nagar Road, Viman Nagar
Pune 411014| Toll free: 1800-103-2529, 1800-22-5858

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Annexure I

List of Day Care Procedures:

1. Suturing - CLW -under LA or GA	66. Incision and excision of tissue in the perianal region
2. Surgical debridement of wound	67. Surgical treatment of anal fistula
3. Therapeutic Ascitic Tapping	68. Surgical treatment of hemorrhoids
4. Therapeutic Pleural Tapping	69. Sphincterotomy/Fissurectomy
5. Therapeutic Joint Aspiration	70. Laparoscopic appendicectomy
6. Aspiration of an internal abscess under ultrasound guidance	71. Laparoscopic cholecystectomy
7. Aspiration of hematoma	72. TURP (Resection prostate)
8. Incision and Drainage	73. Varicose vein stripping or ligation
9. Endoscopic Foreign Body Removal - Trachea /- pharynx-larynx/ bronchus	74. Excision of dupuytren's contracture
10. Endoscopic Foreign Body Removal -Oesophagus/stomach /rectum.	75. Carpal tunnel decompression
11. True cut Biopsy - breast/- liver/- kidney-Lymph Node/-Pleura/-lung/-Muscle biopsy/-Nerve biopsy/Synovial biopsy/-Bone trephine biopsy/-Pericardial biopsy	76. Excision of granuloma
12. Endoscopic ligation/banding	77. Arthroscopic therapy
13. Sclerotherapy	78. Surgery for ligament tear
14. Dilatation of digestive tract strictures	79. Surgery for meniscus tear
15. Endoscopic ultrasonography and biopsy	80. Surgery for hemoarthrosis/pyoarthrosis
16. Nissen fundoplication for Hiatus Hernia /Gastro esophageal reflux disease	81. Removal of fracture pins/nails
17. Endoscopic placement/removal of stents	82. Removal of metal wire
18. Endoscopic Gastrostomy	83. Incision of bone, septic and aseptic
19. Replacement of Gastrostomy tube	84. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis
20. Endoscopic polypectomy	85. Suture and other operations on tendons and tendon sheath
21. Endoscopic decompression of colon	86. Reduction of dislocation under GA
22. Therapeutic ERCP	87. Cataract surgery
23. Brochoscopic treatment of bleeding lesion	88. Excision of lachrymal cyst
24. Brochoscopic treatment of fistula /stenting	89. Excision of pterigium
25. Bronchoalveolar lavage & biopsy	90. Glaucoma Surgery
26. Tonsillectomy without Adenoidectomy	91. Surgery for retinal detachment
27. Tonsillectomy with Adenoidectomy	92. Chalazion removal (Eye)
28. Excision and destruction of lingual tonsil	93. Incision of lachrymal glands
29. Foreign body removal from nose	94. Incision of diseased eye lids
30. Myringotomy	95. Excision of eye lid granuloma
31. Myringotomy with Grommet insertion	96. Operation on canthus & epicanthus
32. Myringoplasty /Tympanoplasty	97. Corrective surgery for entropion&ectropion
33. Antral wash under LA	98. Corrective surgery for blepharoptosis

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34. Quinsy drainage	99. Foreign body removal from conjunctiva
35. Direct Laryngoscopy with or w/o biopsy	100. Foreign body removal from cornea
36. Reduction of nasal fracture	101. Incision of cornea
37. Mastoidectomy	102. Foreign body removal from lens of the eye
38. Removal of tympanic drain	103. Foreign body removal from posterior chamber of eye
39. Reconstruction of middle ear	104. Foreign body removal from orbit and eye ball
40. Incision of mastoid process & middle ear	105. Excision of breast lump /Fibro adenoma
41. Excision of nose granuloma	106. Operations on the nipple
42. Blood transfusion for recipient	107. Incision/Drainage of breast abscess
43. Therapeutic Phlebotomy	108. Incision of pilonidal sinus
44. Haemodialysis/Peritoneal Dialysis	109. Local excision of diseased tissue of skin and subcutaneous tissue
45. Chemotherapy	110. Simple restoration of surface continuity of the skin and subcutaneous tissue
46. Radiotherapy	111. Free skin transportation, donor site
47. Coronary Angioplasty (PTCA)	112. Free skin transportation recipient site
48. Pericardiocentesis	113. Revision of skin plasty
49. Insertion of filter in inferior vena cava	114. Destruction of the diseases tissue of the skin and subcutaneous tissue
50. Insertion of gel foam in artery or vein	115. Incision, excision, destruction of the diseased tissue of the tongue
51. Carotid angioplasty	116. Glossectomy
52. Renal angioplasty	117. Reconstruction of the tongue
53. Tumor embolisation	118. Incision and lancing of the salivary gland and a salivary duct
54. TIPS procedure for portal hypertension	119. Resection of a salivary duct
55. Endoscopic Drainage of Pseudopancreatic cyst	120. Reconstruction of a salivary gland and a salivary duct
56. Lithotripsy	121. External incision and drainage in the region of the mouth, jaw and face
57. PCNS (Percutaneous nephrostomy)	122. Incision of hard and soft palate
58. PCNL (percutaneous nephrolithotomy)	123. Excision and destruction of the diseased hard and soft palate
59. Suprapubiccytostomy	124. Incision, excision and destruction in the mouth
60. Tran urethral resection of bladder tumor	125. Surgery to the floor of mouth
61. Hydrocele surgery	126. Palatoplasty
62. Epididymectomy	127. Transoral incision and drainage of pharyngeal abscess
63. Orchidectomy	128. Dilatation and curettage
64. Herniorrhaphy	129. Myomectomies
65. Hernioplasty	130. Simple Oophorectomies

i. The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/disease under treatment. Only 24 hours hospitalization is not mandatory.

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Annexure II:-

List I: List of Non-Medical Items

SL No	Item	
1	BABY FOOD	Not Payable
2	BABY UTILITIES CHARGES	Not Payable
3	BEAUTY SERVICES	Not Payable
4	BELTS/ BRACES	Not Payable
5	BUDS	Not Payable
6	COLD PACK/HOT PACK	Not Payable
7	CARRY BAGS	Not Payable
8	EMAIL / INTERNET CHARGES	Not Payable
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
10	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
11	LAUNDRY CHARGES	Not Payable
12	MINERAL WATER	Not Payable
13	SANITARY PAD	Not Payable
14	TELEPHONE CHARGES	Not Payable
15	GUEST SERVICES	Not Payable
16	CREPE BANDAGE	Not Payable
17	DIAPER OF ANY TYPE	Not Payable
18	EYELET COLLAR	Not Payable
19	SLINGS	Not Payable
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Not Payable
21	SERVICE CHARGES WHERE NURSING CHARGES ALSO CHARGED	Not Payable
22	Television Charges	Not Payable
23	SURCHA RGES	Not Payable
24	ATTENDANT CHARGES	Not Payable
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Not Payable
26	BIRTH CERTIFICATE	Not Payable
27	CERTIFICATE CHARGES	Not Payable
28	COURIER CHARGES	Not Payable
29	CONVEYANCE CHARGES	Not Payable
30	MEDICAL CERTIFICATE	Not Payable
31	MEDICAL RECORDS	Not Payable
32	PHOTOCOPIES CHARGES	Not Payable
33	MORTUARY CHARGES	Not Payable
34	WALKING AIDS CHARGES	Not Payable
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable

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36	SPACER	Not Payable
37	SPIROMETRE	Not Payable
38	NEBULIZER KIT	Not Payable
39	STEAM INHALER	Not Payable
40	ARMSLING	Not Payable
41	THERMOMETER	Not Payable
42	CERVICAL COLLAR	Not Payable
43	SPLINT	Not Payable
44	DIABETIC FOOT WEAR	Not Payable
45	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
46	KNEE IMMOBILIZER/S HOULDER IMMOBILIZER	Not Payable
47	LUMBOSACRAL BELT	Not Payable
48	NIMBUS BED OR WATER OR AIR BED CHARGES	Not Payable
49	AMBULANCE COLLAR	Not Payable
50	AMBULANCE EQUIPMENT	Not Payable
51	ABDOMINAL BINDER	Not Payable
52	PRIVATE NURSES CHARGES - SPECIAL NURSING	Not Payable
53	SUGAR FREE Tablets	Not Payable
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)	Not Payable
55	ECG ELECTRODES	Not Payable
56	GLOVES	Not Payable
57	NEBULISATION KIT	Not Payable
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT,	Not Payable
59	KIDNEY TRAY	Not Payable
60	MASK	Not Payable
61	OUNCE GLASS	Not Payable
62	OXYGEN MASK	Not Payable
63	PELVIC TRACTION BELT	Not Payable
64	PAN CAN	Not Payable
65	TROLLY COVER	Not Payable
66	UROMETER , URINE JUG	Not Payable
68	VASOFIX SAFETY	Not Payable

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

S. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED /INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CARDLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER

9	GOWN
10	SLIPPERS
11	TISSUE PAPPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINEFCTANT 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	INCTDENTAL EXPENSES / MtSC. CHARGES (NOT EXPLATNED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

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

S. 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

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8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPE 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

S. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALIZATION 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 PERPOXIDE\SPIRIT\DISINFECTION ETC
9	NUTTRITION 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

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Annexure III: Modern Treatment Methods and Advancement in Technologies

Modern Treatment Methods and Advancement in Technologies (as per below list) are covered up to 50% of Sum Insured or 5 lacs whichever is lower, subject to policy terms, conditions, coverages and exclusions

A. Uterine Artery Embolization and HIFU
B. Balloon Sinuplasty
C. Deep Brain stimulation
D. Oral chemotherapy
E. Immunotherapy- Monoclonal Antibody to be given as injection
F. Intra vitreal injections
G. Robotic surgeries
H. Stereotactic radio surgeries
I. Bronchical Thermoplasty
J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
K. IONM -(Intra Operative Neuro Monitoring)
L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

Annexure IV - Preventive and Wellness Benefit

What is Healthkarats-
Healthkarats are reward points earned for each activity specified in activity chart.
Healthkarats can be earned by complying with various activities listed below under step 2 activities.
How to earn Healthkarats-
Step 1- Portal registration

- Download the android and iOS based mobile application “Insurance Wallet” from Play Store
  Or register in the Bajaj Allianz General Insurance Company’s (BAGIC) Preventive and Wellness Benefit Portal insurance wallet / pro-fit.bjaz.in
- Fill up essentials mentioned for registration
- Create Log in id and Password
- Post registration, log in to your account by using the USER ID and PASSWORD
- The Insured Person can also earn Healthkarats for the Registration and addition of your policy details

Step 2- Activities

- Prevention and Identification
- Care Management
- Claim Management
- Connected Health
- Fitness Subscription

I. Prevention and Identification-

Early prevention of any medical condition helps for early and uncomplicated recovery resulting in healthy and longer life.
This can be achieved by doing a regular “Health Check-up” and Investigations (Tests).
During The Insured Person’s regular “Health Check-up” if he/she is identified for any disease/illness, he/she is expected to take a disease specific tests.
Healthkarates can be earned by performing regular “Health Check-up”, “Investigations” (Tests) and “Disease specific tests” as indicated in the table provided in policy wording.

II. Care Management

The Insured Person can enroll yourself to a Disease Management Programme where our experts will provide him/her specific disease protocol to follow for his/her better health.
This will assist the Insured Person along with his/her regular physician’s treatment to have effective control on chronic diseases.
Healthkarates can be earned once The Insured Person enroll in the programme and ensuring compliance with protocols specified by the Company

III. Claim Management

The Company always pray for your good health and best of our service if in case of any claim.
Healthkarats are achieved in multiple activities like No claim reported, in time claim intimation, Cashless Treatment at Preferred Provider Network etc. as mentioned in policy wording.

IV. Connected Health

The Company ensure the Insured Person’s participation for good health with his/her everyday activity.
Helathkarats can be earned for the Insured Person’s daily exercise i.e calculating steps and or completed health challenges which can be tracked and calculated by mobile app informed earlier in Step 1 i.e. Portal registration by the Company

V. Fitness Subscription

The Company will provide the Insured Person information on health and wellness training, online fitness portals, sporting events, various sports and health related applications, latest fitness accessories through periodic communications like e-mailers, blogs, forums etc.

The Insured Person can earn Healthkarats by enrolling himself/herself in any of the registered activity like Swimming/ Sports Classes/Gym/Yoga/Meditation/Marathon participation,.

How to redeem Healthkarats-
Eligibility for redemption of Healthkarats :-

- 1 Healthkarats = INR 0.50 or 50 Paisa
- Healthkarats redemption benefit can be availed only if the healthkarats exceeds 2000 points.

e.g.-
Scenario 1:

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If score = 2000
Eligible score = 2000 - 2000 = 0;
Pay-out = 0 (as there is a minimum limit on the score of 2000)
Scenario 2:
If Score = 3000,
Eligible score = 3000 as it exceeds 2000;
Pay-out = 3000 x INR 0.50 = INR 1500/-

Process of Redemptions of healthkarats

1. Portal registration and self-enrolment is mandatory.
2. The Insured Person can participate in any or all the activities mentioned in activity chart.
3. The cost of Medical Risk Assessment, Preventive disease specific check-up, chronic disease management program, and Fitness subscription specified in the Activity chart will be borne by the Insured Person.
4. Medical tests can also be done at any of the Company's Network Providers*.
5. The reward Healthkarats earned/ redeemed and the reward amount will be updated as per the scheduler on the Portal during the Policy Period and at the end of the Policy Period. Reward amount if any shall be intimated to the Insured Person via SMS, EMAIL or can be checked on our portal as well i.e insurance wallet/pro-fit.bjaz.in.
6. In cases of family floater policy, the average of the Healthkarats of all the adult Insured Persons (Above the age of 18 years) will be considered for per person utilization
7. All of these Healthkarats will be accrued and can be used for one of the below-

- Waiving of NME for individual or Group clients
- Co-pay as applicable for Group clients
- Redeem discounted vouchers of Outpatient consultations or treatments, Pharmaceuticals and Health check-ups - Select and claim a privilege browsed from our site insurance wallet/pro-fit.bjaz.in or Pro Fit Application

8. The Healthkarat Benefit Amount earned during the Policy Period shall be updated real-time during the current Policy Period and shown on the portal and also intimated to the Insured Person via SMS/ email.

Illustration of Healthkarats Redemption

Scenario I: - Individual Policy

- Ram is enrolled under Group Health Guard for INR 5lacs Sum Insured.
- He has undergone pre-Policy medical examination due to his Age and is found to have diabetes.
- He opt for a Chronic Management Program to keep his diabetes condition in control.

Let's understand how he can earn Healthkarats under the Policy under different circumstances.

Activity Description	Earned Healthkarats
Step 1- Portal registration	
Signed up and added the Policy details	275
Step 2- Activities Prevention and Identification	
Taken Health Risk Assessment	
Completed in single session (Attempt and Completed)	250
Achieved Wellness score- 41-60	50
Taken HRA again after 6 months where wellness score came at 61-80	75
Improvement by one slab	50
Health Check-up- Basic taken twice in a year	500
*HbA1c- For Diabetes done 4 times in a year	200
Done PSA for males above 40yrs	200
Care Management	
Purchased the Diabetes Disease management program which includes below activities	1000
HbA1c	
Blood Sugar- Fasting and PP	
Urine Analysis- Protein and Sugar	
Thyroid Function	
Diet plan	
Health Coach	
Additional Bonus Points	

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Claimed once in a policy and Given Claim Intimation for Hospitalization	500
Taken Cashless Treatment at PPN	250
Opted twin sharing room	500
Connected Health	
Average Steps taken every day was 6000- 8000 steps/day	5 per day for 365 days = 1825
Fitness Subscription	
Subscribe to Yoga classes, entered the log thought the year	1000
Total Points Earned	**6675**

In case of Claim:-
Based on the total points earned in a year Ram will be entitled to redeem his points against claims.

- Total points earned- 6675
  6675 points x INR 0. 50 (1 point = INR 0.50) = INR 3338/-
- INR 3338/- can be redeemed against the Non-medical expenses as defined under Annexure II of policy wordings.
- If the non-medical expenses are INR. 2000/- i.e. 4000 reward points
- 4000 points would be redeemed
- Remaining 2675 points would be updated to be utilize for the next claim.
  Scenario II: - Floater Policy
- Mr. Abhijit and his wife Mrs. Kapila are enrolled under Group Health Guard for INR 3lacs Sum Insured.
- Both are living healthy life and not diagnosed or having treatment for any chronic Management programme.
  Let's understand how he can earn Healthkarats under the Policy under different circumstances.

Activity Description	Earned Healthkarats	Activity Description	Earned Healthkarats
	Mr Abhijit		Mrs. Kapila
Step 1- Portal registration		**Step 1- Portal registration**	
Signed up and added the Policy details	275	Signed up and added the Policy details	275
Step 2- Activities		**Step 2- Activities**	
Prevention and Identification		**Prevention and Identification**	
Taken Health Risk Assessment		Taken Health Risk Assessment	
Completed in single session (Attempt and Completed)	250	Completed in single session (Attempt and Completed)	250
Achieved Wellness score- 41-60	50	Achieved Wellness score- 41-60	50
Taken HRA again after 6 months where wellness score came at 61-80	75	Taken HRA again after 6 months where wellness score remain same at 41-60	50
Improvement by one slab	50	Improvement by one slab	-
Done PSA for males above 40yrs	200	No additional Tests done	-
Additional Bonus Points		**Additional Bonus Points**	
No claim in policy	1000	Claimed once in a policy and Given Claim Intimation for Hospitalization	500
	-	Taken Cashless Treatment at PPN	250
	-	Opted twin sharing room	500
Connected Health		**Connected Health**	
Average Steps taken every day was 6000-8000 steps/day	5 per day for 365 days = 1825	Average Steps taken every day was 8001-10000 steps/day	7.5 per day for 365 days = 2738
Fitness Subscription		**Fitness Subscription**	

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Subscribe to Yoga classes	750	Subscribe to Gym	750
Total Points Earned	**4475**	**Total Points Earned**	**5363**

Under floater policy you will be entitled for the benefit by taking average of points earned by all adult members covered under the policy.
Since this is a floater policy the average points earned would be 4919

- Mr Abhijit had earned 4475 points
- Mrs. Kapila had earned 5363 points,
- Total points earned 9838 and average will be 4919.

Based on the average points earned in a year Mr Kapila will be entitled to redeem his points against claims.
4919 points x INR 0.50 (1 point = INR 0.50) = INR 2460/- can be redeemed against the Non-medical expenses as defined under Annexure II of policy wordings.

Annexure V:
Contact details of the Ombudsman offices

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If you are still not satisfied, you can approach the Insurance Ombudsman in the respective area for resolving the issue. The contact details of the Ombudsman offices are mentioned below:

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory,District)**
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, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
BHUBANESHWAR - Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH - Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 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 / 24335284 Email: bimalokpal.chennai@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
DELHI - Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

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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 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM - Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 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, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 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 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar..
MUMBAI - Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).

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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.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

"List of Ombudsman offices established by the Central Government for redressal of grievance are also available at https://www.cioins.co.in/Ombudsman"

Note: Address and contact number of Governing Body of Insurance Council:

Council for Insurance Ombudsmen, 3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W), Mumbai - 400 054.
E-mail: inscoun@cioins.co.in, **Tel:** 022 -69038800/69038812, **Website:** https://www.cioins.co.in

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