SECTION-1 PREAMBLE

WHEREAS the Policyholder designated in the Policy Schedule to this Reliance HealthWise Policy having by a proposal and declaration together with any statement, report or other document which shall be the basis of the contract and shall be deemed to be incorporated herein, has applied to Reliance General In surance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate pre mium and agreed for the Policy Period as specified in the Policy Schedule.

NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, under takes, that if during the Policy Period as specified in the Policy Schedule, any claim is incurred which becomes admissible and payable under this Policy then the Company shall pay for such claim, as per terms, conditions and benefits and exclusions and the limits and Sum Insured as set forth in this Policy.

SECTION-2 DEFINITIONS

1. **"Accident"** An Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **"Act"** means the Insurance Act 1938
3. **"Age"** The completed age of the Insured Person as on his last Birthday
4. **"AIDS"** means Acquired Immuno Deficiency Syndrome, a condition characterized by a combination of signs and symptoms, caused by Human Immuno Deficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time.
5. **"Ambulance"** A road vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
6. **"Annexure"** A document attached and marked as Annexure to this Policy.
7. **"Any One Illness"** means continuous period of illness and it includes relapse within forty-five days from the date of last consultation with the Hospital where treatment has been taken.
8. **"Authority"** An Authority means the Insurance Regulatory and Development Authority of India established under sub section 1 of section 3 of IRDA Act 1999.
9. **"AYUSH Day Care Centre"** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
10. **"AYUSH Hospital"** is a healthcare facility wherein medical/ surgical/Para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
    i. Central or State Government AYUSH Hospital or
    ii. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
    iii. AYUSH Hospital, standalone or co-located with inpatient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
       a. Having at least 5 in-patients beds;
       b. Having qualified AYUSH Medical Practitioner in charge round the clock;
       c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
       d. Maintaining daily records of the patient and making the accessible to the insurance company's authorized representative.
11. **"AYUSH Treatment"** refers to the medical and /or Hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
12. **"Bank Rate"** means bank rate fixed by the Reserve Bank of India(RBI) at the beginning of the financial year in which claim has fallen due.
13. **"Break in Policy"** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
14. **"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.
15. **"Child"** means biological or legally adopted son or daughter of the Insured Person whose completed age is less than 25 years

as on the Policy Period Start Date

16. **"Claim"** a demand made by the Insured Person or on his behalf, for payment under "Scope of Cover" as covered under the Policy

17. **"Company"** means Reliance General Insurance Company Limited"

18. **"Complainant"** means a Policyholder or Prospect or any beneficiary of an insurance policy who has filed a Complaint or Grievance against the Company or a Distribution Channel.

19. **"Complaint or Grievance"** means written expression (includes communication in the form of electronic mail or other electronic scripts), of dissatisfaction by a Complainant with insurer, Distribution Channels, intermediaries, insurance intermediaries or other regulated entities about an action or lack of action about the standard of service or deficiency of service of such insurer, Distribution Channels, intermediaries, insurance intermediaries or other regulated entities.

    Explanation: An inquiry or request would not fall within the definition of the "Complaint" or "Grievance"

20. **"Condition precedent"** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

21. **"Congenital Anomaly"** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

    i. Internal Congenital Anomaly: Congenital anomaly which is not in the visible and accessible parts of the body.

    ii. External Congenital Anomaly: Congenital anomaly which is in the visible and accessible parts of the body

22. **"Co-payment"** means a cost sharing requirement under a health insurance policy that provides that the Policyholder/ Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured."Cosmetic Surgery" Surgery / treatment which is primarily done for the enhancement of appearance through surgical and medical techniques. It concerns with maintaining normal appearance, restoring or enhancing it.

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

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

    i. Has qualified nursing staff under its employment;

    ii. Has qualified medical practitioner/s in charge;

    iii. Has fully equipped operation theatre of its own where surgical procedures are carried out;

    iv. Maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

25. **"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 hours because of technological advancement, and

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

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

    Day Care Treatment shall only include procedures listed in Annexure "D

    iii. Has qualified nursing staff under its employment;

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

27. **"Dependent"** means financially dependent on the Insured Person and does not have independent source of income.

28. **"Dental Treatment"** means a treatment related to teeth or structures supporting teeth including examinations, filings (where appropriate), crowns, extractions and surgery

29. **"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.

30. **"Distribution Channels"** means persons and entities authorised by the Authority to involve in sale and service of insurance products. For the purpose of this Policy it means the Distribution Channels who is an Intermediary of the Company

31. **"Domiciliary Hospitalisation"** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

    i. The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

    ii. The patient takes treatment at home on account of nonavailability of room in a Hospital.

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

33. **"Family"** means the Insured Person, his/her lawful spouse and maximum of two dependent children below the age of 25 years.

34. **"Grace Period"** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

35. **"Hospital"** means any institution established for inpatient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010

or under enactments specified under the Schedule of Section 56(1) and 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 inpatient beds, in towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;

iii. Has qualified medical practitioner(s) in charge round the clock;

iv. Has a fully equipped operation theatre of its own where surgical procedures are carried out;

v. Maintains daily records of patients and makes these accessible to the insurance Company's authorized personnel

36. **"Hospitalisation"** means admission in a Hospital for a minimum period of 24 consecutive 'Inpatient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

37. **"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

38. **"ICU 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.

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

i. **Acute condition** - Acute condition is a disease, illness or injury that is likely to response 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 Chronic condition - A **chronic condition** is defined as a disease, illness, or injury that has one or more of the following characteristics:

a. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

b. It needs ongoing or long-term control or relief of symptoms

c. It requires rehabilitation for the patient or for the patient to be special trained to cope with it

d. It continues indefinitely

e. It recurs or is likely to recur

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

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

42. **"Insured Person/Insured"** means a person accepted by the Company to be insured under this Policy and who meets and continues to meet all the eligibility requirements and whose name specifically appears under Insured /Insured Person in the Policy Schedule and with respect to whom the premium has been received by the Company..

43. **"Life Threatening Medical Condition"/ "Life threatening condition"** is a medical condition suffered by the Insured Person which has any of the following characteristics:

i. Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate)' or

ii. Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or

iii. Critical Care being provided, which involves highly complex decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology; or

iv. Critical Care being provided in critical care areas such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department and

v. Is certified by the attending Medical Practitioner as a Life Threatening Medical Condition

44. **"Maternity Expenses"** Maternity expenses means;

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);

ii. expenses towards lawful medical termination of pregnancy during the policy period

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

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

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

The registered practitioner should not be the insured or close member of the family.

Medical Practitioner for **Mental Illness** shall be in accordance with The Mental Healthcare Act, 2017.

'Physician', wherever mentioned under this Policy shall also satisfy the definition of a **Medical Practitioner.**

48. **"Mental Illness"** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions

associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.

49. **"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 Person;
    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.

50. **"Migration"** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

51. **"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 Person by a cashless facility.

52. **"New Born Baby"** means baby born during the Policy Period and is aged up to 90 days.

53. **"Nominee"** means the person whose name specifically appears as such in the Policy Schedule and is the person to whom the proceeds under this Policy, if any, shall become payable in the event of the death of the Policyholder/Insured Person. Nominee for all other Insured Person(s) shall be the Policyholder himself.

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

55. **"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.

56. **"Out-Patient (OPD) Treatment"** means the 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.

57. **"Plan"** means a specific set or sub-set of coverages, limits, Deductibles, Co-pays, terms and conditions as pre-defined under this Policy. The three plans Standard, Silver and Gold plan available under this product are summarized in Section 7 COVERAGE SUMMARY. The applicable plan under this Policy is as selected by the Policyholder and specified in the Policy Schedule.

58. **"Policy"** The Company's contract of insurance with the Policyholder providing cover as detailed in the Policy Terms and Conditions, the Proposal form, Policy Schedule, Endorsements, if any and Annexures, which form part of the contract and must be read together

59. **"Policy Schedule"** The Schedule attached to and forming part of the Policy mentioning apart from other details, Policyholder's details, details of the Insured Person, the Sum Insured, the Policy Period, Premium paid (including duties, taxes and levies thereon) and the limits to which benefits under the Policy are subject to.

60. **"Policyholder"** means the person who is the proposer and whose name specifically appears in the Policy Schedule as such

61. **"Policy Period"** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date and as specifically appearing in the Policy Schedule.

62. **"Policy Period End Date"** the date on which the Policy expires, as specifically appearing in the Policy Schedule

63. **"Policy Period Start Date"** the date on which the Policy commences, as specifically appearing in the Policy Schedule

64. **"Post-hospitalisation 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:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

65. **"Portability"** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

66. **"Pre-existing Disease (PED)"** means any condition, ailment, injury or disease:
    i. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
    ii. For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

67. **"Pre-hospitalisation Medical expenses"** Prehospitalization Medical Expenses means medical expenses incurred during pre defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by

68. **"Proposal Form"** means a form to be filled in by the Prospect in written or electronic or any other format as approved by the Authority, for furnishing all material information as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted

    Explanation: **"Material Information"** shall mean all important, essential and relevant information sought by the Company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the riskhe Insurance Company

69. **"Prospect"** means any person who is potential customer of an insurer and is likely to enter into an insurance contract either directly with the insurer or through a Distribution Channel.

70. **"Prospectus"** means a document either in physical or electronic or any other format issued by the insurer to sell or promote the insurance products.

71. **"Qualified nurse"** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any State of India.

72. **"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.

73. **"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.

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

75. **"Senior Citizen"** means any person who has completed sixty or more years of age as on the date of commencement/Policy Period Start Date or renewal of policy.

76. **"Sum Insured"** means the sum as specified in the Policy Schedule, which sum represents the Company's maximum liability for any or all claims under this Policy during the Policy Period.

77. **"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.

78. **"Telemedicine"** means Medical consultation service availed via telecommunications and digital communication technologies by the Insured Person from a Medical Practitioner while taking treatment for the health condition that has resulted in an admissible Claim under a cover in this Policy. Such Telemedicine services shall be delivered in compliance with the Medical Council of India's 'Telemedicine Practice Guidelines' dated March 2020 or its subsequent amendments, if any.

79. **"Unproven / Experimental Treatments"** treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

SECTION-3 SCOPE OF COVER

The Policy Schedule and all Endorsement Schedules shall be as per terms and conditions accepted and agreed with the Policyholder.

The Company hereby agrees subject to the terms, conditions and exclusions contained or expressed in the Policy, to compensate the Insured Person as per the covers and limits specified in the Policy Schedule.

In addition to the terms laid out herein, liability arising due to any treatment relating to Mental Illness shall be assessed in accordance with the relevant provisions of The Mental Healthcare Act, 2017.

The total payment under all benefits under the Policy shall not exceed the Sum Insured mentioned in the Policy Schedule (and the additional Critical Illness Sum Insured if applicable).

3.A BASIC COVERS

3.1. IN PATIENT HOSPITALIZATION

This benefit covers Medical Expenses incurred by the Insured Person during the Policy Period on In-Patient Hospitalisation (including AYUSH Hospitalization) for illness / injury contracted or sustained by the Insured Person. Medical Expenses shall include:

i. Room Rent
ii. Nursing Expenses
iii. Intensive Care Unit (ICU) Charges
iv. Fees of Medical Practitioner including Surgeon and anesthetist
v. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
vi. Medicines, drugs and consumables
vii. Diagnostics procedures
viii. The cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure unless specifically excluded

3.2. IN PATIENT HOSPITALIZATION

This benefit covers payment of Medical Expenses incurred during the Policy Period for Medically Necessary Treatment pertaining to Domiciliary Hospitalisation of the Insured Person provided that:

i. The condition for which the medical treatment is required continues for at least 3 continuous and completed days, in which case the Company will pay for the Medical Expenses incurred from the first day of Domiciliary Hospitalisation, and

ii. The payment under Domiciliary Hospitalisation benefit shall be limited to 10% of the Sum Insured, and shall, in no case cover expenses incurred for:

a. Treatment of any of the following illness / injury:

- Asthma
- Bronchitis
- Chronic nephritis and nephritic syndrome
- Diarrhea & all types of dysenteries including gastroenteritis
- Diabetes mellitus and insipidus
- Epilepsy
- Hypertension
- Influenza, cough and cold
- All psychiatric or psychosomatic disorders
- Pyrexia of unknown origin for less than 10 days
- Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis
- Arthritis, Gout and Rheumatism.

Domiciliary Hospitalisation benefit also covers Medical Expenses on Qualified Nurses engaged on the written medical advice of the attending Medical Practitioner.

3.3. DAY CARE TREATMENT

This benefit covers, up to the Sum Insured, the Medical Expenses incurred for medically necessary treatment pertaining to Day Care treatment of the Insured Person, on the written advice of a Medical Practitioner.

The list of covered Day Care Treatments is appended as per Annexure D.

3.4. PRE-HOSPITALISATION MEDICAL EXPENSES

This benefit covers relevant Pre-Hospitalisation Medical Expenses incurred by the Insured Person during the Policy Period, for number of days as specified in Policy Schedule.

3.5. POST-HOSPITALISATION MEDICAL EXPENSES

This benefit covers relevant Post-Hospitalisation Medical Expenses incurred by the Insured Person during the Policy Period, for number of days as specified in Policy Schedule.

3.6. PRE-EXISTING DISEASE

This Policy covers relevant Medical Expenses of the Insured Person incurred from the 3rd continuous year/5th continuous year of the Policy with the Company (depending upon the plan chosen and as specified in the Policy Schedule), for Medically Necessary Treatment of Pre-Existing Disease, subject to all other terms and conditions under the Policy.

This cover may be made available earlier than 3rd or 5th continuous Policy year in accordance with any reduction applicable to the Section 3.1 Pre-Existing Disease Waiting Period according to the terms and conditions of the Policy.

3.7. CRITICAL ILLNESS

This benefit, if applicable to the chosen plan and specified in the Policy Schedule, provides for an additional amount equivalent to the Sum Insured opted under In-patient Hospitalisation, towards treatment of listed Critical Illnesses. For the purposes of this Policy and the determination of the Company's liability under it, the Insured Event in relation to the Insured, shall mean any illness, medical event or surgical procedure as specifically defined below whose signs or symptoms first commence and first diagnosis occurs more than 30 days after the Policy Period Start Date and shall only include those defined hereunder.

1. 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 –

a. 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.

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

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

d. 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

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

f. Chronic lymphocytic leukemia less than RAI stage 3

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

h. 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;

i. All tumors in the presence of HIV infection.

2. Open Chest CABG

i. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

ii. The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures.

3. Myocardial Infarction (First Heart Attack of specific severity)

i. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

a. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

b. New characteristic electrocardiogram changes

c. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

ii. The following are excluded:

a. Other acute Coronary Syndromes

b. Any type of angina pectoris

c. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure

4. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

5. Multiple Sclerosis with persisting symptoms

i. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

a. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

b. There must be current clinical impairment of motor

or sensory function, which must have persisted for a continuous period of at least 6 months.

ii. Other causes of neurological damage such as SLE and HIV are excluded.

6. Major Organ / Bone Marrow Transplant The actual undergoing of a transplant of:

i. One of the following organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cell The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

7. Stroke resulting in permanent symptoms

i. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

ii. The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. Aorta Graft Surgery

The actual surgical repair of an aortic aneurysm (an abnormal bulge in the wall of the aortic blood vessel causing the aorta to dilate or widen and the aortic valve to leak leading to bursting of arterial wall) for the first time by a surgeon. The diagnosis to be evidenced by any two of the following:

i. Computerised tomography (CT) scan

ii. Magnetic resonance imaging (MRI) scan

iii. Echocardiography (an ultrasound of the heart)

iv. Abdominal ultrasound (for associated abdominal aneurysms)

v. Angiography (an x-ray of the blood vessels)

9. Permanent Paralysis of Limbs

Total and irrecoverable loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. Primary (Idiopathic) Pulmonary Hypertension

i. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

ii. The NYHA Classification of Cardiac Impairment are as follows:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

b. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

iii. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

3.8. DONOR EXPENSES

This benefit covers the Medical expenses incurred during the Policy Period towards the In-patient Hospitalisation of donor, in case of a major organ transplant ,subject to the overall limit of the Sum Insured and Plan opted and specified in the Policy Schedule, provided that

i. The organ donation is in accordance with The Transplantation of Human Organs Act, 1994 (amended) and other applicable laws and rules.

ii. The Company has admitted the Insured Person's Hospitalization claim under the Policy.

iii. The organ donated is for the use of the Insured Person

iv. Company shall not pay the donor's Pre and Post Hospitalization Expenses

3.9. COST OF HEALTH CHECK UP

The Company shall provide Reimbursement of the cost of medical check-up up to 1% of average Sum Insured for Individual Policies and up to 1.25% of Sum Insured for Floater covers, once at the end of a block of four consecutive and continuous Policy years provided there are no claims reported under the Policies by any Insured Person, during this block. The limit specified for Individual Policies applies to each Insured Person, and that specified for floater cover is the overall limit available for all members.

3.10. MODERN TREATMENT

This benefit covers the Insured Person upto 50% of Sum Insured for the Medical Expenses incurred during the Policy Period on In Patient Hospitalisation or DayCare Treatment or Domiciliary Hospitalisation for the below mentioned Modern Treatment Methods:

i. Uterine Artery Embolization and HIFU

ii. Balloon Sinuplasty

iii. Deep Brain Stimulation

iv. Oral Chemotherapy

v. Immunotherapy-Monoclonal Antibody to be given as injection

vi. Intra Vitreal injections

vii. Robot surgeries

viii. Stereotactic radio surgeries

ix. Bronchial Thermoplasty

x. Vaporization of the prostrate (Green laser treatment or

holmium laser treatment)

xi. IONM- (Intra Operative Neutro Monitoring)

xii. Stem Cell therapy: including Hematopoietic stem cells for bone marrow transplant for hematological conditions

The claim under this benefit shall be subject to all other terms under Sections 2.1 to 2.15

3.B VALUE ADDED COVERS

Benefits under this Section are Value added services payable up to the limit as specified in the Policy Schedule and shall not exceed the Sum Insured opted by the Insured during the Policy Period. Benefits under each value added cover shall be available separately to each Insured Person and available per Hospitalization.

A valid claim should have been admitted under the basic cover of the Policy, for admission of liability under each of the value added covers.

3.11. DAILY HOSPITALIZATION ALLOWANCE

This benefit provides for payment to the Insured Person of Daily Hospital Allowance up to limits specified in the Policy Schedule in case of hospitalization exceeding 3 days.

3.12. NURSING ALLOWANCE

This benefit provides an allowance up to the limit as specified in the Policy Schedule for services of a Qualified Nurse at the Insured Person's residence or the Hospital on the medical advice which is confirmed as medically necessary by the attending Medical Practitioner and the same relate directly to an illness / injury for which the Company has admitted a Hospitalization claim for Insured Person.

3.13. LOCAL ROAD AMBULANCE SERVICE

This benefit indemnifies the Insured Person for Reasonable and Customary charges up to the limit as specified in the Policy Schedule incurred for his / her transportation by Ambulance to the Hospital for which a claim is admitted by the Company under Benefits 2.1 or 2.3 of this Policy.

3.14. RECOVERY BENEFIT

This Policy provides for payment of the sum as specified in the Policy Schedule in the event that a covered Hospitalization of the Insured Person exceeds a period of 10 days. This benefit is applicable, separately, to all the members of the floater irrespective of the number of occurrences during the Policy Period. It is subject to overall limit of the Sum Insured.

3.15. EXPENSES ON ACCOMPANYING PERSON

This benefit provides a per day amount to Insured Person as specified in the Policy Schedule, for the expenses incurred by the accompanying person during In-Patient Hospitalization of the Insured Person for which the Company **has admitted a claim under Benefit 2.1 of this Policy.**

SECTION-4 WAITING PERIOD

The Waiting Periods as defined in Clause 3.1, 3.2 &3.3 shall be applicable individually for each Insured Person and Claims shall be assessed accordingly, irrespective of whether the Sum Insured is on individual or floater basis.

If there is any Break in Policy then the waiting periods including that for Pre-existing Disease shall be applicable afresh and the look-back period of 4 years for Pre-existing Disease shall be counted from the fresh Policy Period Start Date.

The Company shall not be liable to make any payment under the Policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below.

4.1. PRE-EXISTING DISEASES (CODE: EXCL 01)

i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24/48 months (as specified in the Policy Schedule) of continuous coverage after the date of inception of the first policy with us.

ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

iii. If the Insured Person 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.

iv. Coverage under the policy after the expiry of 24/48 months (as specified in the Policy Schedule) for any preexisting disease is subject to the same being declared at the time of application and accepted by us.

4.2. SPECIFIC WAITING PERIOD (CODE: EXCL 02)

Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 12 months of continuous coverage, as may be the case after

i. The date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.

ii. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

iii. 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.

iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

v. If the Insured Person 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.

12 months waiting period list:

- Cataract
- Benign Prostatic Hypertrophy
- Myomectomy, Hysterectomy or menorrhagia or fibromyoma unless because of malignancy
- Dilation and curettage
- Hernia, hydrocele, congenital internal anomaly/ diseases, fistula in anus, sinusitis
- Skin and all internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant / adenoids and hemorrhoids
- Dialysis required for chronic renal failure
- Gastric and Duodenal ulcers

4.3. FIRST THIRTY DAYS WAITING PERIOD (CODE: EXCL 03)

i. 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.

ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

iii. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently

SECTION-5 EXCLUSIONS

5.1 GENERAL EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

i. Investigation & Evaluation (CODE: EXCL 04)

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

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

ii. Rest Cure, rehabilitation and respite care (CODE: EXCL 05)

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

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. Obesity/ Weight Control (CODE: EXCL 06):

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

- greater than or equal to 40 or
- 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:
- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnea
- Uncontrolled Type2 Diabetes

iv. Change-of-Gender treatments (CODE: EXCL 07):

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

v. Cosmetic or Plastic Surgery (CODE: EXCL 08):

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

vi. Hazardous or Adventure sports (CODE: EXCL 09):

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.

vii. Breach of law (CODE: EXCL 10):

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

viii. Excluded Providers (CODE: EXCL 11):

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. (For updated and detailed list of Excluded Providers refer website- www.reliancegeneral.co.in)

ix. Substance Abuse and Alcohol (CODE: EXCL 12):

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

x. Wellness and Rejuvenation (CODE: EXCL 13):

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.

xi. Dietary Supplements & Substances (CODE: EXCL 14):

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

xii. Refractive Error (CODE: EXCL 15):

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

xiii. Unproven Treatments-Code (CODE: EXCL 16)

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.

xiv. Sterility and Infertility (CODE: EXCL 17):

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

xv. Maternity Expenses (CODE - 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.

xvi. Circumcision:

Circumcision unless necessary for treatment of an illness not excluded hereunder, or, as may be necessitated due to an accident.

xvii. Dental Treatment:

Any dental treatment or surgery unless necessitated due to an Injury and requiring Hospitalization.

xviii. Treatment outside Discipline:

Treatment taken from anyone not falling within the scope of definition of Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication

xix. Hearing Aids and Spectacles:

Any charges incurred on hearing aids, cost of spectacles, contact lenses and routine eye and ear examinations

xx. Documentation charges:

Any charges incurred to procure any medical certificate, treatment/Illness related documents pertaining to any period of Hospitalization/Illness

xxi. Artificial Life Support Equipment:

Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health

xxii. RMO charges, service charges and alike:

Expenses related to any kind of RMO charges, service charge where nursing charges are also charged, night charges levied by the Hospital under whatever head.

xxiii. STDs:

Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, , Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

xxiv. External durable medical equipment:

Any expenses incurred on corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.)and oxygen concentrator for asthmatic condition

xxv. Transplant other than from human body:

Expenses incurred on organ transplant surgery involving organs not harvested from a human body

xxvi. Sleep Apnea:

Any treatment related to sleep apnea, general debility convalescence

xxvii. External Congenital Anomaly:

Treatment of External Congenital Anomaly.

xxviii. Self-injury:

Any intentional self-inflicted Injury

xxix. Vaccination and Immunization:

All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment).

xxx. Prostheses:

Prostheses, corrective devices and medical appliances, which are not, required intra-operatively or for the disease/ illness/ injury for which the Insured Person was hospitalised.

xxxi. Donor Transplant Expenses:

All expenses related to donor screening, treatment, including surgery to remove organ(s) from the donor, in case of transplant surgery.

xxxii. Non-Allopathy:

Any expenses related to Non-allopathic treatment, except for AYUSH treatment.

xxxiii. Overseas Treatment:

Treatment received outside India

xxxiv. Non-medical expenses:

Any non-medical expenses mentioned in Annexure A"

xxxv. Nuclear Attack:

Nuclear, Chemical or Biological attack/ weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this Clause:

a. Nuclear attack/ weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack/ weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack/ weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organism(s) and/ or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Also excluded herein is any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling,

preventing, suppressing, minimizing or in any way relating to the above.

xxxvi. War:

War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

5.2. PERMANENT EXCLUSION

A permanent exclusion will be applied on Pre-Existing medical or physical condition or treatment of an Insured Person, if such exclusion is accepted by the Proposer and specifically mentioned in the Policy Schedule. This option, as per Company's underwriting policy, will be used for such condition(s) or treatment(s) that otherwise would have resulted in rejection of insurance coverage under this Policy to such Insured Person. The list of such diseases/conditions or treatments are specified as an Annexure-F

SECTION-6 CLAIMS PROCEDURE

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying with the following steps, shall be the condition precedent to the admissibility of the Claim.

Upon the discovery or happening of any Illness / Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admissibility of the Claim, the Policyholder/ Insured Person shall undertake the following:

6.1. CLAIMS INTIMATION

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a Claim covered under the Policy, the Policyholder/ Insured Person, must notify the Company either at the call center or in writing immediately. In the event of

i. Planned Hospitalization, the Company should be notified of such admission at least 48 hours prior to the planned date of admission.

ii. Emergency Hospitalization, the Company should be notified of such admission within 24 hours of such admission.

The following details are to be provided to the Company at the time of intimation of Claim:

i. Policy Number

ii. Name of the Policyholder

Iii. Name of the Insured Person in whose relation the Claim is being lodged

iv. Nature of Illness / Injury

v. Name and address of the attending Medical Practitioner and Hospital

vi. Date of Admission

vii. Any other information as requested by the Company

6.2. PROCEDURE FOR CASHLESS AND REIMBURSEMENT OF CLAIMS

i. Cashless:

Cashless facility is available only at a Network Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured Person:

a. Pre-authorization : Prior to Hospitalization, the Policyholder/ Insured Person must call the call center of the Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.

b. The Company will process the Policyholder's/ Insured Person's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Policyholder/ Insured Person and the Company will confirm such Cashless authorization / rejection in writing or by other means.

c. If the procedure above is followed and the Policyholder's/ Insured Person's request for Cashless facility is authorized, the Policyholder/ Insured Person will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit).Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

d. The Company reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Policyholder/ Insured Person shall, in any event, be required to settle all other expenses, copayment and / or deductibles (if applicable), directly with the Hospital.

e. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.

f. There can be instances where the Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder/ Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the Company which will be considered subject to the Policy Terms &Conditions.

g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 5.4 with the Network Hospital.

Note: Under Cashless facility, the Company may authorize upon the Policyholder's / Insured Person's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the Company. In such cases, the Company will directly settle all eligible amounts as per the Policy Terms &Conditions with the Network Hospital to the extent the Claim is covered under the Policy.

The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on the Company's website.

ii. Re-imbursement:

In case of any Claim under the Benefits, where Cashless Facility is not availed, the list of documents as mentioned in Clause 5.4 shall be provided by the Policyholder/Insured

Person, immediately but not later than 15 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

6.3. POLICYHOLDER'S / INSURED PERSON'S DUTY AT THE TIME OF CLAIM

i. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.

ii. Forthwith intimate / file / submit a Claim in accordance with Clause 5 of this Policy.

iii. Forthwith pay the entire premium for the cover period in case of EMI applicable

iv. If so requested by the Company, the Insured Person will have to submit himself for a medical examination by the Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such examination will be borne by the Company.

v. The Policyholder/ Insured Person is required to check the applicable list of Network Hospitalization the Company's website or call center before availing the Cashless services.

vi. On occurrence of an event which will lead to a Claim under this Policy, the Policy holder/ Insured Person shall:

a. Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.

b. Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

If the Policyholder / Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

6.4. CLAIM DOCUMENTS

The Policyholder / Insured Person shall submit to the Company/ Network Hospital (as applicable) the following documents for or in support of the Claim:

i. Duly completed and signed Claim Form, in original

ii. Medical Practitioner's referral letter advising Hospitalization

iii. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation

iv. Original bills, receipts and discharge card from the Hospital / Medical Practitioner

v. Original bills from pharmacy / chemists

vi. Original pathological / diagnostic test reports and payment receipts

vii. Indoor case papers

viii. Ambulance receipt and bill

ix. First Information Report/ Final Police Report, if applicable

x. Post mortem report, if available

xi. Any other document as required by the Company to assess the Claim When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

Note :

i. Claim once paid under one Benefit cannot be paid again under any other Benefit.

ii. All invoices / bills should be in Insured Person's name.

6.5. PROPORTIONATE DEDUCTIONS

Subject to the other Terms and Conditions of this Policythe Associate Medical Expenses (and the Room Rent) incurred by the Insured Person pertaining to a Hospitalization shall be proportionately reduced in deriving at the payable amount of the corresponding Claim, in the event of (as the case maybe):

i. The Insured Person chooses a higher room category than the category that is eligible as per the terms and conditions of the Policy. In this case, higher room category means a room category in which the room rent expenses charged by the Hospital is more expensive than the eligible room category as per the terms and conditions of the Policy.

ii. The Insured Person chooses a room category in which the room rent charges are more than the applicable Sum Insured sub-limit (in percentage or Rupee term In the above, Associate Medical Expense, means all admissible invoice break ups (or bill heads) of the Hospitalization Medical Expenses as mentioned in Benefit-2.1 (i.e. In-Patient Hospitalisation) barring the below mentioned expense break ups:

i. Cost of Pharmacy and Consumables

ii. Cost of Implants and Medical Devices

iii. Cost of Diagnostics

The proportional reduction will be done in a manner consistent with the below table :s) on the room rent as per the Policy terms and conditions.

Sr. No.	Header	Explanation
A	Actual Medical Bills Incurred	As per submitted documents
B	Covered Medical Expenses	A - Any expense not covered under Policy Benefits
C	Actual Room Rent	Room Rent (Including items to be subsumed under Room Rent as defined under Annexure A)
D	Covered Medical Expenses which shall be subject to Proportionate Deduction	B - cost of Pharmacy and consumables, implants and medical devices and diagnostics
E	Claim after Proportionate Deduction	D * Eligible Room Rent Limit ÷ Actual Room Rent (If Actual Room Rent is within eligibility, then no deduction to be applied [E=D])
F	Ground up claim amount	E + cost of Pharmacy and consumables, implants and medical devices and diagnostics
G	Amount after Co-pay	F - Co-payment, if any on account of age
H	Payable claim amount	G - Deductions for Policy Deductibles and Limits*

Proportionate Deduction is subject to the following:

i. Apart from the Associate Medical Expenses, no other expenses will be proportionately reduced ii. If the given Hospital do not follow differential billing or if there are items in the claim for which the Hospital do not follow differential billing, the Insurer shall not be proportionately reducing the Claims. This shall be applied in case of admissions in Government Hospitals and the Network Hospitals of the Insurer.

iii. ICU charges shall not be proportionately reduced in all cases

5.6. PAYMENT TERMS

i. This Policy covers medical treatment taken within India, and payments under this Policy shall be made in Indian Rupees within India.

ii. Claims shall not be admissible under this Policy unless the Company has been provided with the complete documentation / information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.

iii. The Company shall not indemnify the Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure D (List of Day Care Treatments).

iv. The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Period.

v. The Company is not obliged to make payment for any Claim or that part of any Claim that could have been avoided or reduced if the Policyholder/ Insured Person could reasonably have minimized the costs incurred, or that is brought about or contributed to by the Policyholder/ Insured Person failing to follow the directions, advice or guidance provided by a Medical Practitioner.

vi. For Cashless Claims, the payment shall be made to the Network Hospital whose discharge would be complete and final.

vii. For the Reimbursement Claims, the Company will pay the Policyholder. In the event of death of the Policyholder, the Company will pay the nominee (as named in the Policy Schedule) and in case of no nominee at its discretion to any adult Insured Person in the Policy whose discharge shall be treated as full and final discharge of its liability under the Policy.

viii. The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form

SECTION-7 TERMS AND CONDITIONS

7.1. 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 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)

7.2. 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.

7.3. 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.nt of claim at a rate 2% above the bank rate.

7.4. 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

7.5. REASONABLE CARE

The Insured Person shall take all reasonable steps to safeguard the interests of the Insured Person against accidental loss or damage that may give rise to a claim.

7.6. MATERIAL CHANGE

The Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation / business at his own expense and the Company may adjust the scope of cover and/or premium, if necessary, accordingly.

7.7. RECORDS TO BE MAINTAINED

The Policyholder/ Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period and up to three years after the policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

7.8. NO CONSTRUCTIVE NOTICE

Any knowledge or information of any circumstance or condition in connection with the Insured Person in possession of any official of the Company shall not be notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

7.9. SPECIAL PROVISIONS

Any special provisions subject to which this Policy has been

entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

7.10. 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

7.11. FRAUD

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this Policy and the premium paid shall be forfeited.

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

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

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

iii. any other act fitted to deceive; and

iv. any such act or omission as the law specially declares to be fraudulent

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

7.12. CANCELLATION (OTHER THAN FREE-LOOK)

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

- **In case of no claim in the policy**

  In the event of cancellation by the insured the refund amount shall be on pro-rata basis and shall be calculated as per the terms laid out below:

  Calculation of Pro-Rata refund:

  Return Premium=Total Policy Premium*(1-((Number of Policy days expired)/(Total Policy Days)))

  For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000, and if cancellation is effected on expiry of 243 days from policy inception, then The Return Premium = 10000 * (1- (243 / 365)) = Rs. 3342.47.

- **In case of claim in the policy**

  Where any claim has been admitted or has been lodged by the person under the Policy, there shall be no refund of premium for the Policy Year in which the claim occurs.

  For e.g. If Policy Premium for 1 year (365 days) policy is Rs. 10000. Considering the claim year is 1st Year (200 days), then no refund shall be made for the Policy Year.

ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

7.13. CAUSE OF ACTION

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India and in Indian Rupees only.

7.14. POLICY DISPUTES

Any and all disputes or differences under or in relation to validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and subject to Indian law.

7.15. 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

7.16. MIGRATION

The Insured Person 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 Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration

For Detailed Guidelines on migration, kindly refer the www.irdai.gov.in(Circular-IRDA/HLT/REG/CIR/003/012020, Dated-01012020)

7.17. PORTABILITY

The Insured Person 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 Person will get the accrued continuity benefits in Waiting Periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the www.irdai.gov.in(Circular- IRDA/HLT/REG/CIR/003/012020, dated 01012020)

7.18. MORATORIUM PERIOD

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

7.19. OVERRIDING EFFECT OF POLICY SCHEDULE

In case of any inconsistency in the terms and conditions in this Policy vis-à-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

7.20. FLOATER POLICY

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Policy Schedule, shall be available to the Insured and all and any one of the Insured Persons for one or more claims during the Policy Period, upto the limit of Sum Insured specified in the Policy Schedule.

Where the Policy is issued on Floater basis, the Policy can cover only the Insured Person, his/her lawful spouse and 2 dependent children who are upto the age of 25 years. A Floater Policy cannot cover any other person apart from the above category of persons.

7.21. PRE-POLICY HEALTH CHECK-UP

The prospect whose medical test is conducted and for whom the company grants an insurance cover under this policy and whose name specifically appears as Insured Person in the Schedule, the Company shall be liable to reimburse 50% of the cost of such medicals conducted at the Company's designated centre

7.22. 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 thirty 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;

7.23. 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 the 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 continuiy 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.

vi. Renewal Discount equivalent to 5%, on cumulative basis, of renewal premium for each continuous claim free year will offered as No Claim Bonus subject to maximum upto 20%, where the Policy which is claim free & is renewed without a break. In case of claim all discount shall be forfeited at renewal

7.24. 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

7.25. LIMITATION PERIOD

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 5 – Claims procedure above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

7.26. ALTERATIONS IN THE POLICY

This 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 a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy subject to underwriting decision of the Company

7.27. COMMUNICATION

Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder will be sent by the Company to his last known address or the address as shown in the Policy Schedule.

All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

7.28. 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

7.29. REDRESSAL OF GRIEVANCE

In case of any grievance the Insured Person may contact the Company through

Website: www. Relianceada.com

Telephone Number: 022 4890 3009 (paid)

Dedicated Senior Citizen helpline: 022-33834185 (paid line)

E-mail: rgicl.services@relianceada.com

Fax: +91 22 3303 4662

Courier: Any branch Office, the correspondence address, during normal business hours.

Write to us at: Reliance General Insurance.

Winway Building 2nd and 3rd Floor, 11/12 Block No - 4, Old No - 67, South Tukoganj, Indore (M.P) - 452001

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance Officer at:

Grievance Redressal Officer

The Grievance Cell,
Reliance General Insurance Co. Limited
No. 1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500 081

Grievance Redressal Officer email ID:
rgicl.headgrievances@relianceada.com

(For updated details of grievance Officer, kindly refer the link. https: //reliance general.co.in/ Insurance/About - Us/Grievance- Redressal.aspx

If Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the Office of Insurance Ombudsman of the respective area/ region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The contact details of the Insurance Ombudsman offices have been provided as Annexure-B Grievance may also be lodged at IRDAI Integrated Grievance Management System https:// igms. irda.qov. in/

SECTION-8 GENERAL CONDITIONS (APPLICABLE TO ALL BENEFITS UNDER THE POLICY):

1. Minimum and Maximum age of the Insured / Insured person shall be 3 months up to 80 years
2. The maximum number of travel days under a single trip that may be insured, under the Policy, shall be 182 days. Provided that the Policy may be extended only once beyond the initial period of 182 days during the trip duration by a maximum of additional 183 days at the sole discretion of the Company by collecting additional premium. Provided further that for an Insured / Insured person being up to the age of 60 years, the maximum trip duration (including any extension provided) shall not exceed 365 days in total. In case of an Insured / Insured Person being more than 60 years of age, the maximum trip duration (including any extension provided) shall not exceed 180 days in total.
3. The Policy start date shall be on or before the trip start date.
4. Extension of the Policy during the duration of the trip can be done only once at the sole discretion of the Company. The Insured / Insured Person shall submit a declaration letter clearly mentioning the claims filed during the original Policy duration and also that he / she is unaware of any existing health condition which could result in a claim during the extension period. In case a claim has been filed in the original Policy duration, then the Policy may be extended only if the claim filed relates to the following benefits,
   a. Dental treatment
   b. Loss of passport
   c. Total loss of checked baggage
   d. Delay of checked baggage
   e. Financial Emergency Assistance
   f. Hijack Distress Allowance
   g. Trip delay
   h. Trip cancellation & interruption
   i. Missed connection

   The extension of any Policy is at the sole discretion of the Company, and the Company is not liable to offer any reason to the Insured / Insured Person if the Policy is not extended.
5. A Policy may not be extended if a claim is already filed by the Insured /Insured Person. If the Insured / Insured person does not declare the claims filed or the claims that are to be filed under the original Policy, then any extension of the Policy if granted shall be deemed to be invalid. No refund of premium will be given in case of extensions so invalidated. The Company will also not be liable to pay any claim filed under the extended Policy.
6. Termination of the Policy at a date earlier than the end date can be done only if the Insured / Insured Person returns back to the Republic of India earlier than the end date of the Policy. Refund of premium for the days between the arrival date and the end date of the Policy will only be given if the same are exceeding 10 days. A cancellation charge will be deducted from the refund premium. Premium refunded will be equal to the amount of premium to be paid for the original Policy duration minus the premium to be paid by taking the arrival date as the new end date. No refunds will be given on Policies with claims.

7. The premium payable for the extension of the Policy during the trip duration shall be the premium payable for the overall trip duration (including the extension) less the initial premium already paid.
8. Policy is applicable for one-way travel also, including immigration travel with the condition that the maximum duration of coverage will be 60 days.
9. The Insured / Insured shall take all reasonable precautions to prevent illness and injury in order to minimize claims. Failure to do so will prejudice the Insured / Insured person's claim under this Policy.
10. The Insured / Insured Person shall provide the Company with the details of the trip and other information as may be required by the Company from time to time.
11. Deductible will be charged for each separate incident reported for claims payment, even though the claim may be registered under the same benefit more than once.
12. Claim Procedure - What is to be done in case of a claim?
    a. The Insured / Insured Person shall immediately contact the Help Line of Emergency Assistance Service Provider stating necessary details. The details of phone numbers and Help Line are given in the Schedule attached to this Policy.
    b. The Insured / Insured Person needs to contact the Help Line number while abroad as soon as possible and inform in case the Insured / Insured Person is/will be filing any claim, even if assistance is not required. The Company will not be liable to pay any claim that has not been informed by the Insured / Insured Person while abroad to the Help Line.
    c. The Help Line of the Emergency Assistance Service Provider will verify the identity of the caller by asking appropriate information.
    d. In the event of a illness / injury where it is not possible contact the Help Line before consulting a Physician or going to the Hospital, the Insured / Insured Person shall contact the Help Line as soon as possible. In either case, when being admitted as a patient, the Insured / Insured Person shall show the concerned Physician or personnel this Policy.
    e. In case financial emergency assistance is required, the Insured /Insured Person shall immediately contact the Help Line of the Emergency Assistance Service Provider stating the details of his / her Policy along with the police report containing the passport number and a written statement narrating the incident of loss i.e. causes, circumstances and the place. Failure to do so may prejudice the Insured / Insured person's claim.
    f. In case of Medical Expenses, Dental Treatment, Repatriation of Mortal Remains and Financial Emergency Assistance, the Company's liability will only attach if these are incurred with the approval of Emergency Assistance Service Provider.
    g. In case of Hijacking, the fact of the incident having occurred should be confirmed by police authorities. The police report should contain details such as the passport number of the Insured / Insured Person, the period of hijack, etc. In rare cases, the Company may consider other supporting documents such as a report issued by the airlines, newspaper reports, TV and other media coverage with regard to the particular hijacking incident.
13. Claims Settlement - How to get the claim paid?
    a. If the procedure stated above is complied with, Emergency Assistance Service Provider, as the case may be, will guarantee to the Hospital / other providers the costs of hospitalisation, transportation for emergency services, transportation home of the Insured / Insured Person including accompanying person, if any, and provide financial emergency assistance to the Insured / Insured Person. All costs will be directly settled by Emergency Assistance Service Provider on the Company's behalf and the same shall constitute due discharge of the Company's obligations hereunder.
    b. If the Hospital / other providers do not accept the guarantee of payment from Emergency Assistance Service Provider, the Company cannot be held liable for the same. The cost will then have to be borne by the Insured / Insured Person and the same will then be reimbursed by the Emergency Assistance Service Provider / the Company on submission of required documents.
    c. Reimbursement of all claims (except claims under Financial Emergency Assistance) will be made by the Emergency Assistance Service Provider / the Company in Indian Rupees on the Insured / Insured Person's return back to the Republic of India, at the exchange rate specified by the Reserve Bank of India, as applicable on the date the amount is billed. Claims under Financial Emergency Assistance shall be settled / arranged directly to the Insured / Insured Person, whilst abroad, by the Emergency Assistance Service Provider.
    d. Insured / Insured Person with an immigrant visa, going abroad permanently and having declared an immigrant status on the Policy will be reimbursed claims abroad.
    e. In case of claim under home burglary insurance, the loss shall be intimated to the Company and the Company shall appoint an independent surveyor to assess the loss.
14. Claim Documentation - What documents I need to submit?
    a. The original ticket / boarding pass or a copy of the passport Indicating the travel dates must be submitted with every claim, along with the completed claim form.
    b. Original bills / vouchers / reports and discharge summary must be submitted along with all claims.
    c. Bills / vouchers / reports / discharge summary must mention the name of the person treated, the type of illness, details of the individual items of medical treatment provided and the dates of treatment. Prescriptions must clearly show the medicines prescribed. The pharmacy bills must clearly show the price and bear the receipt stamp of the pharmacy. In the case of dental treatment, the bills / vouchers / reports must give the details of the tooth treated and the treatment performed. Treatment taken on different dates for separate ailments will be treated as separate claims. The claim forms should clearly indicate the same and supporting documents should be provided for each one. Deductible will apply to each claim separately.
    d. For reimbursement of the costs of transporting the mortal remains of the Insured / Insured Person to the Republic of India or of costs of burial abroad, an official death certificate and a physician's statement giving the cause of death needs to be submitted. Medical statements from spouses/ relatives will not be accepted. Original bills / receipts of expenses incurred need to be submitted also. These would be paid as per the usual and customary charges incurred for the same.

e. For reimbursement of extra expenses of transportation of Insured / Insured Person to the Republic of India, a medical statement from a registered Physician indicating the cause of illness and the necessity of transportation needs to be submitted. Medical statements from spouses/ relatives will not be accepted. Original bills / receipts of the expenses incurred need to be submitted also. These would be paid as per the usual and customary charges Incurred for the same.

f. For loss of passport, a Police Report obtained within 24 hours of the Insured / Insured person becoming aware of the theft needs to be submitted. Along with this, original bills / receipts of expenses incurred for new / fresh passport needs to be submitted

g. In case of total loss of checked-in baggage, a Property Irregularity Report or other report usually issued by the common carriers in the event of loss of checked-in baggage will need to be submitted with the claim form. A letter from the airline will also need to be submitted stating the compensation, if any received from them for the lost baggage.

h. Adequate proof of ownership of items contained within checked-in baggage valued in excess of the Indian Rupee equivalent of US$ 100 for loss/delay of checked-in baggage will need to be submitted.

i. Original bills of emergency items purchased and the Property Irregularity Report or any such other report from the airline statingthe date and time of arrival of delayed baggage needs to be submitted in case of delay of checked-in baggage claims.

j. For personal accident, original bills / vouchers / reports / discharge summary are to be submitted, mentioning the name of the person treated, the cause of accident, details of the individual items of medical treatment provided and the dates of treatment. In case of death a Post mortem report, shall also be submitted.

k. For personal liability, proof of judicial decision rendered by a Court needs to submitted.

l. For claims under financial emergency assistance benefit, the police report filed within 24 hours of becoming aware of the robbery needs to be submitted.

m. For claims under trip delay the following documents need to be furnished. Medical reports and doctors' statement or police report confirming the incident causing the trip delay. In case the delay is owing toillness, injury or death of a travelling companion, the original tickets of the Insured / Insured Person and the travelling companion indicating travel to the same destination on the same dates. It should contain the Passport number of the Insured / Insured Person and period. All original bills / receipts of reasonable additional expenses incurred and/or proof of cancellation charges levied by the carriers shall be submitted.

n. For claims under trip cancellation and interruption the following documents need to be submitted. Medical reports and doctors statement if trip is cancelled or interrupted due to medical reasons. If due to employment, termination letter from the company. If due to other events, police report confirming the incident shall be submitted. In case of illness, injury or death of a travelling companion, the original tickets of the Insured / Insured person and the travelling companion indicating travel to the same destination on the same dates. It should contain the Passport number of the Insured / Insured Person and period. All original bills / receipts of reasonable additional expenses incurred and/ or proof of cancellation charges levied by the carriers shall be submitted.

o. For claims under missed connection the following documents need to be submitted i.e. confirmation from the airline, mentioning the scheduled arrival time and the actual arrival time. The reason for delay in the flight also needs to be mentioned. All original bills / receipts of reasonable additional expenses incurred and / or proof of cancellation charges levied by the carriers shall be submitted.

p. Any other document(s) that the Company may require from the Insured / Insured Person to process a claim may be asked for. If the Emergency Assistance Service Provider or the Company request that bills / vouchers in a foreign language be accompanied by an appropriate translation then the costs of such translation must be borne by the Insured / Insured Person.

q. Claim documents to be submitted in event of a claim benefit under home burglary insurance are

- First Information Report from the Police
- Panchnama
- Investigation Report by the Police
- Estimate and final bills of repairers
- Invoices of owned articles, if required by the Company
- And any other document as may be appropriately applicable for the claims preferred under this benefit.

15. Obligations of the Insured / Insured person:

a. Claims for benefits must be submitted to the Emergency Assistance Service Provider not later than one (1) month after the completion of the treatment or transportation home, or in the event of death, after transportation of the mortal remains/ burial.

b. Insured / Insured Person shall provide to the Emergency Assistance Service Provider on demand any information that is required to determine the occurrence of the insurable event or the Company's liability to pay the benefits. In particular, upon request, proof shall be furnished of the actual commencement date of the trip.

c. If requested to do so by the Emergency Assistance Service Provider, the Insured / Insured Person is obliged to undergo a medical examination by a physician designated by the Emergency Assistance Service Provider.

d. Emergency Assistance Service Provider is authorized by the Insured / Insured Person to take all measures that are suitable for loss prevention and claim minimization which includes the Insured / Insured Person's transportation back to the Republic of India.

e. The Company shall be released from any obligation to pay benefits under this Policy, if any, of the aforementioned obligations are breached by the Insured / Insured person.

16. Transfer and Set-off of Claims:

a. If the Insured / Insured Person has any outstanding claims against third parties, such claims shall be transferred in writing to the Company up to the amount for which the reimbursement of costs is made by the Company in accordance with the terms hereunder.

b. In so far as an Insured / Insured Person receives compensation for costs he/she has incurred either from third parties liable

for damages or as a result of other legal circumstances, the Company shall be entitled to set off this compensation against the insurance benefits payable, if any.

c. Claims to the insurance benefits may be neither pledged nor transferred by the Insured / Insured Person.

17. No sum payable under this Policy shall carry any interest / penalty.

18. The cover applies to all countries stated in the Schedule except the Republic of India where the Insured / Insured Person has a permanent place of residence, except as otherwise provided.

19. In the event of the Insured / Insured Person's death, the Company shall have the right to demand the submission of a post mortem / autopsy report.

The Company shall settle the claim within 30 days from the date of receipt of last necessary document.However, where the circumstances of a claim warrant an investigation in Company's opinion 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, Company shall settle the claim within 45 days from the date of receipt of last necessary document.

SECTION-9 STANDARD TERMS AND CONDITIONS (APPLICABLE TO ALL BENEFITS UNDER THE POLICY):

1. Duty of Disclosure

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or nondisclosure of any material fact. In the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or device being used by the Policyholder/ Insured Person or any one acting on his/ their behalf to obtain a benefit under this Policy, the Company may cancel this Policy at its sole discretion and the premium paid shall be forfeited in its favor.

2. Observance of terms and conditions

The due observance and fulfillment of the Policy Terms & Conditions and Endorsements of this Policy in so far as they relate to anything to be done or complied with by the Policyholder / Insured Person, shall be a condition precedent to any of the Company's liability to make any payment under this Policy.

3. Reasonable Care

The Insured / Insured person shall take all reasonable steps to safeguard the interests of the Insured / Insured Person against accidental loss or damage that may give rise to a claim.

4. Material change

The Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation / business at his own expense and the Company may adjust the scope of cover and/or premium, if necessary, accordingly.

5. Records to be maintained

The Policyholder/ Insured Person shall keep an accurate record containing all relevant medical & other relevant records and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period and up to three years after the policy expiration, or until final adjustment (if any) and resolution of all Claims under this Policy.

6. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in possession of the Company and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

7. Complete discharge

Payment made by the Company to the Policyholder/ adult Insured Person or the Nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

8. Special Provisions

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

9. Electronic Transactions

The Policyholder/ Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company'sother products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

10. Duties of the Insured/ Insured Person on occurrence of loss

On the occurrence of any loss, within the scope of this Policy the Insured /Insured Person shall:

a) Forthwith file / submit a Claim Form in accordance with 'Claim Procedure'.

b) Allow the Surveyor or any agent of the Company to inspect the lost / damaged properties premises /goods.

c) Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties.

d) Not to abandon the insured property / items in the premises, nor take any steps to rectify / remedy the damage before the same has been approved by the Company or any of its agents or the Surveyor.

If the Insured / Insured Person does not comply with this provision of this Clause, all benefits under this Policy shall be forfeited, at the option of the Company.

11. Right to inspect

If required by the Company, an agent / representative of the Company including a loss assessor or a Surveyor appointed in

that behalf shall in case of any loss or any circumstances that have given rise to the claim to the Insured / Insured Person be permitted at all reasonable times to examine into the circumstances of such loss. The Insured / Insured Person shall on being required so to do by the Company produce all books of accounts, receipts, documents relating to or containing entries relating to the loss or such circumstance in his possession and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or will in any way assist the Company to ascertain in the correctness thereof or the liability of the Company under this Policy.

12. Position after a claim

The Insured / Insured Person shall not be entitled to abandon any insured property whether the Company has taken possession of the same or not. As from the day of receipt of the claim amount by the Insured / Insured Person, the Sum Insured for the remainder of the period of insurance shall stand reduced by the amount of the compensation.

13. Indemnity

The Company may at its option, if applicable reinstate, replace or repair the property or premises lost or damaged or any part thereof instead of paying the amount of loss or damage or may join with any other insurer in so doing. The Company shall not be bound to reinstate exactly or completely but only as circumstances permit and in reasonably sufficient manner. In no case shall the Company be bound to expend more in reinstatement than it would have cost to reinstate such property as it was at the time of the occurrence of such loss or damage and in any event not more than the sum Insured Person thereon. If in any case the Company shall be unable to reinstate or repair the insured property/item, because of any law or other regulations in force affecting insured property or otherwise, the Company shall, in every such case, only be liable to pay such sum as would be requisite under this Policy.

14. Subrogation

Subrogation shall mean the right of the Company to assume the rights of the Insured Person/Policyholder to recover expenses paid out under the Policy that may be recovered from any other source. The Policyholder/ Insured Person shall at his own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which the Company is/or would become entitled upon the Company paying for a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after its payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at his own expense provide the Company with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and any costs and expenses incurred by the Company of affecting a recovery, where after the Company shall pay any balance remaining to the Policyholder. This clause shall not apply to any Benefit offered on fixed benefit basis.

15. Contribution

Contribution is essentially the right of the Company to call upon other Insurers liable to the same Insured to share the costs of an indemnity claim on a rateable proportion of Sum Insured. If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company shall not be liable to pay or contribute more than its ratable proportion of any Claim. This clause shall not apply to any Benefit offered on fixed benefit basis.

16. Fraudulent claims

If a Claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a Claim, or if any fraudulent means or devices are used by the Policyholder / Insured Person or anyone acting on his/ their behalf to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to the Company by the Policyholder / all Insured Persons who shall be jointly liable for such repayment.

17. Cancellation

The Company may at any time, cancel this Policy, by giving 7 days notice in writing by Registered Post Acknowledgment Due to the Insured / Insured Person at his last known address in which case the Company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of the cancellation. Cause of Action No claim shall be payable under this Policy where the cause of action arises in India, unless otherwise specifically provided in the Schedule.

18. Policy Disputes

Any and all disputes or differences under or in relation to validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and subject to Indian law.

19. Limitation Period

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 13,14 & 15 above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable

20. Withdrawal/Revision/Modification of the Product

The Company reserves the right to withdraw, revise or modify this product /policy in the future. The revision/modification may be in respect of Benefits, coverages, premiums, policy terms and conditions &/or exclusions. In the event of any such withdrawal of product the company will notify in advance to the policyholder providing him the option to port to the specified existing health products of the company with continuity benefit.

21. Payment of Interest

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

22. Communication

Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule.

Any communication meant for the Policyholder will be sent by the Company to his last known address or the address as shown in the Policy Schedule. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery,facsimile or e-mail.

23. Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-avis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

24. Pre-policy Health Check up

The full cost of any pre-policy health check up wherever required shall be borne by the PolicyHolder / Insured Person.

25. Customer Service

If at any time the Insured / Insured Person requires any clarification or assistance, the Insured / Insured Person may contact either the Help Line of the Emergency Assistance Service Provider or the Policy issuing office of the Company at its address during normal office hours.

26. Grievances

If the Policyholder has a grievance that the Policyholder wishes the Company to redress, the Policyholder may contact the Company with the details of his grievance through:

Website : https://reliancegeneral.co.in

e-mail : rgicl.services@relianceada.com

Telephone : 022 4890 3009 (paid)

Post/Courier : Any branch office, the correspondence address, during normal business hours

Write to us at : Reliance General Insurance, (Correspondence Only) Correspondence Unit, 301 302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

For further details on Grievance redressal procedure please refer:https://reliancegeneral.co.in/Insurance/About-Us/Grievance-Redressal.aspx

If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned below:

ANNEXURE-B

OMBUDSMAN OFFICE

Office of the Ombudsman	Address	Contact Details	Areas of Jurisdiction
AHMEDABAD	Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 001.	Tel.: 079 - 27546150/27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078.	Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	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 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009.	Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneshwar@cioins.co.in	Orissa
CHANDIGARH	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 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, UT - Pondicherry Town and Karaikal (which are part of UT of Pondicherry)

DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@cioins.co.in	Delhi
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar Over Bridge, S.S. Road, Guwahati – 781001 (ASSAM).	Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana and UT of Yanam - a part of UT of Pondicherry.
JAIPUR	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	Office of the Insurance Ombudsman, LIC OF INDIA, 10th Floor, 'Jeevan Prakash', Divisional Office, M. G. Road, Ernakulam, Kochi – 682011.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, UT of (a) Lakshadweep, (b) Mahe-a part of UT of Pondicherry.
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072.	Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, UT of Andaman & Nicobar Islands, Sikkim
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: Laitpur, 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, Ambedkar Nagar, Sultanpur, Maharajgang, Sant Kabir Nagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharath Nagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Dist: Gautam Buddh Nagar, U.P. - 201301.	Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Budha Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, .

			Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiram Nagar, Saharanpur
PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006.	Tel.: 0612 - 2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	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, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.giccouncil.in, our website www.reliancegeneral.co.in

Reliance Healthwise Policy. UIN No.: RELHLIP22185V042122.