

Customer Information Sheet

Description is illustrative and not exhaustive

SI No.	Title	Description	Reference
1	Product Name	Liberty Health Connect Policy	
2	What am I covered for:	<ol style="list-style-type: none"> 1. Hospitalisation Expenses: <ol style="list-style-type: none"> a. In-Patient Treatment – Following any Illness or Injury , provides for in-patient care expenses incurred at any Hospital in India incurred towards Room, Boarding expenses, Intensive Care Unit bed charges, Doctor’s fees, Nursing Expenses, Surgical Fees, Operation Theatre Charges, Anesthetist, Anesthesia, Blood, Oxygen and their administration, Physical Therapy, Prescribed Drugs and medicines consumed on the premises, Investigation Services such as Laboratory, X-Ray, Diagnostic tests, Dressing, Ordinary splints and plaster casts, Cost of Prosthetic devices if implanted during a surgical procedure b. Day Care Treatment - Covers hospitalization for less than 24 hours towards day care procedures due to technological advancement. 2. Pre-Hospitalisation Expenses: Covers medical expenses incurred for specified days immediately before the hospitalisation towards consultations, tests & medications. 3. Post-Hospitalisation Expenses: Covers medical expenses incurred for specified days immediately after the discharge from the Hospital towards follow-up visits, confirmatory tests, medications & physiotherapy. 4. Domiciliary Hospitalisation Treatment: Covers medical expenses incurred for treatment taken at home in India as the patient cannot be moved to a hospital, or the patient takes treatment at home on account of non-availability of room in a hospital. 5. Hospital Daily Cash Allowance: Pays a Hospital Daily Cash allowance to take care of non-medical expenses incurred for each continuous and completed period of 24 hours of hospitalization of the Insured Person for a maximum up to 10th day of continuous hospitalization. A deductible of first 48 hours of hospitalization is however applicable. 6. Emergency Local Road Ambulance Charges: Covers expenses incurred towards transfer of Insured Patient to nearest Hospital having adequate emergency facilities. 7. Organ Donor Expenses: Covers expenses incurred towards organ donor’s screening & treatment for harvesting of the organ donated. 8. Second Opinion: A second medical opinion service from our expert panel of doctors is available for seeking information that will give the Insured Patient confidence in their medical diagnosis and treatment plan. This benefit can be availed once during the policy Year. 	<p>Part II.1.a</p> <p>Part II.1.b</p> <p>Part –II.2</p> <p>Part II.3</p> <p>Part II.4</p> <p>Part II.5</p> <p>Part II.6</p> <p>Part -II.7</p> <p>Part II.8</p>

		<p>9. Recovery Benefit: Provides for payment of the specified amount in terms of the plan selected, in the event of Insured Person’s hospitalization for a continuous period of not less than 10 days subject to a valid claim being admissible under In-patient Treatment Expenses of the Policy. In case of a floater, this benefit is applicable, separately, to all the members of the floater irrespective of the number of occurrences during the Policy period subject to overall limit of the Sum Insured.</p> <p>10. Nursing Allowance: Provides for payment of a daily allowance, as per plan, towards engaging the services of a qualified nurse either at the Hospital or at the Insured Person’s residence provided - such services are confirmed as being necessary by the attending Medical Physician and the same relate directly to a disease / illness / injury for which the Insured Person has been hospitalized. - A valid claim is admissible under Inpatient Treatment Expenses of the Policy - Deductible of 48 hours of hospitalization is applicable for Any One Illness.</p> <p>Additional Features (available based on plan selected)</p> <p>11. Restoration of Sum Insured: If the Basic Sum Insured is exhausted due to claims made and paid during the Policy Period or made during the Policy Period and accepted as payable, then we will restore the entire Sum Insured once during the Policy Period. This restored amount can be used for future claims, not related to the Illness/Injury for which the claim has been made during the same year. Any unutilized restored Sum Insured cannot be carried forward to any subsequent Policy Period.</p> <p>12. Extended Policy Tenure: In case you are going out of the country for a period of more than 15 days continuously and/or maximum up to 180 days, then you may extend your Policy for the number of days you are out of the country.</p> <p>13. Health Check Up: All members covered under the Policy above 18 years of age is/are entitled to a health check-up on cashless basis, at our empaneled diagnostic centers after a block of every 2 years of continuous yearly Policy renewal with Us irrespective of the claims history. This is available for the individuals who were insured with Us for the above specified period.</p> <p>14. Loyalty Perk: This Policy provides for auto increase in Basic Sum Insured by 10% of the Basic Sum Insured for every claim free Policy year up to a maximum of 100% of the Basic Sum Insured.</p> <p>15. Basic Sum Insured Enhancement: Basic Sum Insured can be enhanced only at the time of renewal subject to no claim having been lodged/ paid under the earlier policy/ies and with the specific approval and acceptance by the Company. In all such case of increase in the Basic Sum Insured, waiting period will apply afresh in relation to the amount by which the Basic Sum Insured has been enhanced.</p>	<p>Part II.9</p> <p>Part II.10</p> <p>Part III.11</p> <p>Part III.12</p> <p>Part III.13</p> <p>Part III.14</p> <p>Part III.15</p>
3	<p>What are the major exclusions in the policy</p>	<p>Major policy exclusions are listed below. Please refer to the policy wording for the complete list of exclusions.</p> <ul style="list-style-type: none"> • Admission primarily for investigation & evaluation • Admission primarily for rest Cure, rehabilitation and respite care 	<p>Part IV. E</p>

		<ul style="list-style-type: none"> • Circumcision, sex change surgery, cosmetic surgery & plastic surgery. • Substance abuse, self-inflicted injuries • Hazardous sports, war, terrorism, civil war or breach of law. • Experimental, investigational or unproven treatments 	
4	Waiting Period	<ul style="list-style-type: none"> • Pre-existing Diseases will be covered after a waiting period of 48/36/24 months as per plan opted. • Specified surgeries/treatments/diseases are covered after specific waiting period of 12 months. • Specified surgeries/treatments/diseases are covered after specific waiting period of 24 months • Specified surgeries/treatments/diseases are covered after specific waiting period of 48 months • 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. 	<p>Part IV.E.1</p> <p>Part IV.E.2</p> <p>Part IV.E.2</p> <p>Part IV.E.2</p> <p>Part IV.E.3</p>
5	Payment basis	Payment on indemnity basis (Cashless / Reimbursement) except for Hospital Daily Cash Allowance, Recovery Benefit and Nursing Allowance	
6	Loss sharing	A deductible of first 48 hours of hospitalization is applicable to Hospital Daily Cash Allowance and Nursing Allowance	Part II. 5 & 10
7	Renewal Conditions	The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.	Part V.F.10
8	Renewal Benefits	<ul style="list-style-type: none"> • Lifelong Policy Renewal without any exit Age • Grace Period - Grace Period of 30 days for renewing the Policy is provided under this Policy • Waiting Period - The waiting periods mentioned in the Policy wording will get reduced by 1 year on every continuous renewal of your Policy. • You can change your Plan/ Optional Cover / Instalment Premium frequency at renewal of your Policy. • Loyalty Perk: Auto increase in Sum Insured by 10% for every claim free year up to maximum of 100% if the Policy is renewed without any break. • Health check up on cashless basis: facility for the member above 18 years of age is available after a block of every 2 years of continuous yearly Policy renewal with Us, irrespective of the claims history, as per the pre-defined Investigations package. 	<p>Part V.F.10</p> <p>Part III.14</p> <p>Part III.13</p>
9	Cancellation	<p>a. The Insured may cancel this Policy by giving 15 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed in the policy terms and conditions.</p> <p>b. The Company may cancel the policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person by giving 15 days' written notice.</p>	Part V.F.7
10	Claims	a. For Cashless Service: You may call to our Customer care number for obtaining Cashless facility. You may also visit to our Company website www.libertyinsurance.in to know the list of empaneled Hospitals.	Part V.G.5

		b. For Reimbursement of Claim: You need to intimate Us immediately on hospitalization/ injury/ death, further submit all claim documents with supporting details/documents at your own expense to the TPA within 15 days of discharge from the hospital.	
11	Policy Servicing/ Grievances/ Complaints	<p>Step 1 Call us on Toll free number: 1800-266-5844 (8:00 AM to 8:00 PM, 7 days of the week) or Email us at: care@libertyinsurance.in Senior Citizens can email us at: seniorcitizen@libertyinsurance.in or Write to us at: Customer Service Liberty General Insurance Limited 10th Floor, Tower A, Peninsula Business Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai 400 013</p> <p>Step 2 If our response or resolution does not meet your expectations, you can escalate at Manager@libertyinsurance.in</p> <p>Step 3 If you are still not satisfied with the resolution provided, you can further escalate at ServiceHead@libertyinsurance.in</p> <p>IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/</p> <p>Insurance Ombudsman – The contact details of the Insurance Ombudsman offices have been provided as Annexure-B of Policy document.</p>	Part V.F.15
12	Insured's Rights	<p>a. Free Look period of 15 days from the date of receipt of the policy shall be applicable at the inception. b. Lifelong renewability (except on certain specific grounds) c. Right to migrate from one product to another product of the company d. Right to port the from one company to another company</p> <p>Migration & Portability – Call Centre 1800 266 5844 Email address- care@libertyinsurance.in</p> <p>Write to us: Liberty General Insurance Limited 10th Floor, Tower A, Peninsula Business Park, Lower Parel, Mumbai - 400013 E-mail: care@libertyinsurance.in Toll Free No: 1800 266 5844</p> <p>e. Change in SI during the policy term or at the time of renewal –For more details contact Call Centre 1800 266 5844 Email address- care@libertyinsurance.in</p>	Part V.F.14 Part V.F.10 Part V.F.8 Part V.F.9
13	Insured's Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid.	
<p>Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.</p>			

Liberty Health Connect Policy

A. POLICY SCHEDULE

The Policy Schedule is enclosed with the Policy document shared with you comprising the benefits and Sum Insured/Limits applicable to every available cover

B. PREAMBLE

Liberty General Insurance Limited (hereinafter called the “Company”, “Insurer”, “We, Our, or Us”) will provide insurance cover to the person(s) (hereinafter called the “Insured”, “You, Your, or Yourself”) based on the Proposal and Declaration made and agreed premium paid within such time, as may be prescribed under the provisions of the Insurance Act, 1938, for the Policy Period stated in the Schedule or during any further period for which the Company may accept payment for the renewal or extension of this Policy, subject always to the following terms, conditions, provisos, exclusions, and limitations contained herein or endorsed or otherwise expressed herein. This Policy records the agreement between the Company (We) and the Insured (You), and sets out the terms of insurance and obligations of each party.

Part I: Definitions

C. DEFINITIONS

The words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female.

i. Standard Definitions (Definitions whose wordings are specified by IRDAI)

1. **“Accident”** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **“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/nursing home where treatment was taken.
3. **“AYUSH Hospital”** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
 - a. Central or State Government AYUSH Hospital or
 - b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy;
or
 - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

- i. Having at least 5 in-patient beds;
 - ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
4. **“AYUSH Day Care Centre”** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:
 - i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
 - ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **“Cashless facility”** means a facility extended by the Insurer to the Insured where the payments, of the costs of treatment undergone by the Insured person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization approved.
6. **“Condition Precedent”** means a policy term or condition upon which the Insurer's liability under the Policy is conditional.
7. **“Congenital Anomaly”** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
 - a) **Internal Congenital Anomaly**
Congenital anomaly which is not in the visible and accessible parts of the body.
 - b) **External Congenital Anomaly**
Congenital anomaly which is in the visible and accessible parts of the body.
8. **“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.
9. **“Cumulative Bonus/Loyalty Perk”** shall mean any increase or addition in the Sum Insured granted by the Insurer without an associated increase in premium.

10. **“Day Care Centre”** means any institution established for day care treatment of illness and /or injuries or a medical set up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under-
 - a) has qualified nursing staff under its employment;
 - b) has qualified medical practitioner(s) in charge;
 - c) has a fully equipped operation theater of its own where surgical procedures are carried out;
 - d) maintains daily records of patients and will make these accessible to the insurance company’s authorized personnel

11. **“Day care Procedure/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 twenty four (24) hours because of technological advancement, and
 - ii. which would have otherwise required hospitalization of more than twenty four (24) hours.

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

12. **“Deductible”** is 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.

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

14. **“Disclosure to information norm”** The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

15. **“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 moved to a hospital or,
 - ii. the patient takes treatment at home on account of non-availability of room in a hospital.

16. **“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.

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

18. **“Hospital”** means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
 - i. has qualified nursing staff under its employment round the clock;
 - ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
 - iii. has qualified medical practitioner (s) in charge round the clock;
 - iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
 - v. maintains daily records of patients and shall make these accessible to the Company’s authorized personnel.
19. **“Hospitalization”** means admission in a hospital for a minimum period of twenty four (24) consecutive ‘In-patient care’ hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours..
20. **“Illness”** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
 - i. **Acute Condition** means 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.
 - ii. **Chronic Condition** means 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
21. **“Injury”** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.
22. **“Inpatient Care”** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event
23. **“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.
24. **“ICU Charges”** ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivists charges.

25. **“Maternity expenses”**
Maternity expenses means;
a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
b) expenses towards lawful medical termination of pregnancy during the policy period.
26. **“Medical Advise”** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
27. **“Medical Practitioner”** A Medical Practitioner is a person who holds a valid registration from the medical council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license provided that this person is not a member of the Insured Person’s family.
28. **“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.
29. **“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 illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
30. **“Migration”** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.
31. **“Network Provider”** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
32. **“New Born Baby”** means baby born during the Policy Period and is aged upto 90 days
33. **“Non-Network Provider”** means any hospital, day care centre or other provider that is not part of the Network.
34. **“Notification of Claim”** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

35. **“Out-Patient (OPD) Treatment”** means treatment 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
36. **“Pre-Existing Disease”** Preexisting disease means any condition, ailment, injury or disease
 - a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
 - b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
37. **“Pre-hospitalization”** means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that:
 - i. Such Medical Expenses are incurred for the same condition for which the Insured Person’s Hospitalisation was required, and
 - ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
38. **Post-hospitalization Medical Expenses”** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
 - i. Such Medical Expenses are for the same condition for which the insured person’s hospitalisation was required, and
 - ii. The inpatient hospitalisation claim for such hospitalisation is admissible by the Insurance Company.
39. **“Portability”** means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
40. **“Qualified Nurse”** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
41. **“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.
42. **“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.
43. **“Room rent”** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
44. **“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 of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.

45. **“Unproven/Experimental treatment”** Treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

ii. Specific Definitions (Definitions other than those mentioned under C(i) above)

1. **“Age”** means age of the Insured person on last birthday as on date of commencement of the Policy.
2. **“Ambulance”** means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
3. **“AYUSH Treatment”** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
4. **“Basic Sum Insured”** means the amount specified against each Insured Person/s specified in the Schedule to this Policy, subject to terms, conditions and exclusions of this Policy. For policies with more than one year tenure, the Basic Sum Insured specified on the Policy is the limit for each year. This limit will lapse at the end of every year and fresh limits up to the full Basic Sum Insured as opted, will be available for the next year.
5. **“Break in Policy”** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof
6. **“Dependent Child”** refers to a child (naturally or legally adopted), who is financially dependent on the Primary Insured or Proposer and does not have his/her independent sources of income between the age of 91 days and eighteen (18) years, or up to and including the age of twenty-five (25) years if undergoing full time education at an accredited educational institution.
7. **“Family”** means the Insured, his/her lawful spouse, dependent child/children, Parents and/or Parents-in-laws.
8. **“Family Floater”** means Policy wherein all Insured Person/s of a family are covered under a single Basic Sum Insured.
9. **“Insured”** means an individual, a Resident Indian, who has proposed for Insurance and on whose name the Policy is issued.
10. **“Insured Person/s”** means the person (s) named in the Schedule of the Policy.

11. **“Nominee”** means the person named in the Proposal or Schedule to whom the benefits under the Policy is nominated by the Insured Person.
12. **“Policy”** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.
13. **“Policy Period”** means the period between the inception date and expiry date of the Policy as specified in the Schedule to this Policy or the date of cancellation of this Policy, whichever is earlier.
14. **“Policy Schedule”** means the Policy Schedule attached to and forming part of Policy.
15. **“Policy year”** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.
16. **“Third Party Administrator or TPA”** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
17. **“Waiting Period”** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
18. **“We/Our/Us”** means the Liberty General Insurance Limited.
19. **“You/Your”** means the Insured named in the Schedule who has concluded this Policy with Us.

Part II: Scope of Cover

D. BENEFITS COVERED UNDER THE POLICY

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay and/or reimburse actual expenses incurred or up to the limits specified in the schedule against each benefit whichever is less.

However, Our total liability under this Policy for payment of any and all Claims in aggregate during each Policy Year of the Policy Period shall not exceed the total sum of Basic Sum Insured, earned Cumulative Bonus and Restoration of Basic Sum Insured as stated in the Policy Schedule.

1. Hospitalisation Expenses

a. In-Patient Treatment Expenses

The Company undertakes to indemnify Insured person against any disease or Any One Illness or any injury during the Policy Period and if such disease or injury shall require any such Insured Person, upon the advice of a duly qualified physician/Medical Practitioner to incur in-patient care expenses for medical/surgical treatment at any Hospital in India, towards following expenses, subject to the terms, conditions, exclusions and definitions contained herein or endorsed.

1. Room, Boarding expenses
2. Intensive Care Unit bed charges
3. Doctor's fees
4. Nursing Expenses
5. Surgical Fees, Operation Theatre Charges, Anesthetist, Anesthesia, Blood, Oxygen and their administration, Physical Therapy
6. Prescribed Drugs and medicines consumed on the premises
7. Investigation Services such as Laboratory, X-Ray, Diagnostic tests
8. Dressing, Ordinary splints and plaster casts
9. Cost of Prosthetic devices if implanted during a surgical procedure

b. Day Care Procedure/Treatment

The Company will indemnify medical expenses incurred on a treatment towards a Day Care procedure, where the procedure or surgery is taken by the Insured Person as an inpatient in less than 24 hours in a Hospital or standalone day care center but not in the Outpatient department of a Hospital.

2. Pre-Hospitalisation Expenses

The Medical Expenses incurred during the Policy Period for the period as mentioned in the Schedule, immediately before the Insured Person was hospitalised, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and
- ii. There is a valid claim admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

3. Post-Hospitalisation Expenses

The Medical Expenses incurred during the Policy Period for the period as mentioned in the Schedule, immediately after the Insured Person was discharged following Hospitalisation, provided that:

- i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and
- ii. There is a valid claim admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

4. Domiciliary Hospitalisation Treatment

The Company will indemnify medical expenses incurred by an Insured Person/s for Domiciliary Hospitalization treatment taken at his home in India limited to 10% of the Basic Sum Insured for a Policy year.

No payment will be made if the condition for which the Insured Person requires medical treatment is:

- a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract
- b. Infection including Laryngitis and Pharyngitis, Cough and
- c. Cold, Influenza,
- d. Arthritis, Gout and Rheumatism,
- e. Chronic Nephritis and Nephritic Syndrome,
- f. Diarrhoea and all type of Dysenteries including Gastroenteritis,
- g. Diabetes Mellitus and Insipidus,
- h. Epilepsy,
- i. Hypertension,
- j. Psychiatric or Psychosomatic Disorders of all kinds
- k. Pyrexia of unknown Origin.

5. Hospital Daily Cash Allowance

The Company will pay the amount as specified in the Schedule to this Policy against Hospital Cash allowance benefit for each continuous and completed period of 24 hours of hospitalization of the Insured Person for a maximum up to 10th day of continuous hospitalization., provided a valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy. A deductible of first 48 hours of hospitalization is applicable.

6. Emergency Local Road Ambulance Charges

The Company will indemnify expenses incurred on an ambulance offered by a healthcare or ambulance service provider used to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of health services following Accidental Bodily Injury/ illness / disease occurring during the Policy Period., provided that:

- i) Our maximum liability shall be as specified in the Schedule to this Policy.
- ii) There is a valid claim admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy
- iii) The coverage also includes the cost of the transportation of the Insured Person from one Hospital to another nearest Hospital which is prepared to admit the Insured Person and provide necessary medical services if such medical services cannot satisfactorily be provided at a Hospital where the Insured Person was first admitted, provided that the transportation has been prescribed by a Medical Practitioner and is Medically Necessary.

7. Organ Donor Expenses

The Company will indemnify organ donor's screening charges & the medical expenses for an organ donor's treatment for the harvesting of the organ donated up to the amount as specified in the Schedule to this Policy, provided that:

- i. The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act 1994 (Amended) and the organ donated is for the use of the Insured Person, and
- ii. We will not pay the donor's pre- and post-hospitalisation expenses or any other medical treatment for the donor consequent on the harvesting, and
- iii. A valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

8. Second Medical Opinion

A second medical opinion service from our expert panel of doctors is available for all Insured Person/s seeking information that will give them confidence in their medical diagnosis and treatment plan. At the request of the Insured Person/s, the company shall arrange for a Second Medical Opinion which is subject to the following:

- i. This benefit can be availed only once in a Policy year for the Insured Person
- ii. The Insured Person is free to choose whether or not to obtain the Second Medical Opinion, and if obtained, whether or not to act on the same.
- iii. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Medical Opinion or for any consequences of actions taken or not taken in reliance thereon
- iv. Any Second Medical Opinion provided under the Benefit shall not be valid for any medico-legal purposes.

9. Recovery Benefit

The Policy provides for payment to the Insured Person of the sum as specified in the Schedule to this Policy in the event of his / her hospitalization for a continuous period of not less than 10 days subject to a valid claim being admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy.

In case of a family floater, this benefit is applicable, separately, to all the members of the policy irrespective of the number of occurrences during the Policy Period subject to overall limit of the Basic Sum Insured.

10. Nursing Allowance

This benefit provides for payment of a daily allowance, as specified in the Schedule to this Policy, towards engaging the services of a qualified nurse either at the Hospital or at the Insured Person's residence provided

- such services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to a disease / illness / injury for which the Insured Person has been hospitalized.
- A valid claim is admissible under Part II 1.a (In-patient Treatment Expenses) of the Policy
- A deductible of first 48 hours of hospitalization is applicable for Any One Illness/injury.

Part III: Additional Features

11. Restoration of Sum Insured

The Policy provides, as applicable to the relevant plan specified in the schedule to the policy, that, where the Basic Sum Insured is exhausted due to claims made and paid during the Policy Year or made during the Policy Year and accepted as payable, then the Company agrees to automatically make available a Restore Sum Insured equal to 100% of the Basic Sum Insured for the particular policy year, provided that:

- a. The Restored Sum Insured will be utilized only after the Basic Sum Insured and loyalty perk earned if any have been completely exhausted in that Policy Period; and
- b. The Restored Sum Insured cannot be clubbed with balance if any available under the Basic Sum Insured and loyalty perk earned if any.
- c. The Restored Sum Insured can be used only for such claims as is admissible in terms of Part II-1 of the Policy.

- d. The Restored Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an illness/disease for which a claim has been paid in the current policy year under Part II-1 of the Policy.
- e. The Restored Sum Insured will be available during the Policy Year till it is exhausted completely.
- f. Any unutilized restored amount cannot be carried forward to any subsequent Policy Year.
- g. The Restored Sum Insured shall not be considered while calculating the Loyalty Perk
- h. The total amount of restored Sum Insured shall not exceed the Basic Sum Insured for that Policy Year.
- i. In case of Portability, the credit for Sum Insured would be only to the extent of the Basic Sum Insured.

If the policy is a Family Floater, then the Restored Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Basic Sum Insured was exhausted and for whom we have not incurred or paid any claim during the current Policy Period.

12. Extended Policy tenure

In case the Insured Person is out of the country for a period of more than 15 days continuously and/or maximum up to 180 days, then this Policy will be extended for the number of days the Insured Person were out of the country.

If the Insured person/s is/are out of the country frequently within a Policy Year, the coverage will be extended for the number of days of the single visit which has maximum/ higher number of overseas days within a Policy Year.

In case of a Family Floater policy, the maximum number of days all Insured/Insured Person/s is/are out of the country for a period of more than 15 days continuously and/or up to 180 numbers of days continuously, together in a single visit shall be considered while extending the Policy tenure.

The Insured Person/s needs to intimate the requirement for extension of Policy tenure to the Company, before the Policy expiry date.

13. Renewal Health Check-up

The Insured Person/s above 18 years of age is/are entitled to a health check-up, on Cashless basis, at a diagnostic center specified by the Company after a block of every 2 years of continuous yearly Policy renewal with Us irrespective of the claims made under the Policy and subject to continuation of Policy with Us. This is available for the Insured Person/s who were insured with Us for the above specified period.

14. Loyalty Perk

This Policy provides for auto increase in Basic Sum Insured by 10% on the Basic Sum Insured for every claim free Policy year up to a maximum of 100% of the Basic Sum Insured

- a. For a Family Floater policy, the loyalty perk shall be available only on floater basis and shall accrue only if no claim has been made in respect of any Insured Person during the expiring Policy Year. The loyalty perk which is accrued during the claim free Policy Year will only be available to those Insured Persons who were insured in such claim free Policy Year and continue to be insured in the subsequent Policy Year.

- b. If the Insured Person/s in the expiring Policy are covered on a Floater Basis and the Policy renewal for such Insured Person/s is done by splitting the floater Sum Insured into 2 or more floater / individual covers, then the Loyalty Perk of the expiring Policy shall be apportioned to such renewed Policy/ies in proportion to the Sum Insured under each of the renewed Policy/ies.
- c. If the Insured Person/s in the expiring Policy are covered on an Individual basis and thereby enjoy separate Loyalty Perk in the expiring Policy/ies, and such expiring Policy/ies is renewed with the Company on a Floater Basis, then the Loyalty Perk carried forward under such renewed floater Policy would be the least of the Loyalty Perk/s earned under the expiring Policy/ies..
- d. Entire loyalty perk will be forfeited if the Policy is not continued / renewed on or before Policy Period End Date or the expiry of the Grace period whichever is later.
- e. Where a portion of/ full Loyalty Perk earned is utilized following a claim, the balance if any available will be carried forward for the immediate renewal. However, the Policy would not qualify for any fresh Loyalty Perk on the immediate Policy renewal.

15. Basic Sum Insured Enhancement

Basic Sum Insured can be enhanced only at the time of renewal subject to no claim having been lodged/ paid under the earlier policy/ies and with the specific approval and acceptance by the Company. In all such case of increase in the Basic Sum Insured, waiting period will apply afresh in relation to the amount by which the Basic Sum Insured has been enhanced.

Part IV: General Exclusions

E. EXCLUSIONS

The Company shall bear no liability to make the payment in respect of claims arising directly or indirectly out of or attributable or traceable to any of the following:

- i. **Standard Exclusions (Exclusions for which standard wordings are specified by IRDAI)**
 1. **Pre- Existing Diseases – Code –Excl01**
 - a. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded as per the Plan mentioned in the Policy schedule i.e.until the expiry of 48 months, 36 months or 24 months of continuous coverage after the date of inception of the first policy with Us.
 - b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum insured increase.
 - c. If the Insured 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 be extent of prior coverage.
 - d. Coverage under the policy after the expiry of applicable months as per the Plan, for any Pre-existing Disease is subject to the same being declared at the time of application and accepted by the Insurer.

2. Specified disease/procedure waiting period- Code- Excl02

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of below mentioned months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured 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.
- f) List of specific diseases/procedures

Sr. No	First Year (12 months) Waiting Period	Two Year (24 months) Waiting Period	Four Year (48 months) Waiting Period
1.	Cataract	Calculus diseases of Gall bladder and Urogenital system	*Treatment related to Neurotic, stress-related and somatoform disorders (F45 and F48)
2.	Benign Prostatic Hypertrophy	Joint Replacement due to Degenerative condition,	Treatment of Bipolar (F31), Delirium (F05), Dementia (F00-F03), Depression (F30,F32,F33), Hyperkinetic (F90), Mental retardation (F70-79), Schizophrenia (F20-29
3.	Hernia	Surgery for prolapsed inter vertebral disc unless arising from accident	Surgical treatment of Obesity
4.	Hydrocele	Age related Osteoarthritis and Osteoporosis	
5.	Fistula in anus	Spondylosis / Spondylitis	
6.	Piles	Surgery of varicose veins and varicose ulcers.	
7.	Sinusitis and related disorders	Diabetes & related complications: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hypo/Hyperglycemic Shocks	
8.	Fissure	Hypertension & related complications: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive	

		Nephropathy, Internal bleed/Haemorrhages.	
9.	Gastric and Duodenal ulcers	Treatment for correction of eye sight (laser surgery) due to refractive error	
10.	Gout and Rheumatism	*Treatment related to Anxiety (F06,F40-41), Conduct & Mood disorders (F34,F38-39,F92-93,F98), Personality disorders (F60-61,F93) and stress (F43) F04, F07, F09 (Organic, including symptomatic, mental disorders)	
11.	Internal tumors, cysts, nodules, polyps , breast lumps (unless malignant)		
12.	Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus		
13.	Polycystic ovarian diseases		
14.	Skin tumors (unless malignant)		
15.	Benign ear, nose and throat (ENT) disorders and surgeries, adenoidectomy,mastoid ectomy, tonsillectomy and tympanoplasty		
16.	Dilatation and Curettage (D&C);		
17.	Congenital Internal Diseases		
*The illnesses/diseases mentioned with the coding in the bracket such as F06, F40 are as per the International Classification of Diseases (ICD's). ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion.			

3. 30-day waiting period- Code- Excl03

- a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

The within referred waiting period is made applicable to the enhanced sum insured in

the event of granting higher sum insured subsequently.

4. Investigation & Evaluation – Code-Excl04

- a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
- b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

5. Rest Cure, rehabilitation and respite care- Code- Excl05

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

- i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
- ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. Obesity/ Weight Control: Code- Excl06

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

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI);
 - a) greater than or equal to 40 or
 - b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy
 - ii. Coronary heart disease
 - iii. Severe Sleep Apnea
 - iv. Uncontrolled Type 2 Diabetes

7. Change-of-Gender treatments: Code- Excl07

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

8. Cosmetic or plastic Surgery: Code- Excl08

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

9. Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

10. **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.

11. **Excluded Providers : Code-Excl11**

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

12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

13. Treatments received in health 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. **Code - Excl 13**

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. **Code-Excl 14**

15. Refractive error: **Code – Excl15**

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

16. Unproven Treatments: **Code- Excl16**

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

17. **Sterility and Infertility: Code- Excl17**

Expenses related to sterility and infertility. This includes:

- (i) Any type of contraception, sterilization
- (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- (iii) Gestational Surrogacy
- (iv) Reversal of sterilization

18. **Maternity: Code Excl18**

- ii. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- iii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period

ii. **Specific Exclusions (Exclusions other than those mentioned under E(i) above)**

1. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice & 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.
2. Any dental treatment or surgery unless requiring hospitalization arising out of an accident.
3. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
4. Charges incurred in connection with cost of spectacles and contactlenses, hearing aids, routine eye and ear examinations, dentures, artificial teeth and all other similar external appliances and /or devices whether for diagnosis or treatment.
5. Any expenses incurred on prosthesis, 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.P.A.D) and oxygen concentrator or asthmatic condition, cost of cochlear implants.
6. External Congenital Anomaly.
7. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.
8. AYUSH Treatment
9. Any OPD treatment except pre and post – hospitalization as covered under Scope of the Policy.
10. Treatment received outside India.
11. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, mutiny, military or usurped acts, seizure, capture, arrest, restraints and detainment of all kinds.
12. Act of self-destruction or self-inflicted, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.
13. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.
14. Personal comfort and convenience items or services including but not limited to TV(wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs, (except patient's diet), cosmetics,

hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

15. Expenses related to any kind of RMO charges, service charge, surcharge, admission fees, registration fees, night charges levied by the hospital under whatever head.
16. Nuclear, chemical or biological attack or 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 exclusion:
 - a. Nuclear attack or 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 or 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 or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and /or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or deathIn addition to the foregoing, 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 shall also be excluded.
17. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products.
18. Drugs or treatment and medical supplies not supported by a prescription from a Medical Practitioner.

Part V: General Conditions

F. GENERAL TERMS AND CLAUSES

i. Standard General Terms and Clauses (General terms and clauses whose wordings are specified by IRDAI)

1. Disclosure of information

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

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

2. Condition Precedent to admission of Liability

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

3. Claim Settlement (Provision for Penal Interest)

- a) 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.
- b) 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 2% above the bank rate.
- c) 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 the claim within 45 days from the date of receipt of last necessary document.
- d) In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Explanation: “bank rate” shall mean the rate fixed by Reserve Bank of Indian (RBI) at the beginning of the financial year in which the claim falls due

4. Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, 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.

5. 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 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 the 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 the insurer from whom he/she wants to claim the balance amount.
- iv. Where an insured person(s) has/have policies from more than one insurer to cover the same risk on indemnity basis, the insured person(s) shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy

6. 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:

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

The Company shall not repudiate the 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. Cancellation/Termination

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

Period on Risk	Rate of Premium Refunded
Up to 1 Month	75% of Annual Rate
Up to 3 Months	50% of Annual Rate
Up to 6 Months	25% of Annual Rate
Exceeding 6 Months	Nil

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

- ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

In the event of the death of the Insured Person/s during the currency of the Policy, due to any reason and subject to there being no claim reported under the Policy, the Policy would cease to operate and the nominee/legal heir would be entitled to a refund in premium from the date of death to the expiry of policy and such refund would be governed by the provisions relating to the Cancellation by Insured / Insured Person/s as specified above. In case of a family floater, upon the death of the Policy holder, this Policy shall continue till the end of the Policy Period. If the other Insured Person/s wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of an Insured.

8. 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 the IRDA Guidelines on Migration. If such person is presently covered and has been continuously covered without any lapse under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDA Guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link <https://www.libertyinsurance.in/>

9. 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 link <https://www.libertyinsurance.in/>

10. Renewal of Policy

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

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience

11. 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.

12. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be

applicable for the sum insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sum insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

13. 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 affected.

14. Free Look Period

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

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

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

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

All rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

15. Redressal of Grievance

In case of any grievance the insured person may contact the company through

Step 1	Step 2
<p>Call us on Toll free number: 1800-266-5844</p> <p>(8:00 AM to 8:00 PM, 7 days of the week)</p> <p>or</p> <p>Email us at: care@libertyinsurance.in</p> <p>Senior Citizens can email us at: seniorcitizen@libertyinsurance.in</p> <p>or</p> <p>Write to us at:</p> <p>Customer Service</p> <p>Liberty General Insurance Limited</p>	<p>If our response or resolution does not meet your expectations, you can escalate at Manager@libertyinsurance.in</p>
	Step 3
	<p>If you are still not satisfied with the resolution provided, you can further escalate at ServiceHead@libertyinsurance.in</p>

10 th Floor, Tower A, Peninsula Business Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai 400 013	
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Insured person may also approach the grievance cell at any time of the Company's branches with the details of the grievance.

If the insured person is not satisfied with the redressal of the grievance through one of the above methods, insured person may contact the grievance officer at gro@libertyinsurance.in.

For updated details of grievance officer kindly refer <https://www.libertyinsurance.in/customer-support/grievance-redressal>

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. The contact details of the Insurance Ombudsman offices have been provided in **Annexure B**:

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

The updated grievances redressal procedure shall be provided on the website of the Company and is subject to change in compliance with guidelines/regulations issued by Insurance Regulatory and Development Authority of India.

16. 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.

ii. Specific terms and clauses (terms and clauses other than those mentioned under F(i) above

1. Observance of Terms and Conditions

The due observance and fulfillment of the terms, conditions and endorsements, including the payment of premium of this Policy and compliance with specified claims procedure insofar as they relate to anything to be done or complied with by the Insured shall be a Condition Precedent to any liability of the Company to make any payment under this Policy.

2. Alterations to the Policy

This Policy together with the Policy Schedule constitutes the complete contract of insurance. This Policy cannot be changed or varied by any one (including an insurance agent or broker) except the Company, and any change We make will be evidenced by a written endorsement signed and stamped by the Company.

3. Material Change

It is a Condition Precedent to the Company's liability under the Policy that the Insured Person/s shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his/ their own expense. The Company may, in its discretion, adjust the scope of cover and/or the premium paid or payable, accordingly.

4. Records to be maintained

The Insured Person/s shall keep an accurate record containing all relevant medical documents including a variety of types of "notes" entered over time by Medical Practitioner, recording observations and administration of drugs and therapies, Investigation reports and shall allow the Company to inspect such record. The Insured Person/s shall furnish such information to the Company as may be required under this Policy, during the Policy Period or until the final adjustment, if any, and resolution of Claim/s under this Policy whichever is later.

5. Notice of charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured Person/s, his/her nominees or legal representatives, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construed as an effectual discharge in favor of the Company.

6. Disclaimer

It is 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 a court of law then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

7. Area of Validity

The policy shall provide for eligible medical treatment taken within India & all the benefits under the policy shall be payable in Indian rupees only.

8. Policy Disputes

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to, by both the Insured and the Company to be subject to Indian law. Each party agrees to be subject to the executive jurisdiction of the High Court of Mumbai and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

9. Arbitration

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the

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

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

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

10. **Notice**

Every notice and communication to the Company required by this Policy shall be in writing, within specified time and be addressed to the nearest office of the Company. In case the Policy is sold via voice log the notice to the Company may be placed via same mode.

11. **Electronic Transaction**

The Insured agrees to adhere to and comply with all such terms, conditions and exclusions as the Company may prescribe from time to time, and hereby agrees and validates that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, has his concurrence and full understanding of the terms and conditions affecting this Contract and 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. Sales through such electronic transactions shall ensure adherence to conditions of section 41 of the Insurance Act 1938 with full disclosures on terms, conditions and exclusions. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and sent to the Insured Person, duly validated/confirmed by the Insured Person.

G. OTHER TERMS AND CONDITIONS:

1. **Entry Age**

Minimum entry Age: Adult –18 years; Dependent Child -91 days

Maximum entry Age: 65 Years

2. **Dependent child/children**

Dependent child/children covered with Us under Family Floater shall have the option to continue renewal by migrating to a suitable policy at the end of the specified exit age. Due

credit for continuity in respect of the previous policy period will be allowed provided the earlier policies have been maintained without a break.

3. Sub standard Risk

Proposals where the Health status is adverse, as revealed in the proposal form or as evidenced in the pre policy check up may be accepted at the sole discretion of the Company with an increased risk rating which shall not exceed 100% of normal slab premium per diagnosis / medical condition and not over 200% of normal slab premium per person. Applicable for all subsequent renewal(s) involving age slab changes and increase in Basic Sum Insured. In all such cases, we would send a communication letter to the Proposer and obtain his/her consent before acceptance of the Proposal.

4. Discount Parameters

- i. Family Discount: A Family discount of 10% will be given if more than 2 family members are covered on Individual Sum Insured basis
- ii. Multi-year Policy Discount: A discount of 7.5% will be given on selection of 2 year tenure policies.

5. Claim Procedure:

- a. **Notification of claim:** Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, the Insured Person/s shall give immediate notice to the TPA named in the Policy/Health Card or the Company by calling toll-free number as specified in the Policy/Health Card or in writing to the address shown in the Schedule with Particulars below:
 - i. Policy Number / Health Card No
 - ii. Name of the Insured / Insured Person availing treatment
 - iii. Details of the disease/illness/injury
 - iv. Name and address of the Hospital
 - v. Any other relevant information

Intimation must be given atleast 48 hours prior to planned hospitalization and within 24 hours of hospitalization in case of emergency hospitalization. In event of any claim for Pre – Post Hospitalization expenses incurred, all claim related documents needs to be submitted within 7 days from the date of completion of treatment or eligible Post Hospitalization period as mentioned in the policy schedule whichever is earlier.

The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured Person/s. The Insured Person/s shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder. The Company shall settle claims, including its rejection, within thirty working days of receipt of the last required documents.

- b. For opting Cashless Facility: (applicable where the Insured Person/s has opted for cashless facility in a Network Hospital) - The Insured Person must call the helpline and furnish membership no and Policy Number and take an eligibility number to confirm

communication. The same has to be quoted in the claim form. The call must be made 48 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 24 hours of admission.

- i. The company may provide Cashless facility for Hospitalisation expenses either directly or through the TPA if treatment is undergone at a Network Hospital by issuing Pre-Authorisation letter to the health care service provider.
 - ii. For the purpose of considering Pre-Authorisation and Cashless facility, the Insured Person/s shall submit to the TPA complete information of the disease, requiring treatment along with necessary certification from the Hospital/Medical Practitioner.
 - iii. If the claim for treatment appears admissible, the Company either directly or through the TPA shall issue Pre-Authorisation to the Hospital concerned for cashless facility whereby hospitalization expenses shall be paid directly by the Company/ through the TPA as confirmed in the Pre-Authorisation.
 - iv. Cashless facility will not be available in Non-network Hospital and may be declined even for treatment at a network hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such cases, the Insured Person/s shall bear such expenses and claim reimbursement immediately after discharge from the Hospital.
 - v. The list of Network hospitals where we are having cash less arrangement would be made available to the Policy holder and subsequent amendments to the same would also be duly communicated by us/ the TPA service provider.
- c. **Reimbursement Claims** - Notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/ Hospital should be given to Us immediately on hospitalization /injury/ death, failing which admission of claim would be based on the merits of the case at our discretion. The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the TPA within 15 days of discharge from the hospital the following:
- i. Claim form duly completed in all respects
 - ii. Original Bills, Receipt and Discharge certificate / card from the Hospital.
 - iii. Original Cash Memos from Hospital(s)/Chemist(s), supported by proper prescriptions.
 - iv. Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.
 - v. Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.
 - vi. Attending Doctor's / Consultant's / Specialist's / - Anesthetist's original bill and receipt, and certificate regarding diagnosis.
 - vii. Medical Case History / Summary.
 - viii. Original bills & receipts for claiming Ambulance Charges
 - ix. Any additional documents or information, as may be deemed necessary by the Company or TPA.

The Insured Person/s shall at any time as may be required authorize and permit the TPA and/or Company to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim. The

Company may call for additional documents/information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company.

The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

Applicable Taxes prevailing at the time of claim will be considered as part of the Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Basic Sum Insured opted.

No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

➤ **In-patient Treatment /Day Care Procedures**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Detailed Discharge Summary / Day care summary from the hospital. Original consolidated hospital bill with bill no. and break up of each Item, duly signed by the Insured.
- Original payment Receipt of the hospital bill with receipt number
- First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from attending Medical Practitioner / Surgeon demanding such test.
- Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts
- Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same
- Original medicine bills and receipts with corresponding Prescriptions.
- Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.
- Hospital Registration Number and PAN details from the Hospital
- Doctors registration Number and Qualification from the doctor

➤ **Road Traffic Accident**

In addition to the In-patient Treatment documents:

- Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
In Non Medico legal cases
- Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

In Accidental Death cases

- Copy of Post Mortem Report (if conducted) & Death Certificate

➤ **For Death Cases**

In addition to the In-patient Treatment documents:

- Original Death Summary from the hospital.
- Copy of the Death certificate from treating doctor or the hospital authority.
- Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

➤ **Pre and Post-hospitalisation expenses**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine bills, original payment receipt with prescriptions.
- Original Investigations bills, original payment receipt with prescriptions and report.
- Original Consultation bills, original payment receipt with prescription.
- Copy of the Discharge Summary of the main claim.

➤ **Ambulance Benefit**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Bill with Original Payment Receipt.
- Treating Doctor's consultation prescription indicating Emergency Hospitalization.

➤ **Reimbursement of Organ Donor Expenses**

In addition to the documents of general hospitalization

- Organ Function test / blood test proving organ failure.
- Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

➤ **Hospital Cash Allowance**

Same as In-patient Hospitalisation treatment

➤ **Restoration of Basic Sum Insured**

Same as In-patient Hospitalisation treatment

➤ **Recovery Benefit**

Same as In-patient Hospitalisation treatment

➤ **Nursing Allowance**

In addition to the In-patient Treatment documents:

- Duly signed prescription for Private Nursing requirement and its necessity from the treating Medical Practitioner

- Original Bill with Original Payment Receipt of Nursing charges from the utilized Nursing Burrow/Private Nurse
- **Extended Policy Tenure**
- Proof of travel outside the Country specifying a period more than 15 days consecutively.
- **Tele-medicine**
- A proper invoice or numbered bill of consultation with date
- A proof of payment either a Online, G-PAY or Pay-TM
- The consultation note or Prescription with Physicians registration number and details
- All investigation report advised with bills and prescription

We may call for additional documents/ information as relevant to the claim.

Applicable to all claims under the Policy:

- a. In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, We shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.
- b. If required, the Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
- c. If required, the Insured person must agree to be examined by a medical practitioner of our choice at Our expenses.
- d. The Policy - excludes the Standard List of excluded items - attached in the Policy document.
- e. We shall make the payment of claim that has been admitted as payable by Us under the Policy terms and conditions or reject the claim as per the Policy terms and conditions within 30 days of submission of all necessary documents / information and any other additional information required for the settlement of the claim. However, where the circumstances of a claim warrant an investigation in the opinion of the insurer, 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, Insurer shall settle the claim within 45 days from the date of receipt of last necessary document.
- f. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDA (Protection of Policyholders Regulation), 2017, we shall pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us For the purpose of this clause, '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"
- g. No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy

Benefit Schedule

Benefit Schedule Liberty Health Connect Policy						
	Age Group	Minimum Age at Entry (Adult) - 18 Years				
		Maximum Age at Entry (Adult) - 65 Years				
		Children between 91 days and 25 years can be insured provided either parent is getting insured under the Policy				
	Renewal	Lifelong				
	Tenure	1 / 2 years				
	Option	Individual Sum Insured basis and Family Floater Sum Insured basis				
	Family Discount	10% if more than 2 family members are covered on Individual Sum Insured basis				
	Relationship Covered	Self, Spouse, Dependent Children, Parents, Parents-in-laws (maximum 2 Adults can be covered under one Family Floater Policy)				
	Basic Sum Insured (BSI)	Applicable Per Year and Per Insured member in an Individual Sum Insured Policy and for all Insured members combined in a Family Floater Policy. Benefits from 1 to 10 are included within the Basic Sum Insured.	3,4,5, 7.5L	2,3,4,5,6,7, 5,10L	3,4,5,6,7.5, 10,15L	2,3,4,5,6, 7.5,10,15 L
Sr. no	Benefits	Description	E-Connect	Basic	Elite	Supreme
1	Hospitalisation Expenses					
A	In-Patient Treatment Expenses	Minimum 24 Hrs hospitalisation as an In-patient	√	√	√	√
B	Day Care Treatment	Medical treatment, and/or surgical procedure undertaken in a hospital/day care centre in less than 24 hours due to Technological advancement.	√	√	√	√
2	Pre-hospitalisation Expenses	Medical expenses incurred prior to the covered Hospitalization	30 days	60 days	60 days	60 days
3	Post-hospitalisation Expenses	Medical expenses incurred after the covered Hospitalization	60 days	90 days	90 days	90 days
4	Domiciliary Hospitalisation Treatment	Home hospitalisation due to non-availability of hospital bed or because the patient is not in a condition to be moved to a hospital	10% of SI	10% of SI	10% of SI	10% of SI
5	Hospital daily Cash Allowance	Daily cash Per day of hospitalization max up to 10th day of continuous hospitalization. A deductible of first	Rs.500/day	Rs.500/day	Rs.1000/day	Rs.1000/day

Sr. no	Benefits	Description	E-Connect	Basic	Elite	Supreme
		48 hours of hospitalization is applicable.				
6	Emergency Local Road Ambulance Charges	Ambulance expenses incurred while transfer the Insured Person to the nearest Hospital (per hospitalization/included within the basic SI)	Rs.1500	Rs.1500	Rs.2000	Rs.2000
7	Organ Donor Expenses	Organ donor's screening charges & the medical expenses for an organ donor's treatment for the harvesting of the organ (Included within the Basic SI)	Upto 1 lac	upto basic SI	upto basic SI	upto basic SI
8	Second Medical Opinion	Second Medical opinion to augment confidence in the medical diagnosis and treatment plan available once during the Policy period.	√	√	√	√
9	Recovery Benefit	A lump-sum of Rs. 10, 000 in case of hospitalization for more than 10 days.				√
10	Nursing Allowance	Payment of Rs.500 as daily allowance up to 30 days per Policy period, towards engaging the services of a qualified nurse either at the Hospital or at the Insured Person's residence				√
Additional Features						
11	Restoration of Basic Sum Insured (Injury and Sickness hospitalization both)	100% restoration of basic SI on occurrence of another unrelated event	√		√	√
12	Extended policy tenure	Extended policy tenure when out of country for a continuous period of more than 15 days	√	√	√	√
Renewal Features						
13	Renewal Health Check Up	Cashless Health Check up after a block of 2 Renewals with Us (irrespective of Claims History)	√	√	√	√
14	Loyalty Perk	Auto increase in Sum Insured by 10% on basic sum insured for every claim free year up to max. of 100%.	√	√	√	√
15	Basic Sum Insured Enhancement/Change in Plan	Enhancement in Sum Insured/ Change in Plan can be done at renewal of the policy subject to approval by the Company.	√	√	√	√

Waiting Period					
1	30 days Exclusion	Yes	√	√	√
2	12 months Exclusion	Yes	√	√	√
3	24 Years Exclusion	Yes	√	√	√
4	Pre- existing Diseases Waiting Period	Policy will cover the Pre - existing diseases after a waiting period of	48 months	48 months	36 months
					24 months

List of Day Care Procedures/ Treatments:

Day Care Procedures/ treatments include the following Day Care Surgeries & Day Care Treatments and can include other Day Care procedures or surgery or treatment undertaken by the Insured Person as an inpatient for less than 24 hours in a Hospital or standalone day care centre but not in the Outpatient department of a Hospital:

Microsurgical operations on the middle ear

1. Stapedotomy
2. Stapedectomy
3. Revision of a stapedectomy
4. Other operations on the auditory ossicles
5. Myringoplasty (Type -I Tympanoplasty)
6. Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
7. Revision of a tympanoplasty
8. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

9. Myringotomy
10. Removal of a tympanic drain
11. Incision of the mastoid process and middle ear
12. Mastoidectomy
13. Reconstruction of the middle ear
14. Other excisions of the middle and inner ear
15. Fenestration of the inner ear
16. Revision of a fenestration of the inner ear
17. Incision (opening) and destruction (elimination) of the inner ear
18. Other operations on the middle and inner ear

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration

Operations on the eyes

23. Incision of tear glands
24. Other operations on the tear ducts
25. Incision of diseased eyelids
26. Excision and destruction of diseased tissue of the eyelid
27. Operations on the canthus and epicanthus
28. Corrective surgery for entropion and ectropion
29. Corrective surgery for blepharoptosis
30. Removal of a foreign body from the conjunctiva
31. Removal of a foreign body from the cornea
32. Incision of the cornea
33. Operations for pterygium
34. Other operations on the cornea
35. Removal of a foreign body from the lens of the eye

36. Removal of a foreign body from the posterior chamber of the eye
37. Removal of a foreign body from the orbit and eyeball
38. Operation of cataract

Operations on the skin & subcutaneous tissues

39. Incision of a pilonidal sinus
40. Other incisions of the skin and subcutaneous tissues
41. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42. Local excision of diseased tissue of the skin and subcutaneous tissues
43. Other excisions of the skin and subcutaneous tissues
44. Simple restoration of surface continuity of the skin and subcutaneous tissues
45. Free skin transplantation, donor site
46. Free skin transplantation, recipient site
47. Revision of skin plasty
48. Other restoration and reconstruction of the skin and subcutaneous tissues
49. Chemosurgery to the skin
50. Destruction of diseased tissue in the skin and subcutaneous tissues

Operations on the tongue

51. Incision, excision and destruction of diseased tissue of the tongue
52. Partial glossectomy
53. Glossectomy
54. Reconstruction of the tongue
55. Other operations on the tongue

Operations on the salivary glands & salivary ducts

56. Incision and lancing of a salivary gland and a salivary duct
57. Excision of diseased tissue of a salivary gland and a salivary duct
58. Resection of a salivary gland
59. Reconstruction of a salivary gland and a salivary duct
60. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

61. External incision and drainage in the region of the mouth, jaw and face
62. Incision of the hard and soft palate
63. Excision and destruction of diseased hard and soft palate
64. Incision, excision and destruction in the mouth
65. Plastic surgery to the floor of the mouth
66. Palatoplasty
67. Other operations in the mouth

Operations on the tonsils & adenoids

68. Transoral incision and drainage of a pharyngeal abscess
69. Tonsillectomy without adenoidectomy
70. Tonsillectomy with adenoidectomy
71. Excision and destruction of a lingual tonsil
72. Other operations on the tonsils and adenoids

Trauma surgery and orthopaedics

- 73. Incision on bone, septic and aseptic
- 74. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
- 75. Suture and other operations on tendons and tendon sheath
- 76. Reduction of dislocation under GA
- 77. Arthroscopic knee aspiration

Operations on the breast

- 78. Incision of the breast
- 79. Operations on the nipple

Operations on the digestive tract

- 80. Incision and excision of tissue in the perianal region
- 81. Surgical treatment of anal fistulas
- 82. Surgical treatment of haemorrhoids
- 83. Division of the anal sphincter (sphincterotomy)
- 84. Other operations on the anus
- 85. Ultrasound guided aspirations
- 86. Sclerotherapy etc.

Operations on the female sexual organs

- 87. Incision of the ovary
- 88. Insufflation of the Fallopian tubes
- 89. Other operations on the Fallopian tube
- 90. Dilatation of the cervical canal
- 91. Conisation of the uterine cervix
- 92. Other operations on the uterine cervix
- 93. Incision of the uterus (hysterotomy)
- 94. Therapeutic curettage
- 95. Culdotomy
- 96. Incision of the vagina

- 97. Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas

- 98. Incision of the vulva
- 99. Operations on Bartholin's glands (cyst)

Operations on the prostate & seminal vesicles

- 100. Incision of the prostate
- 101. Transurethral excision and destruction of prostate tissue
- 102. Transurethral and percutaneous destruction of prostate tissue
- 103. Open surgical excision and destruction of prostate tissue
- 104. Radical prostatovesiculectomy
- 105. Other excision and destruction of prostate tissue
- 106. Operations on the seminal vesicles
- 107. Incision and excision of periprostatic tissue
- 108. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

- 109. Incision of the scrotum and tunica vaginalis testis
- 110. Operation on a testicular hydrocele
- 111. Excision and destruction of diseased scrotal tissue
- 112. Plastic reconstruction of the scrotum and tunica vaginalis testis
- 113. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

- 114. Incision of the testes
- 115. Excision and destruction of diseased tissue of the testes
- 116. Unilateral orchidectomy
- 117. Bilateral orchidectomy
- 118. Orchidopexy
- 119. Abdominal exploration in cryptorchidism
- 120. Surgical repositioning of an abdominal testis
- 121. Reconstruction of the testis
- 122. Implantation, exchange and removal of a testicular prosthesis
- 123. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

- 124. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
- 125. Excision in the area of the epididymis
- 126. Epididymectomy
- 127. Reconstruction of the spermatic cord
- 128. Reconstruction of the ductus deferens and epididymis
- 129. Other operations on the spermatic cord, epididymis and ductus deferens

Operations on the penis

- 130. Operations on the foreskin
- 131. Local excision and destruction of diseased tissue of the penis
- 132. Amputation of the penis
- 133. Plastic reconstruction of the penis
- 134. Other operations on the penis

Operations on the urinary system

- 135. Cystoscopic removal of stones

Other Operations

- 136. Lithotripsy
- 137. Coronary angiography
- 138. Haemodialysis
- 139. Radiotherapy for Cancer
- 140. Cancer Chemotherapy

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

Annexure-A

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

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER

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

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

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER

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

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

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON

19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION\STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure-B

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

Areas of Jurisdiction	Office of the Insurance Ombudsman	
Gujarat , UT of Dadra and Nagar Haveli, Daman and Diu	Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in	Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Karnataka	Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PI D No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Punjab ,Haryana, Himachal Pradesh, Jammu and Kashmir, UT of 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@ecoi.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, JanakVihar 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@ecoi.co.in	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry) 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@ecoi.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.	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@ecoi.co.in
	Assam , Meghalaya, Manipur,	Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor,

Mizoram, Arunachal Pradesh, Nagaland and Tripura	Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in
Andhra Pradesh, Telangana and UT of Yanam – a part of the UT of Pondicherry	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@ecoi.co.in
Rajasthan	Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.1.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe – a part of UT of Pondicherry	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in

West Bengal, UT of Andaman and Nicobar Islands, Sikkim	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@ecoi.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, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur,	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in

Chandauli, Ballia, Sidharathnagar.	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.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,	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514251 / 2514253 Email: bimalokpal.noida@ecoi.co.in

Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 1st Floor,Kalpna Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 - 32341320 Email: bimalokpal.pune@ecoi.co.in