SURAKSHA AUR BHAROSA DONO

VECTOR BORNE DISEASE COVER - GROUP
POLICY WORDING

PREAMBLE

In consideration of payment of premium paid by You, SBI General Insurance Company (hereinafter called "SBIG") agrees to provide insurance cover to the Insured Person(s) under this policy up to Sum Insured, subject to waiting period, Co-payment and deductible / time deductible as mentioned on the Policy Schedule / Certificate of Insurance.

A. DEFINITIONS

1. **Age or Aged** means completed years as at the Policy Commencement Date.
2. **Bank Rate** means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.
3. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule
4. **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and / or by distribution channel.
5. **Complainant** means a Policyholder or prospect or Nominee or assignee or any beneficiary of an insurance Policy who has filed a Complaint or Grievance against an Insurer and/or distribution channel.
6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
7. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital cash policies, which will apply before any benefits are payable by the insurer. A Deductible does not reduce the sum insured.
8. **Dependents** means only the family members listed below:
   a) Your legally married spouse as long as she continues to be married to You
   b) Your children, if they are unmarried, still financially dependent on You and have not established their own independent households.
   c) Your natural parents or parents that have legally adopted You, and Your parent in laws
9. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
10. **Emergency Care** means management for an Illness 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.
11. **Family** means, the Family that consists of the Insured Person and any one or more of the family members as mentioned below
    i. Legally wedded spouse
    ii. Dependent Parents or Parents-in-law
    iii. Dependent Children (i.e. natural or legally adopted). If the child is married or financially independent, he or she shall be ineligible for coverage in the subsequent renewals.
12. **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 or to induce the Company 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
13. **Grace Period** means means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The Grace Period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
14. **Hospital** means any institution established for In-patient Care and Day Care Treatment of diseases, injuries and which has been registered as a Hospital with the local authorities under the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:
    a) has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
    b) has qualified nursing staff under its employment round the clock,
    c) has qualified Medical Practitioner(s) in charge round the clock,
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out,
    e) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
15. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.
16. **Illness/ Illnesses** 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
    (a) **Acute condition** - Acute condition is a disease, Illness that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness which leads to full recovery
    (b) **Chronic condition** - A chronic condition is defined as a disease, Illness that has one or more of the following characteristics:

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

17. **In-patient Care** means treatment for which the Insured Person must stay in a Hospital for more than 24 hours for a covered event.
18. **Insured Person/You/Your** means the persons named in the Policy Schedule/Certificate of Insurance.
19. **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.
20. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
21. **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.
22. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.
23. **Material Facts** means, 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
24. **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
25. **Non-Network** means any Hospital, Day Care Centre or other provider that is not part of the Network
26. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
27. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any), and the Policy Schedule (as the same may be amended from time to time).
28. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule
29. **Policy Holder** means Person/Organisation named in the Policy Schedule who has proposed the Policy and in whose name the Policy is issued
30. **Policy Schedule/ Certificate of Insurance** means Schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to (Schedule of coverage), including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
31. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.
32. **Pre-existing disease** means any condition, ailment, injury, or disease.
    i. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the Insurer; or
    ii. for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
33. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India
34. **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
35. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each Insured Person for all benefits claimed for during the Policy Year.
36. **Time Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified number of hours, which will apply before any benefits are payable by the insurer. A Time Deductible does not reduce the sum insured.
37. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy, which is based on established medical practice in India, is a treatment experimental or unproven.
38. **Waiting Period** is the period where we will not be liable for a claim for specified number of days and which will apply before any benefits are payable by Us. The waiting period will be computed from the date of commencement of Policy Period.
39. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/ installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or Grace Period.
40. **Portability** means a facility provided to the health insurance Policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.
41. **Migration** means a facility provided to Policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
42. **Senior Citizen** means any person, who has attained the Age of sixty years or above.
43. **Solicitation** means the act of approaching a prospect or a Policyholder by an Insurer or by a distribution channel with a view

to persuading the prospect or a Policyholder to purchase or to renew an insurance Policy.

44. **Proposal form** means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.

    Explanation:

    (i) "Material Information" for the purpose of these regulations shall mean all important, essential and relevant information and documents explicitly sought by insurer in the proposal form.

    (ii) The requirements of "disclosure of material information" regarding a proposal or policy, apply both to the insurer and the prospect, under these regulations.

45. **We/Our/Us/Company** means the SBI General Insurance Company Limited

46. **You/Your/Yourself** means the Insured Person shown in the Schedule.

B. RISK COVERED

Vector Borne Disease

We will pay under below listed covers on Medically Necessary Hospitalization of Insured Person due to

- Dengue
- Malaria
- Filaria (Lymphatic Filariasis)
- Kala-azar
- Chikungunya
- Japanese Encephalitis
- Zika Virus

1. Dengue

Diagnosis of Dengue Fever should be confirmed by a Medical Practitioner and Laboratory examination result countersigned by a pathologist/ microbiologist confirms the following:

- o Decreasing platelet levels- less than 100,000 cells/mm3; and
- o Immunoglobulins/PCR test showing positive results for Dengue

2. Malaria

Diagnosis of Malaria should be confirmed by a Medical Practitioner with confirmatory tests indicating presence of Plasmodium Falciparum/ Vivax/ Malaria in the patient's blood by laboratory examination countersigned by a pathologist/ microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

3. Filaria (Lymphatic Filariasis)

Commonly known as Elephantiasis, must be confirmed by a Medical Practitioner and the laboratory examination countersigned by a pathologist must be documented with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following criteria:

- o Lymphoedema,
- o Elephantiasis,
- o Scrotal swelling

Filariasis will be payable only once in Insured's lifetime.

4. Kala-azar

Visceral leishmaniasis, also known as Kalaazar, is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anaemia.

The diagnosis must be confirmed by a Medical Practitioner and by parasite demonstration in bone marrow/ spleen/ lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for Kala-azar should clearly indicate the presence of this disease.

5. Chikungunya

Chikungunya is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue, and rash.

The diagnosis must be documented by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (E L I S A), confirming the presence of IgM and IgG anti-chikungunya antibodies.

6. Japanese Encephalitis

Characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis. to confirm Japanese Encephalitis (JE)infection and to rule out other causes of encephalitis, a laboratory testing of serum or preferably cerebrospinal fluid shall be required.

The diagnosis must be confirmed by a Medical Practitioner and positive serological test for JE by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

7. Zika Virus

Diagnosis of Zika virus infection should be confirmed by a Medical Practitioner and by RT-PCR testing done by ICMR (Indian Council of Medical Research) certified testing laboratory in India.

C. SCOPE OF COVER

This Policy is on Individual Sum Insured Basis. We will pay to the Insured Person, the Sum Insured as a lumpsum amount for the listed Vector Borne Diseases in Section B provided it occurs or manifests itself during the Policy Period and meets the conditions specified in this Policy document.

C.1 MAIN BENEFIT

100% of the Sum Insured will be payable on continuous 48 hours of hospitalization due to the covered Vector Borne Diseases as listed in Section B.

C.2 OPTIONAL COVER

In consideration of payment of additional premium or reduction in the premium as applicable, it is hereby and agreed that, We will pay the Sum Insured under below listed covers subject to all other terms, conditions, exclusion, and waiting period applicable to the Policy:

The below covers are optional and applicable only if opted for and up to the Sum Insured or limits mentioned on Policy Schedule/ Certificate of Insurance.

1. Daily Hospital Cash Benefit (DHCB)

On availing of this benefit, We will pay 5% of Sum Insured per day basis i.e. for each calendar day, if the Insured Person has completed the minimum 24 hours Hospitalization due to the covered Vector Borne Diseases. The benefit payment will start after completion of 24 hours Hospitalization subject to maximum of 3/ 5/ 7 or 10 days as mentioned in the Policy Schedule / Certificate of Insurance in addition to the Main Benefit.

Even if the Main benefit has been paid, the cover will continue for the remaining Daily Hospital Cash (DHCB) Benefit (if any) till the end of the policy year.

2. Recovery Benefit

On availing this option, We will pay 10% of Sum Insured (in addition to the main benefit Sum Insured) as specified on Policy Schedule if period of Hospitalization for claim admissible under this Policy, is for 10 continuous days or more.

This benefit is not applicable if the treatment is taken at home.

3. Reinstatement Benefit

We will reinstate 100% of Sum Insured twice during the policy period upon payment of claim under the Main Benefit. This can be used only for the Main Benefit. This reinstated benefit can be claimed for an already claimed disease or a different disease among the covered conditions. There will be a cooling off period of 3 months from the previous claim. The 3 months will compute from hospital discharge date.

Any unutilized amount of Sum Insured reinstated cannot be carried over to next policy year

4. Increased Waiting period

On availing this option, Waiting period will be modified to 30 days and will be applicable for all the claims under this Policy.

D. WAITING PERIOD AND EXCLUSIONS

1. Waiting Periods

We are not liable to pay any claim arising for listed vector borne disease which occurs or manifests itself within period as below from coverage commencement date

Main Benefit	Waiting period	Pre-Existing Disease Waiting Period
Vector Borne Disease	15 Days	36 Months
Optional Cover		
Daily hospital cash	15 Days	36 Months
Recovery Benefit	15 Days	36 Months
Increased Waiting period	30 Days	36 Months

For Reinstatement Benefit cover cooling off period will be 3 months from previous claim

2. Standard Exclusions

1. Any of the listed vector borne disease diagnosed within the first 15 or 30 days (as shown in the policy schedule / certificate of insurance) of the date of commencement of the Policy is excluded. This exclusion shall not apply to an Insured Beneficiary(ies), as the case may be, for whom coverage has been renewed without a break, for subsequent years provided there are NIL claims in the previous Policies.
2. Any Pre-existing disease or any hospitalization for any Illness other than for listed vector borne disease
3. Hospitalization primarily for diagnostic purposes not related to Illness or for any purpose which in normal routine could have been carried out on an out-patient basis and which is not followed by an active treatment or intervention during the period of hospitalization.
4. Experimental or unproven procedures or treatments, hospitalization for treatment other than allopathy
5. Any treatment taken on Outpatient basis
6. Inpatient hospitalization for less than 24 hours for Daily Hospital Cash Benefit (DHCB) (Section No C.2.1) benefit and admission to the hospital for less than 48 hours for Vector Borne Fixed Sum Insured Main benefit (section no. C.1)
7. Diagnosis and treatment outside India except the following countries: Canada, Dubai, Hong Kong, Japan, Australia, New Zealand, Singapore, Switzerland, USA, and countries of the European Union
8. Treatment in any hospital or any other provider network that We have blacklisted as listed on our website www.sbigeneral.in. However, this exclusion will not apply in case the hospitalization is on account of life threatening situations for covered Vector Borne Disease.

E. CONDITIONS

1. Condition Precedent to the contract

a. Age Limit

To be eligible to be covered under the Policy or get any benefits under the Policy, the Insured Person should have attained the age of at least 18 years and shall not have completed the age of 65 years on the date of commencement of the Policy Period as applicable to such Insured Person unless it is renewal of Policy. Dependent children can be covered from 1 day and up to 25 years of age.

*Note - Adult Cover is compulsory for the Child Cover.

b. Currency

The monetary limits applicable to this Policy will be in INR.

c. 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 Insured Person / Policyholder.

d. Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of the Policy (including the realisation of premium by their respective due dates by Us and compliance with the specified procedure on all claims) in so far as they relate to anything to be done or complied with by the Policyholder or any of the Insured Persons or Claimants, shall be the condition precedent to Our liability to make payment under this Policy.

e. Premium

The premium payable under this Policy shall be paid in accordance with the schedule of payments in the Policy Schedule agreed between the Policyholder and Us in writing. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and realization thereof by Us and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Policyholder/Insured Person in so far as they relate to anything to be done or complied with by the Policyholder/Insured Person shall be a condition precedent to Our liability to make any payment under this Policy.

f. Nominee

The Insured Person is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of Your death. 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 Insured Person, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate of Insurance) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

g. Moratorium Period

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

2. Conditions applicable during the contract

a. Alterations in the Policy

The Proposal Form, Certificate, and Policy Schedule / Certificate of Insurance constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and Us. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us. All endorsement requests will be made by the Policy Holder and/or the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us.

b. Cancellation:

a) Cancellation by you -

You may cancel this policy at any time by giving Us written notice in 15-days' by recorded delivery. In the event of such cancellation we shall retain premium for the period that this Policy has been force, calculated in accordance with the short period rates as below. However, there will be no refund of premium if You have made any claim under this Policy.

Period on risk	Rate of premium refunded
Up to one month	75% of annual rate
Up to three months	50%of annual rate
Up to six months	25% of annual rate
Exceeding six months	Nil

b) Free Look Period-

i. Every Policyholder of new individual health insurance policies except those with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of Policy document, whether received electronically or otherwise, to review the terms and conditions of such Policy.

ii. In the event a Policyholder disagrees to any of the Policy terms or conditions, or otherwise and has not made any Claim, he shall have the option to return the Policy to the Insurer for cancellation, stating the reasons for the same.

iii. Irrespective of the reasons mentioned, the Policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the Insurer on medical examination of the proposer and stamp duty charges.

iv. A request received by Insurer for cancellation of the Policy during free look period shall be processed and premium shall be refunded within 7 days of receipt of such request, as stated at sub regulation (3) above.

c) Cancellation by Us -

We reserve the right to cancel this Policy from inception immediately upon becoming aware of any misrepresentation, fraud, non-disclosure of material facts or non-cooperation by or on behalf of You. No refund of premium shall be allowed in such cases.

c. Revision and Modification of the Policy Product-

i. Any revision or modification will be done with the approval of the Authority. We shall notify You about revision /modification in the Policy including premium payable thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

d. Withdrawal of the Product-

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

e. Endorsements

The following endorsements are permissible during the Policy Period:

- **Non-Financial Endorsements – which do not affect the premium**
  - Minor rectification/correction in name of the Insured Person (and not the complete name change)
  - Rectification in gender of the Insured Person (if this does not impact the premium)
  - Rectification of date of birth of the Insured Person (if this does not impact the premium)
  - Change in the correspondence address of the Insured Person (if this does not impact the premium)
  - Change in Nominee Details vi. Change in bank details
  - Any other non-financial endorsement
- **Financial Endorsements – which result in alteration in premium**
  - Cancellation of Policy
  - Any other financial endorsement

3. Conditions when a claim arises

On the occurrence of any vector borne disease that may give rise to a claim under this Policy, the claim procedures set out below shall be followed.

Claim Intimation	You may intimate the claim through any available mode of communication as specified in the Policy, Health Card or Website
Claim Intimation Timelines	Within 15 days of the diagnosis of Vector Borne Disease
Details to be provided to us for claim intimation	1. Policy Number 2. Name of the Insured Person(s) named in the Policy schedule / Certificate of Insurance availing treatment, 3. Nature of disease/illness/injury, 4. Name and address of the attending Medical Practitioner / Hospital 5. Date and time of event if applicable 6. Date of admission
Claims documents to be submitted for claim process	1. Duly filled and signed claim form 2. Certified copy of Hospital discharge Summary 3. Certified copy of Diagnostic report confirming diagnosis. 4. Certified copy of final hospital bill 5. Beneficiary name confirmation from Proposer 6. Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Driving license / Passport / Election Card, etc) for address mentioned in claim form 7. Beneficiary bank account / NEFT details: Cancelled cheque or copy of first page of bank passbook showing account holder's name, Account number, IFSC code, Branch name etc. 8. Certified copy of Death certificate issued by municipal authority (in case of death of insured) 9. KYC details and Documents
Claim documents submission	In case of any Claim, the list of documents as mentioned above shall be provided by the Policy Holder/ Insured Person to Company within 30 days of date of discharge from hospital.
Scrutiny and Investigation of Claim	We will scrutinize the claim based on submission of above claim documents by you and if any deficiency in document we will intimate You in writing within 7 days from the date of submission of claim documents. We will 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
Claim Assessment	We will pay fixed amounts as specified in the applicable Sections in accordance with the terms of this Policy. We are not liable to make any payments that are not specified in the Policy
Condonation of delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

- **Claim Settlement**
  - i. The Company shall settle or reject a claim within 30 days from the date of receipt of last necessary document.
  - ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder / Insured Person from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
  - iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document- In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
  - iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder / Insured Person 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 means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due)
- **Fraud**

  If any claim made by the Insured Person, is any respect of 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 Insured Person / Policyholder who has made that particular claim, who shall be jointly and severally liable for such repayment to Us.

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 Company.

- **Complete Discharge**

  Any payment to the Policyholder / Insured Person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

- **Arbitration clause**

  If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independent 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 who shall act as the presiding arbitrator and Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 (as amended).

  It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore 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.

4. Conditions for renewal of the contract

i. The Policy shall ordinarily be renewable provided the product is not withdrawn, except on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person.

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

iii. Renewal shall not be denied on the ground that the Insured Person had made a Claim or Claims in the preceding Policy years.

iv. Request for Renewal along with the requisite premium shall be received by the Company before the end of the Policy Period

v. 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.

vi. No loading shall apply on Renewals based on individual Claims experience.

5. Grievances Redressal Procedure

Stage 1:

If you are dissatisfied with the resolution provided above or for lack of response, you may write to head.customercare@sbigeneral.in

We will look into the matter and decide the same expeditiously within 14 days from the date of receipt of your complaint.

For Senior Citizens: Senior Citizens can reach us at seniorcitizengrievances@sbigeneral.in; Toll Free - 1800 22 1111 / 1800 102 1111 Monday to Saturday (8 am - 8 pm)

Stage 2:

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may send your Appeal addressed to the Grievance Redressal Officer at : gro@sbigeneral.in or contact at 022-45138021.

Address: Grievance Redressal Officer, 9th Floor, A & B Wing, Fulcrum Building, Sahar Road, Andheri (East), Mumbai 400 099. List of Grievance Redressal Officers at Branch:

https://content.sbigeneral.in/uploads/0449cac1bcd144bbb160d3f6b714fbbd.pdf/

Stage 3:

In case, you are not satisfied with the decision/resolution communicated by the above office, or have not received any response within 14 days, you may Register your complaint with IRDAI on the below given link

https://bimabharosa.irdai.gov.in/Home/Home

Stage 4:

If your grievance remains unresolved from the date of filing your first complaint or is partially resolved, you may approach the Insurance Ombudsman falling in your jurisdiction for Redressal of your Grievance. The details of the Insurance Ombudsman can be accessed at (https://www.cioins.co.in/Ombudsman)

ANNEXURE I - LIST OF OMBUDSMEN OFFICES

Office Details	Jurisdiction of Office
Shri Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
Shri R. M. Singh Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
Shri Manoj Kumar Parida Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh
Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
Ms Sunita Sharma Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Shri Somnath Ghosh Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Shri N. Sankaran Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Pondicherry.
Shri Rajiv Dutt Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
Shri G. Radhakrishnan Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of of Union Territory of Pondicherry.
Ms Kiran Sahdev Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
Shri. Atul Sahai Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh: 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, Basti, Balrampur, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Shri Bimbadhar Pradhan Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of 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, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
Shri Sunil Jain Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
The updated details of Insurance Ombudsman are available on IRDA website: www.irdai.gov.in, on the website of General Insurance Council: www.gicouncil.in, our website www.sbigeneral.in	

Source:- CIO (cioins.co.in)