SURAKSHA AUR BHAROSA DONO

AROGYA TOP UP POLICY

PROSPECTUS

In case of serious Illness or accident, medical cost may be far exceeding than those covered under normal health policy. SBI General Insurance brings for you "Arogya Top Up Insurance Policy Insurance" to provide financial protection against such higher medical cost over and above pre decided medical cost and that too at very low premium.

I. Who can take this insurance

Any Individual can take this Policy for himself and/or his family.

1. "Family" means the spouse, dependent children, dependent parents and parents in law.
2. Minimum entry age is 3 months and maximum entry age is 65 Years.

In case insured wants to opt deductible of INR 5,00,000 or more then maximum entry age will be extended up to 70 Years. There is no exit age.

II. Scope of Cover

If the Insured suffers an illness/disease and/or injury during the Policy period, this Policy covers below medical expenses incurred for medical treatment arising out of that illness/disease and/or injury:

1. **Eligible hospitalisation expenses:** while the Insured was under inpatient care medical expenses incurred for:
   a. Room rent, boarding expenses
   b. Medical practitioners fees including Teleconsultation
   c. Intensive care unit
   d. Nursing expenses
   e. Anesthesia, blood, oxygen, operation theatre expenses, surgical appliances, medicines & consumables, diagnostic expenses and x-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, prosthesis/internal implants and any medical expenses incurred which is integral part of the operation
   f. Physiotherapy as inpatient care and being part of the treatment.
   g. Drugs, medicines and consumables consumed during hospitalization period.
   h. Diagnostic procedures
   i. Dressing, ordinary splints and plaster casts.
2. **Pre-hospitalisation expenses:** the maximum amount that insurer will reimburse under this head is limited to 60 days for each of the admitted hospitalisation and domiciliary hospitalization claim under the Policy.
3. **Post-hospitalisation expenses:** the maximum amount that insurer will reimburse under this head is limited to 90 days for each of the admitted hospitalisation and domiciliary hospitalization claim under the Policy.
4. **Day care expenses:** Insurer shall pay for day care expenses incurred on technological surgeries and procedures requiring less than 24 hours of hospitalisation up to the sum insured. Day care treatments are listed in annexure C of policy wording.
5. **Ambulance expenses:** Actual ambulance expenses or INR 5000 whichever is lower will be reimbursed for per valid hospitalization claim for transferring insured to or between Hospitals in the Hospital's ambulance or in an ambulance provided by any ambulance service provider.
6. **Alternative treatment:** Insurer will reimburse expenses for alternative treatment taken in a government hospital or in any institute recognized by government and/or accredited by quality council of India/national accreditation board on health.
7. **Domiciliary hospitalisation:** Insurer will cover reasonable and customary charges towards domiciliary hospitalisation including pre and post hospitalization expenses. Domiciliary hospitalization 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:
   a. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
   b. The patient takes treatment at home on account of non availability of room in a hospital.
8. **Maternity Expenses:** Insurer will cover reasonable and customary charges towards maternity expenses during hospitalization over and above the deductible as opted.
9. **Organ donor:** The Medical Expenses for an organ donor's treatment for the harvesting of the organ donated including pre and post hospitalization as stated in scope of cover above, provided that:
   a. 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 and the organ donated is for the use of the insured, and
   b. We have accepted an inpatient hospitalisation claim under "Inpatient care" as mentioned under "Eligible hospitalisation expenses".

Admissibility of certain incidental expenses will be as per Standard List of Excluded expenses in Hospitalisation indemnity policies as per IRDA health Insurance guidelines – listed in annexure B of policy wording.

10. **HIV/AIDS Cover:** We will cover expenses incurred for Inpatient treatment due to any condition caused by or associated with human immunodeficiency virus or variant/mutant viruses and or any syndrome or condition of a similar kind commonly referred to as AIDS upto Sum Insured as specified in Policy Schedule,except for the conditions which are permanently excluded.
11. **Mental Illness Cover:** If Insured is hospitalized for any Mental Illness contracted during the Policy Period, We will pay Medical Expenses -upto the limit as specified in Policy Schedule, under Section 1 in accordance with The Mental Health Care Act, 2017, subsequent amendments and other applicable laws and Rules provided that;
    i. The Hospitalization is prescribed by a Medical Practitioner for Mental Illness
    ii. The Hospitalization is done in Mental Health Establishment
12. Genetic Disorders or Diseases are covered up to the Limit Rs. 1,00,000
13. Internal Congenital Diseases are Covered upto the Limit 10% of Sum Insured.
14. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of -of Sum Insured, specified in the policy schedule, during the policy period and not limited to the following:
    A. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)
    B. Balloon Sinuplasty
    C. Deep Brain Stimulation
    D. Oral Chemotherapy
    E. Immunotherapy - Monoclonal Antibody to be given as injection
    F. Intra Vitreal Injections
    G. Robotic Surgeries
    H. Stereotactic Radio Surgeries
    I. Bronchial Thermoplasty
    J. Vaporisation of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
    K. IONM - (Intra Operative Neuro Monitoring)
    L. Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered

III. Exclusions

Time based Exclusions

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 until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
    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 the extent of prior coverage.
    d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by 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 90 Days/12 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 preExisting 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
        i. **12 Months waiting period**
            - Any types of gastric or duodenal ulcers;
            - Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty;
            - Surgery on all internal or external tumor /cysts/nodules/polyps of any kind including breast lumps;

- All types of Hernia and Hydrocele;
- Anal Fissures, Fistula and Piles;
- Benign Prostatic Hypertrophy;
- Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus;
- Non infective Arthritis, Treatment of Spondylosis / Spondylitis, Gout & Rheumatism;
- Surgery of Genitourinary tract;
- Calculus Diseases;
- Sinusitis, nasal disorders and related disorders;
- Gall bladder stones
- Surgery for prolapsed intervertebral disc unless arising from accident;
- Vertebro-spinal disorders (including disc) and knee conditions;
- Surgery of varicose veins and varicose ulcers;
- Chronic Renal failure;
- Medical Expenses incurred in connection with joint replacement surgery due to Degenerative condition, Age related osteoarthritis and Osteoporosis unless such Joint replacement surgery unless necessitated by Accidental Bodily Injury.

ii. 90 Days Waiting Period

- Hypertension, Heart Disease and related complications;
- Diabetes and related complications;

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.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

Other Exclusions:

1. Treatment taken outside India.
2. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.
3. Injury or disease directly or indirectly caused by or contributed to by nuclear weapons/materials.
4. **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.
5. **Refractive Error: Code- Excl15**

   Expenses related to the treatment for correction of eye sight due to refractive error less than dioptres.
6. Expenses incurred on items for personal comfort like television, telephone, etc. Incurred during hospitalization and which have been specifically charged for in the hospitalisation bills issued by the hospital/nursing home.
7. External medical equipment of any kind used at home as post hospitalisation care including cost of instrument used in the treatment of sleep apnoea syndrome (C.P.A.P), continuous ambulatory peritoneal dialysis (C.A.P.D) and oxygen concentrator for bronchial asthmatic condition.
8. Convalescence, general debility, "run-down" condition, rest cure, external congenital anomaly.
9. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)
10. **Breach of law:Code- (Excl10)**

    Expenses tor treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
11. Venereal disease or any sexually transmitted disease or sickness (excluding HIV / AIDS as mentioned under scope of cover)
12. **Sterility and Infertility: (Code- Excl17)**

    Expenses related to sterility and infertility this includes:

    i. Any type of 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

13. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.(Code- Excl14)
14. Surgery to correct deviated septum and hypertrophied turbinate unless necessitated by an accidental body injury.
15. Medical practitioner's home visit expenses during pre and post hospitalization period, attendant nursing expenses.
16. **Change of Gender Treatments (Code- Excl 07)**

    Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. However, such exclusion shall not be applicable to respective Insured Person to comply with Transgender Persons (Protection of Rights) Act, 2019.
17. Outpatient department treatment
18. **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.
19. Stay in a hospital without undertaking any active regular treatment by the medical practitioner, which ordinarily cannot be given without hospitalization.
20. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.(Code- Excl13)
21. **Rest Cure, rehabilitation and respite care (Code- Excl05)**

    a) 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.
22. **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.
23. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.
24. **Obesity/ Weight Control:Code- (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 Apn

          iv. Uncontrolled Type2 Diabetes
25. **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.
26. Disease / illness or injury whilst performing duties as a serving member of a military or police force.
27. Any kind of, surcharges, admission fees / registration charges etc levied by the hospital.
28. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.

IV. Basis of Claim Settlement

Claim will be settled on indemnity basis maximum up to the sum insured above deductible as defined in schedule of the Policy.

V. Position after a claim

As from the day of receipt of the claim amount by the Insured, the Sum Insured for the remainder of the Policy period shall stand reduced by a corresponding amount. However if insured opts, sum insured can be reinstated to original sum insured under the Policy, at prorata premium from the date of such loss to the expiry of policy.

VI. Deductible/Co-Pay

Insured will have to exercise option to select deductible from INR 1,00,000 to INR 10,00,000 in multiple of 1,00,000. The deductible is applicable on per claim basis.

VII. Medical Examination

Proposer with age over 55 years will be subjected to pre-acceptance medical examination. Underwriter will decide acceptance or rejection of the proposal based on relevant tests from the list below.

However, if the proposal is accepted the Insurer will reimburse 50% of the cost incurred towards the medical tests so undertaken at the advice of the insurer.

Medical report is valid for one month.

Medical Test

Medical Examination	Fasting Blood Sugar
Complete Blood Count	Routine Urine Examination
Erythrocyte Sedimentation Rate	Electrocardiogram
Complete Eye Test	Treadmill Test
Chest X-Ray	Liver function tests
Glycosylated Haemoglobin A1C	Lipid profile test
Total proteins(Serum Albumin+ Globulin)	Serum creatinine test
Australia Antigen Test	

VIII. Sum Insured

Minimum SI: INR.1,00,000 and Maximum SI: INR 50,00,000 subject to underlying deductible ranging from INR 1,00,000 to INR 10,00,000.

Sum Insured of dependents will either be less than or equal to Proposer/Primary Insured's Sum Insured.

IX. Mid-term increase and decrease in Sum Insured

Mid-term increase and decrease in Sum Insured is not allowed

X. Policy period

Arogya Top Up Insurance Policy to Individual will be issued for period of one year, two years or three years.

XI. Cancellation

The Policyholder may cancel his/her Policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

i. refund proportionate premium for unexpired Policy Period, if the term of Policy upto one year and there is no Claim (s) made during the Policy Period.

ii. refund premium for the unexpired Policy Period, in respect of policies with term more than 1 year and risk coverage for such Policy years has not commenced.

iii. 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 or misrepresentation, non-disclosure of material facts or fraud.

XII. Termination of Policy

This Policy terminates on earliest of the following events-

a. Cancellation of policy as per the cancellation provision.

b. On the policy expiry date.

XIII. Tax Relief under Income-Tax Act –

Certificate of premium paid will be issued to avail Tax deduction under relevant section of Income-Tax Act.

XIV. Cumulative Bonus

Cumulative bonus is not applicable for this product.

XV. Renewal

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.

XVI. Withdrawal of 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.

in case of withdrawal of this product Insurer will communicate to Insured at least 3 months prior to the withdrawal. Existing policy will continue to remain in force till its expiry, and at the time of renewal, Insured will have option to migrate to Insurer's existing Top up health products available at that time subject to portability condition.

XVII. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

XVIII. Enhancing Sum Insured

Midterm revision of Sum Insured is not allowed, change in sum insured is allowed only on renewals after medical underwriting applicable to similar new business proposal of comparative age.

XIX. Additions/Deletions of insured during the Policy Period

Inclusion of family members for the proposed coverage is allowed only at application time or when eligible (eg, new-born after 3 months), otherwise inclusion should only be done at renewal time. Cover from any Insured Person can be withdrawn by Insured giving 15 days written notice in this regard to the Insurer.

XX. Payment of Premium

Premium should be paid in advance and payment of premium in instalment is not allowed.

XXI. Premium at different deductible, age and sum insured

Based on deductible, age and sum insured of individual insured. Basic Premium will be determined as per "Appendix 1".

XXII. Loading

Basic Premium will be loaded by 5% each for habit of smoking, alcohol and any other type of tobacco including betel nut in any form for which prior consent will taken from insured.

XXIII. Discount

Based on type of Family cover (if any), No of family member covered and policy duration etc following discount will applied. I. Family (floater) Discount

- 2 Members = 10% discount
- 3 Members = 15% discount
- 4 or more Members = 20% discount.

II. Family (non floater) discount

- 2 member = 5%.
- >2 members = 7.5%.

III. Long term discount

- 2 year = 5%
- 3 year = 7.5%

IV Discount for Direct Business = 15%

XXIV. Revision in policy and rates

In case of revision of this Policy and rate we will communicate to you at least 3 months prior to the revision. Existing policy will continue to remain in force till its expiry, and for existing policyholders the revision will be applicable only from the date of renewal.

XXV. 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 30 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 is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period, etc. from the existing Insurer to the acquiring Insurer in the previous Policy.

For Detailed Guidelines on Portability, kindly refer the link-
https://content.sbigeneral.in/uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

XXVI. 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 at least 30 days before the Policy Renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Period for Pre-existing Diseases, Moratorium Period etc. in the previous Policy to the Migrated Policy.

For Detailed Guidelines on Migration, kindly refer the link-

https://content.sbigeneral.in/uploads/c6a2844dd65446019b130ffbae1fa20f.pdf

XXVII. Minimum Premium

Minimum Premium under the policy is INR 200/-.

XXVIII. Claims Procedures

a. Claims Procedure for Reimbursement :

i) The Insured shall without any delay consult a doctor and follow the advice and treatment recommended, take reasonable steps to minimize the quantum of any claim that might be made under this Policy and intimation to this effect must be forwarded to administrator accordingly.

ii) The Insured must provide intimation to administrator immediately and in any event within 48 hours from the date of Hospitalisation. However the administrator at his sole discretion may relax this condition subject to a justifiable reason/evidence being produced by the Insured on the reasons for such a delay beyond the stipulated 48 hours up to a maximum period of 7 days.

iii) The Insured has to file the claim with all necessary documentation within 15 days of discharge from the hospital, provide administrator with written details of the quantum of any claim along with all the original bills, receipts and other documents upon which a claim is based and shall also give administrator such additional information and assistance as administrator may require in dealing with the claim. In case of delayed submission of claim and in absence of a justified reason for delayed submission of claim, the administrator would have the right of not considering the claim for reimbursement. iv) In respect of post hospitalization claims, the claims must be lodged within 15 days from the completion of post hospitalisation treatment subject to maximum of 105 days from the date of discharge from hospital.

v) The Insured shall submit himself for examination by the administrator's medical advisors as often as may be considered necessary by the administrator for establishing the liability under the Policy. The administrator will reimburse the amount towards the expenses incurred for the said medical examination to the Insured.

vi) The Insured must submit all original bills, receipts, certificates, information and evidences from the attending medical practitioner /hospital /diagnostic laboratory as required by administrator.

vii) On receipt of intimation from the Insured regarding a claim under the Policy, administrator is entitled to carry out examination and obtain information on any alleged Injury or disease requiring hospitalisation if and when Insurer may reasonably require.

b. Claims procedure for Cashless:

i) Prior to taking treatment and/or incurring medical expenses at a network hospital, Insured must call administrator and request pre-authorisation by way of the written form administrator will provide.

ii) After considering Insured's request and after obtaining any further information or documentation administrator has sought, administrator may if satisfied send Insured or the network hospital, an authorisation letter. The authorisation letter, the ID card issued to Insured along with this Policy and any other information or documentation that administrator has specified must be produced to the network hospital identified in the pre-authorisation letter at the time of Insured's admission to the same.

iii) If the procedure above is followed, Insured will not be required to directly pay for the medical expenses in the network hospital that Insurer is liable to indemnify under 'Eligible hospitalisation expenses' cover above and the original bills and evidence of treatment in respect of the same shall be left with the network hospital. Pre-authorisation does not guarantee that all costs and expenses will be covered. administrator reserves the right to review each claim for medical expenses and accordingly coverage will be determined according to the terms and conditions of this Policy. Insured will, in any event, be required to settle all other expenses directly.

c. Claims Submission:

Insured will submit the claim documents to administrator. Following is the document list for claim submission:

i) Duly filled Claim form,

ii) Valid Photo Identity Card, residence proof and 2 recent photos of Insured and/or his nominee.

iii) Original Discharge card/certificate/ death summary

iv) Copies of prescription for diagnostic test, treatment advise, medical references

v) Original set of investigation reports

vi) Itemized original hospital bill and receipts Hospital and related original medical expense receipt Pharmacy bills in original with prescriptions

d. Claims processing:

On receipt of claim documents from Insured, administrator shall assess the admissibility of claim as per policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of claim as per the contract only in Indian Rupees and within India only. In case if the claim is repudiated Insurer will inform the claimant about the same in writing with reason for repudiation.

e. Penal interest provision:

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

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

f. Position after a claim:

As from the day of receipt of the claim amount by the Insured, the Sum Insured for the remainder of the Policy period shall stand reduced by a corresponding amount. However if the Insured opts, sum insured can be reinstated to original sum insured under the Policy, at prorata premium from the date of such loss to the expiry of policy.

XXIX. Grievance redressal procedure

Stage 1:

If you wish to register your grievances directly with us, you may write to us at head.customercare@sbigeneral.in or gro@sbigeneral.in or call our toll free number- 1800 102 1111. After examining the matter, final response would be conveyed within a period of 14 days from the date of receipt of your complaint. In our initial acknowledgement of receipt letter, we will provide the name and title of the person who is handling your Grievance. This person will have the authority necessary to investigate and resolve the Grievance.

For Senior Citizens:

Senior citizens can reach us through the following dedicated channels:

Email: Seniorcitizengrievances@SBIGeneral.in

Toll-Free Number: 1800 102 1111 (Available 24/7)

Details of our Grievance Redressal Officer is mentioned on our website at https://www.sbigeneral.in/grievance-redressal

Note: The Company shall endeavour to maintain the regulatory TAT of 14 days in resolving your grievances.

Alternatively, you may Register your grievance with the regulator through Bima Bharosa which is a grievance redressal platform provided by the Insurance Regulatory and Development Authority of India (IRDAI). You may access the Bima Bharosa Portal using the following link: https://bimabharosa.irdai.gov.in/Home/Home

Stage 2: Escalation to Insurance Ombudsman

If you feel that the response to your Grievance was unsatisfactory, or if you believe your concerns have not been adequately addressed by the company, you may escalate the matter to the Insurance Ombudsman.

Submit your Grievance online: https://www.cioins.co.in/Ombudsman

XXX. Contact Us

For any product or service related information or assistance, here's how you can reach Us.

Contact details for Policy Servicing	Contact details for Claim Servicing
SBI General Insurance Company Limited, **Address**:9th Floor, Wing A & B, Fulcrum, Sahar Road, Andheri (East), Mumbai – 400 099. **Email:** customer.care@sbigeneral.in ; seniorcitizengrievances@sbigeneral.in (for Senior Citizens) **Toll free number** 1800 102 1111 (Available 24/7) For agents and intermediaries 1800 22 1111 (Available 24/7) **Website:** www.sbigeneral.in **Fax No:** 1800227244, 18001027244	**Accident & Health claims team,** **SBI General Insurance Company Limited,** **Address:** 9th Floor, Westport, Pan Card Club Road, Baner, Pune, Maharashtra – 411 045. **Email:** sbig.health@sbigeneral.in **Toll Free number:** 1800 210 3366, 1800 210 6366 **Website:** www.sbigeneral.in **Fax No:** +91 20 49334525

Insurance Act,1938, Section 41-Prohibition of Rebates

1. No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind or risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy, accept any rebate except such rebate as may be allowed in accordance with the prospectuses or tables of the Insurer
2. Any person making default in complying with the provisions of this section shall be liable for a penalty, which may extend to Ten Lakh rupees.

Benefit Illustration

Arogya Top Up Policy

	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum Insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum Insured (Only one Sum Insured is available for the entire family)			
Age of the members insured	Premium (₹)	Sum Insured (₹)	Premium (₹)	Discount, if any Family member discount)	Premium after Discount (₹)	Sum Insured (₹)	Premium or consolidated premium for all members of family (₹)	Floater discount if any	Premium after discount (₹)	Sum Insured (₹)
35 yrs	3,149	5 Lacs / 1 Lac	3,149	7.5%	2,913	5 Lacs / 1 Lac	3,149	20%	9,088	5 Lacs / 1 Lac
30 yrs	3,149	5 Lacs / 1 Lac	3,149	7.5%	2,913	5 Lacs / 1 Lac	3,149			
15 yrs	2,531	5 Lacs / 1 Lac	2,531	7.5%	2,341	5 Lacs / 1 Lac	2,531			
10 yrs	2,531	5 Lacs / 1 Lac	2,531	7.5%	2,341	5 Lacs / 1 Lac	2,531			
Total Premium for all members of the Family is ₹ 11,360/- when each member is covered separately. Sum Insured available for each individual is ₹ 5,00,000/- with 1 Lac deductible			Total Premium for all members of the Family is ₹ 10,508/- when they are covered under a single policy. Sum Insured available for each family member is ₹ 5,00,000/- with 1 Lac deductible				Total Premium when policy is opted on floater basis is ₹ 9,088/- Sum Insured of ₹ 5,00,000/- with 1 Lac deductible is available for the entire family.			

Note:

- Premium rates are specified in the above illustration is standard premium rates without considering any loading. Also, the premium rates are exclusive of taxes applicable.
- The above illustration is for Arogya Top Up Plan
- Family size is considered 4 members =2A + 2 Dependent Child
- Illustration is given for Sum Insured 5 Lac with 1 Lac deductible
- Please note above rates are exclusive GST.