SBI general INSURANCE

SURAKSHA AUR BHAROSA DONO

HOSPITAL DAILY CASH - GROUP - MICRO INSURANCE PRODUCT

PROSPECTUS

Your greatest wealth is your health & everybody has differing levels of control over their own wellbeing. Life follows no fixed plan and sudden Illness / Disease or Accidental bodily injury can sometimes leave you financially hurt and highly stressed. SBI General Hospital Daily Cash – Group – Micro Insurance Product provides you with fixed benefit for each day of hospitalization irrespective of the actual medical cost. Thus, provides you with additional protection & takes care of additional expenses which are not covered under your Health Insurance Policy such as traveling, food etc.

KEY FEATURES OF THE POLICY:

- Hospital Daily Cash – Group provides Accident and Sickness Hospital Cash Benefit.
- It also offers optional covers like:-
  1. Accident Hospital Cash Benefit
  2. ICU Cash Benefit
  3. Convalescence Benefit
  4. Compassionate Benefit
  5. Day Care Treatment Benefit
  6. Maternity Hospital Cash Benefit
  7. Shorter Waiting Period (PED)
  8. Increased Deductible/Franchise

AGE CRITERIA & ELIGIBILITY:

	Minimum	Maximum
Adult	18 years	65 years
Child	91 days	25 years

- Family includes Self, Spouse, Dependent Children, Dependent Parents and/or Dependent Parents-in-Law.
- Dependent Children (i.e. natural or legally adopted) between the age 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals.

SUM INSURED

- Minimum per day sum insured shall be Rs.500/day, 750/day, 1000/day to maximum Rs.5000/day. Sum insured offered shall be in multiple of Rs 500/-
- Sum Insured can be opted for 10/15/20/30/60/90/100 days of hospitalisation.

PERIOD OF INSURANCE

- This policy can be issued for a tenure of 1 year only.

TYPE OF POLICY

- Individual basis
- Individual Family basis
- Family Floater basis

SCOPE OF COVER

A. BASE COVER

A.1 ACCIDENT AND SICKNESS HOSPITAL CASH BENEFIT

In the event of Accidental Bodily Injury or illness first occurring or manifesting itself during the Policy Period and causing the Insured Person's Hospitalisation within the Policy Period, the Company will pay:

The Daily Allowance for each calendar day of Hospitalisation is necessitated solely by reason of Accidental Bodily

Injury or illness for a maximum period as stated in the Policy Schedule/Certificate of Insurance, during each policy period.

A franchise/ deductible of 1 day as stated in the Policy Schedule/Certificate of Insurance will be applicable. Our maximum liability shall be restricted to the daily allowance till opted length of stay and Waiting Period mentioned in the Policy Schedule/Certificate of Insurance.

B. OPTIONAL COVERS

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that Policy is extended to pay daily allowance as specified below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits and subject to co-payments/deductibles, if any, mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

B.1 ACCIDENT HOSPITAL CASH BENEFIT

In the event of Hospitalization of Insured Person due to Accidental Bodily Injury during the Policy Period, the Company will pay:

Two times the Daily Allowance as stated in the Policy Schedule/Certificate of Insurance, for each calendar day of Hospitalisation required to be spent by the Insured Person in a Hospital during any period of Hospitalisation necessitated solely by reason of the Accidental Bodily Injury for a maximum period as stated in the Policy Schedule/Certificate of Insurance during each policy period.

- We will not pay for Daily Cash benefit under Base cover above for the period when the Insured Person is hospitalized for Accidental Injury.
- A franchise/deductible of 1 day as stated in the Policy Schedule/Certificate of Insurance will be applicable only once, either in base A.1 - Accident and Sickness Hospital Cash Benefit or under this section.

B.2 ICU CASH BENEFIT

In the event of Accidental Bodily Injury or Illness first occurring or manifesting itself during the Policy Period and causing the Insured Person's Hospitalisation within the Policy Period, the Company will pay:

Two times the Hospital Daily Cash Allowance, for each calendar day of Hospitalisation required to be spent by the Insured Person in the Intensive Care Unit of a Hospital during any period of Hospitalisation necessitated solely by reason of the Accidental Bodily Injury or Illness for a maximum period of 15 days during the policy period.

- We will not pay for Daily Cash benefit under Base cover above for the period when the Insured Person is in Intensive Care Unit.
- A franchise/deductible of 1 day as stated in the Policy Schedule/Certificate of Insurance will be applicable only once, either in base A.1 - Accident and Sickness Hospital Cash Benefit or under this section.

B.3 CONVALESCENCE BENEFIT

On availing this benefit, Policy is extended to pay lump sum amount equal to Five times the Hospital Daily Cash Allowance as mentioned in Certificate of insurance in case of continuous and completed hospitalization beyond consecutive 10 calendar days due to Accidental Bodily Injury or Illness.

- This benefit is available only once per Insured person during Policy Period.
- This benefit shall be payable if claim under A.1 - Accident and Sickness Hospital Cash Benefit or B.1 - Accident Hospital Cash Benefit or B.2 - ICU Cash Benefit section is admissible under the policy.

B.4 COMPASSIONATE BENEFIT

We will pay additional amount lumpsum Ten times the Hospital Daily Cash Allowance towards expenses as a Compassionate Benefit to the Nominee in case of Accidental Death of the Insure Person whilst in Hospital.

- This benefit is available only once per Policy Period.
- This benefit shall be payable if claim under Base cover – Accident and Sickness hospital cash Benefit section is admissible under the Policy.

B.5 DAY CARE TREATMENT BENEFIT

On availing this benefit, We will pay Five times the Hospital Daily Cash Allowance as stated in the Policy Schedule/Certificate of Insurance, subject to maximum of Rs 10,000 per claim towards Day Care Treatment carried out in the Day Care Centre during the policy period.

The Benefit under this Section shall be available for a maximum of 2 Day Care Treatments per Insured Person per Policy Period and No deductible will be applicable.

B.6 MATERNITY HOSPITAL CASH BENEFIT

We will pay daily fixed benefit amount as specified in the Policy Schedule/ Certificate of Insurance for each calendar day of Hospitalisation, in case an Insured Person is hospitalized for delivery of a child / Medically Necessary Treatment during pregnancy/ lawful medical termination of pregnancy. Policy is restricted to pay for first 2 deliveries only.

- This benefit is subject to maternity waiting period of 36 months and deductibles as specified in the Policy Schedule/Certificate of Insurance.
- We will not cover ectopic pregnancy under this benefit (although it shall be covered under Inpatient Hospital Cash Benefit (Base Cover))
- A franchise/deductible of 24 hours as stated in the Policy Schedule/Certificate of Insurance will be applicable only once, either in base A.1 - Accident and Sickness Hospital Cash Benefit or under this section.
- We will not pay for Daily Cash benefit under Base cover above, if the claim is admissible under this Section.

Option available to Reduce Waiting period of Maternity :-

In consideration of payment of additional premium, it is hereby declared and agreed that We will provide reduction/waiver of waiting period for Maternity Hospital Cash Benefit as specified in Policy Schedule/Certificate of Insurance. Insured Person may have an option to choose the reduction/waiver of waiting period as below.

Option 1. 9 months waiting period –

We will reduce waiting period for Maternity Hospital Cash benefit from 36 months to 9 months. We are not liable to make any payment in respect of Maternity Expenses within 9 months from the date of Inception of the first Policy.

Option 2. 1 year waiting period –

We will reduce waiting period for Maternity Hospital Cash Benefit from 3 years to 1 year. We are not liable to make any payment in respect of Maternity Hospital Cash Benefit within 1 year from the date of Inception of the first Policy.

Option 3. 2 years waiting period –

We will reduce waiting period for Maternity Hospital Cash Benefit from 3 years to 2 years. We are not liable to make any payment in respect of Maternity Hospital Cash Benefit within 2 years from the date of Inception of the first Policy.

Option 4. No maternity waiting period –

On availing this option, Waiting Period for Maternity Hospital Cash Benefit shall not be applicable.

If Maternity Hospital Cash Benefit cover is opted, then under the General Exclusion Excl-18 -Maternity Expenses stands deleted.

B.7 OTHER WAITING PERIOD

In consideration of payment of additional premium by the Proposer/ Insured Person, to the Company and realization thereof by the Company, it is hereby agreed and declared that Hospital Daily Cash Policy is extended to reduce waiting period mentioned in Pre-Existing Diseases (Code- Excl01), Specified disease/procedure waiting period- Code- Excl 02 & 30-day waiting period- Code- Excl 03 i.e. Disease Specific and Pre-Existing Waiting Period up to the option opted by Insured Beneficiary.

Option 1: 30 days waiver –

Subsequent to this endorsement, 30-day waiting period- Code- Excl03 cover stands deleted for all the Insured Persons in the Policy.

All other policy terms and conditions remain unaltered.

Option 2: 2 years Specific illness waiting period –

Subsequent to this endorsement, specified disease/ procedure waiting period- Code- Excl02 cover stands modified for all the Insured Persons in the policy with reference to waiting period being increased to 24 months.

All other policy terms and conditions remain unaltered.

Option 3: Specific illness Waiting Period Waiver –

Subsequent to this endorsement, specified disease/ procedure waiting period- Code- Excl02 cover stands waived for all the Insured Persons in the policy

All other policy terms and conditions remain unaltered.

Option 4:1 year waiting period for Pre-Existing Diseases –

Subsequent to this endorsement, General Exclusions (CodeExcl01) cover stands modified for all the Insured Persons in the Policy with reference to waiting period being reduced to 1 year.

All other policy terms and conditions remain unaltered.

Option 5: 2 years waiting period for Pre-Existing Diseases –

Subsequent to this endorsement, General Exclusions (CodeExcl01) cover stands modified for all the Insured Persons in the Policy with reference to waiting period being reduced to 2 years.

All other policy terms and conditions remain unaltered.

Option 6: 3 years waiting period for Pre-Existing Diseases –

Subsequent to this endorsement, General Exclusions (CodeExcl01) cover stands modified for all the Insured Persons in the Policy with reference to waiting period being reduced to 3 years.

All other policy terms and conditions remain unaltered.

Option 7: No waiting period for Pre-Existing Diseases –

Subsequent to this endorsement, General Exclusions (CodeExcl01) stands deleted for all the Insured Persons in the policy

All other policy terms and conditions remain unaltered.

B.8 INCREASED DEDUCTIBLE/FRANCHISE

The Company hereby agrees and declared that upon opting this optional cover, We will provide discount mentioned and time bound deductible/franchise of day(s) as specified in the Certificate of Insurance will be applicable for any claim under Section A i.e. Base Covers and Section B i.e. Optional covers excluding B.5 i.e. Day Care Treatment Benefit

If this optional cover is opted then the increase Deductible/ Franchise will supersede existing Deductible/ Franchise of the policy.

All other policy terms and conditions remain unaltered

WAITING PERIOD & EXCLUSIONS

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy;

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. 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 1 Years 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) List of specific diseases/procedures
      - Cataract
      - 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 of any etiology
      - Sinusitis and related disorders

- Surgery for prolapsed intervertebral disc unless arising from accident.
- Surgery of varicose veins and varicose ulcers.
- Chronic Renal failure including dialysis.

3. **30-day waiting period- Code- Excl03**
   i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
   ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
   iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
4. **Maternity Waiting period (applicable only if optional cover "Maternity Hospital Cash Benefit" is opted)** - 36 months waiting period applicable in case an Insured Person is hospitalized for delivery of a child / Medically Necessary Treatment during pregnancy/ lawful medical termination of pregnancy.
5. **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.
6. **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.
7. **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
8. **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. However, such exclusion shall not be applicable to respective Insured Person to comply with Transgender Persons (Protection of Rights) Act, 2019.
9. **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.
10. **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.
11. **Breach of law: (Code- Excl10)**
    Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
12. **Excluded Providers: (Code-Excl 11)**
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider

specifically excluded by the Insurer and disclosed in its website/ notified to the policyholders are not admissible. However. in case of life-threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

14. 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)**

15. 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)**

16. Refractive Error:(Code- Excl15)

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

17. 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.

18. Maternity (Code-Excl 18)

Medical treatment expenses traceable to child-birth (including complicated deliveries and caesarean sections incurred during Hospitalization) except ectopic pregnancy;

Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy Period.

Specific Exclusions

19. Any medical treatment outside India.

20. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.

21. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:

a. any nuclear fuel or from any nuclear waste; or

b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);

c. nuclear weapons material;

d. nuclear equipment or any part of that equipment;

22. 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.

23. Injury or Disease caused by or contributed to by nuclear weapons/materials.

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

25. Prostheses, corrective devices, medical appliances, 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 Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

26. Treatments in health hydro, spas, nature care clinics and the like.

27. Treatment with alternative medicines like Ayurvedic, Homeopathic, acupuncture, acupressure, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.

28. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.

29. Vaccination or inoculation except as post bite treatment for animal bite.

30. Convalescence, general debility, "Run-down" condition, rest cure, Congenital Internal and /or external illness/disease/defect.

31. Any fertility, sub fertility or assisted conception operation or sterilization procedure and related treatment.

32. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy

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 (3) months before the changes are affected.

CLAIM PROCEDURE

On the occurrence of an event that may give rise to a claim under this Policy, the claim procedures set out below shall be followed.

- List of necessary claim documents/information to be submitted for reimbursement are as following:
  1. Duly filled and signed claim form
  2. Certified copy of Hospital discharge Summary with first consultation paper (if any)
  3. Certified copy of Diagnostic report confirming diagnosis.
  4. Certified copy of final hospital bill with detailed break up
  5. KYC documents of primary insured/beneficiary
  6. Beneficiary (Primary Insured) bank account / NEFT details

Any additional documents may be called as required based on the circumstances of the claim.

- Claim documents submission:

  All claim related documents need to be sent to the address below within 30 days of date of discharge from hospital. Please do mention appropriate claim number on claim documents dispatched.

Accident & Health claims team:

SBI General Insurance Co Ltd

9th Floor, Westport, Pan Card Club Road, Baner, Pune, Maharashtra – 411 045

- 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 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 Insured Person from the date of receipt of claim submission to the date of payment of claim at a rate 2% above the bank rate.

iii. In case of delay beyond stipulated 15 days, the Company shall be liable to pay interest to the 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.)

TURN AROUND TIME (TAT) FOR CLAIM SETTLEMENT

1. Acceptance of cashless claims by TPA /Company to Hospital and communicate to them – 1 hour
2. TPA's offer of settlement to the Company/ Hospital after 3 hours submission of document – 3 hours
3. Settlement of claims (other than cashless) – 15 days

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 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.

PAYMENT OF CLAIM

All claims will be payable in India and in Indian rupees.

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 refund premium for the unexpired Policy Period as detailed below.

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

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 You under this Policy.

b. 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.

FREE LOOK PERIOD

1. 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.
2. 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.
3. 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.
4. 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.

RENEWAL PROCESS

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.

ALTERATIONS IN THE POLICY

The Proposal Form, Certificate, and Policy Schedule 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.

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

PREMIUM RATES

As per Rating Chart attached

REVISION AND MODIFICATION OF THE POLICY PRODUCT

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.

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.

WITHDRAWAL OF THE PRODUCT

In case the Policy is found to be financially unviable or is deficient in any manner, we shall, in terms of Insurance Regulatory & Development Authority Health Insurance Regulations (2016), have the option to withdraw this Policy from the market subject to prior approval of such withdrawal from the Regulatory Authority.

Any withdrawal of the Policy would be duly intimated to the Policy Holder/Insured Person at least ninety (90) days prior to date of such revision or modification, who on expiry of the existing Policy will have an option to obtain Renewal under similar product/s available with Us. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

REDRESSAL OF GRIEVANCES

Stage 1: Bima Bharosa

You can register your grievances with the regulator using the following link:

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

Stage 2: Head – Customer Care

Alternatively, if you wish to register your grievances directly with us, you may write to the Head – Customer Care. We aim to respond to all Grievances within 7 days. In our initial acknowledgement of receipt letter, we will provide the name and title of the person that is handling your Grievance. This individual will have the authority necessary to investigate and resolve the Grievance.

Email:head.customercare@sbigeneral.in

Phone: 1800 102 1111

For Senior Citizens:

Senior citizens can reach us through the following dedicated channels:

Email:Seniorcitizengrivences@sbigeneral.in

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

Stage 3: Grievance Redressal Officer (GRO)

In case, you are still not satisfied with the decision/resolution communicated by the above officer or have not received any response within 5 days, you may escalate the matter to the Grievance Redressal Officer (GRO) which will undergo a detailed case investigation, and we aim to resolve the issue within 7 days from the date of receipt of your Grievance at GRO Desk

Email: gro@sbigeneral.in

Phone: 022-45138021

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

Stage 4: 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

ANTI REBATING WARNING

As per Section 41 of the Insurance Act 1938, as amended, the practice of rebating is prohibited, as follows:

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 of 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 published prospectus 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.

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

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