SURAKSHA AUR BHAROSA DONO

KUTUMB SWASTHYA BIMA - GROUP

POLICY WORDING

A. PREAMBLE

This is a legal contract between the Company and the Policyholder which is subject to realization of full premium in advance by Us and the terms, conditions and exclusions to this Policy. This Policy has been issued on the basis of Disclosure to Information Norm, including the information provided by the Policyholder in respect of the Insured Persons in the Proposal and the Policy Schedule/ Certificate of Insurance.

The Policy, the Schedule, the Certificate of Insurance and any Endorsement(s) shall be read together and any word or expression to which a specific meaning has been attached in any part of this Policy or of Schedule shall bear such meaning whenever it may appear.

B. DEFINITIONS

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the feminine and vice versa, wherever the context so permits:

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Age or Aged** means completed years as at the Commencement Date of the Policy Period.
3. **Alternative Treatments** are forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context
4. **AYUSH Hospital** is a healthcare facility wherein medical/ surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a) Central or State government AYUSH Hospital; or
   b) Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
   c) AYUSH hospital standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with the following criterion:
      a. Having at least 5 in-patient beds
      b. Having qualified AYUSH Medical Practitioner in charge round the clock
      c. Having dedicated AYSUH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
      d. Maintaining daily records of patients and making them accessible to the insurance company's authorized representative
5. **Beneficiary** in case of death of the Insured Person, the Beneficiary means, unless stipulated otherwise by the Insured Person, the surviving Spouse of the Insured Person, mentally capable and not divorced, followed by the children recognized or adopted, followed by the Insured Person's legal heirs. For all other benefits, the Beneficiary means the Insured Person himself unless stipulated otherwise
6. **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.
7. **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.
8. **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.
9. **Commencement Date** means the commencement date of this Policy as specified in the Policy Schedule/Certificate of Insurance.
10. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
11. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
    a. Internal Congenital Anomaly - Congenital anomaly which is not in the visible and accessible parts of the body.
    b. External Congenital Anomaly - Congenital anomaly which is in the visible and accessible parts of the body.
12. **Dependent Children or Parents** who are dependent upon primary insured person for their survival.
13. **Disclosure to information** norm means 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 materialfact.
14. **Grace period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The Grace Period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
15. **Hazardous and Dangerous sports** means certain activities perceived as having a high level of inherent danger. These activities often involve speed, height, a high level of physical exertion, and highly specialized gear such as racing on wheels or horseback, big game hunting, mountaineering, winter sports, Skydiving, Parachuting, Scuba Diving , Riding or Driving in Races or Rallies, Mountain Climbing, hunting or equestrian activities, rock climbing, pot holing, bungee jumping, skiing, ice hockey, ballooning, hand gliding, diving or under-water activity river rafting, canoeing involving rapid waters, polo, yachting or boating outside coastal waters.
16. **Hospital** means any institution established for in- patient care and day care treatment of illness and / or 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 qualified nursing staff under its employment round the clock;

b. has at least 10 in-patient beds, in - towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;

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 makes these accessible to the insurance

f. company's authorized personnel.

17. **Hospitalisation** means admission in a Hospital for a minimum period of 24 In patient care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

18. **Immediate Family Member** means the legal spouse, dependent children, dependent parents and dependent parents in law.

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

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

21. **Insured** means the person named in the policy Schedule as insured, who is a citizen and resident of India and for whom the insurance is proposed, and appropriate premium paid.

22. **Insured Person** means the persons named as such in the schedule of the policy.

23. **Insurer** means SBI General Insurance Company Limited.

24. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment by a medical practitioner.

    a. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering

    b. the disease/illness/injury which leads to full recovery.

    c. Chronic condition - A chronic condition is defined as adisease, illness, or injury that has one or more of the following characteristics

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

        ii. it needs ongoing or long-term control or relief of symptoms

        iii. it requires your rehabilitation or for you to be specially trained to cope with it

        iv. it continues indefinitely

        v. it comes back or is likely to come back.

25. **Medical Advise** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

26. **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.

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

28. **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.

29. **Notification of Claim** is the process of notifying a claim to the Insurer by specifying the timelines as well as the address / telephone number to which it should be notified.

30. **Permanent Total Disablement** means when Insured is permanently, totally and absolutely unable to engage in any occupation or employment of any description whatsoever.

31. **Policy Schedule / Certificate of Insurance** means the complete documents consisting of the policy wording, schedule and endorsements and attachments if any.

32. **Policy period** means the period commencing with the commencement date of the Policy and terminating with the expiry date of the Policy as stated in the policy schedule.

33. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

34. **Professional Sports** means a sport, which would remunerate a player in excess of 50% of his or her annual income as a means of their livelihood.

35. **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.

36. **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.

37. **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.

38. **Proposer** means the person furnishing complete details and information in the proposal form for availing the benefits either for himself and/or towards the person to be covered under the Policy and consents to the terms of the contract of insurance by way of signing the same.
39. **Renewal** defines 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 all waiting periods.
40. **Schedule** means that portion of the Policy which sets out Insured's details, the type of insurance cover in force, the Policy period and the sum insured. Any annexure and/or endorsement to the schedule shall also be a part of the schedule.
41. **Senior Citizen** means any person, who has attained the Age of sixty years or above.
42. **Specific Waiting Period** means a period up to 90 Days/ 1/ 2/ 3 Years (as per plan opted) from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
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. **Sum Insured** means, in respect of each Benefit, the sum shown in the Schedule against that Benefit and such sum represents the Company's maximum liability for each Insured Person for any and all claims made during the Policy period under that Benefit.
45. **Tele-consultation** means engagement between licensed tele-consultation service provider/ professional and the insured/covered member that is provided via a range of technology enabled communication media other than face-to-face interactions, such as telephone, internet, and others.
46. **Tele-consultation healthcare services** - Comprises of a limited set of healthcare services as specified in the section below called 'included services' are allowed to be provided via teleconsultation.

    Included services:

    a. Recommendation for self-care

    b. Follow Up care and Case Management

    c. Any other tele-consultation medical services having met the requirements of regulatory framework (if any), examples may include provision of patient education, counselling and services associated with disease management programs.
47. **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 days, which will apply before any benefits are payable by the insurer. A Time Deductible does not reduce the sum insured.
48. **Unproven/Experimental treatment** including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
49. **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.
50. **You/Your** means the person(s) named as Insured in the Policy Schedule / Certificate of Insurance.
51. We/Our/Us/Company/Insurer means the SBI General Insurance Company Limited

C. SCOPE OF COVER

I. **Tele-consultation Benefit**

This policy provides the facility of telephonic-consultation or hereafter called Tele-consultation to the policyholder and the insured family members of the policyholder. The provisions of the policy are provided herewith.

The covered members under this policy can avail of the Tele-consultation healthcare services

Specific Conditions

- A defined number of Tele-consultation calls will be offered to insured person as mentioned in the Policy Schedule or Certificate of Insurance.
- There will be monthly capping as indicated in the policy schedule, post which each (additional) call made in a month would result in deduction of 2 calls (instead of 1) from the remaining number of entitled annual calls.
- Once, a defined threshold limit of calls gets exhausted (before policy period), this policy benefit will get over.
- Despite exhaustion of entitled calls within the Policy Period, cover under Personal Accident and Hospitalization Benefit cover will continue, if opted.
- Section D - Standard Exclusions does not apply to this section.

Disclaimer: - "Tele consultation is intended to offer the medical advice as primary health care support only and does not guarantee the diagnosis and treatment or promise attending the health emergencies."

II. Hospitalization Benefit

a. Hospital Daily Cash

If any Insured Person suffers an Illness or Accident during the Policy Period that requires Hospitalization as an inpatient, then a hospitalization benefit will be payable as per the conditions below and subject to the time deductible as defined.

- Hospital Daily Cash benefit for each continuous and completed period of 24 hours (deemed as 1 day) of hospitalization with the per day benefit payable as reflected in the schedule will be paid subject to deductible of first 24 hrs. of such hospitalisation for each and every claim.

b. Conveyance Allowance Benefit

If we have accepted a claim under Daily Hospital Cash (2.a) benefit of this policy, then we will in addition pay benefit amount towards conveyance expenses of the Insured Person a fixed lumpsum amount Per admissible claim as mentioned in the Policy Schedule/Schedule of Insurance.

This benefit is over and above the base Sum Insured.

Specific Exclusions and Waiting Period:

1. Specified disease/procedure waiting period Exclusion 02 :-

a. Expenses related to the treatment of the listed conditions, surgeries/treatments shall be excluded until the expiry of months (as per list below) 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. 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.

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

d. 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. (Applicable for Hospital Daily Cash section under Hospitalization Benefit only)

List of specific diseases/procedures in respect of which waiting period imposed is as under;

Exclusions applicable to Ninety days of cover from commencement of the Policy, from the following Diseases / Illness and its related complications:

a) Hypertension,

b) Cardiac condition

c) Diabetes

Exclusions applicable to first year of cover from commencement of the Policy, from the following Diseases / Illness and its related complications:

a. Any types of gastric or duodenal ulcers,

b. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty

c. All internal or external tumor /cysts/nodules/polyps of any kind including breast lumps

d. All types of Hernia and Hydrocele

e. Anal Fissures, Fistula and Piles

Exclusions applicable to first two years of cover from commencement of the Policy, from the following Diseases / Illness and its related complications:

a. Cataract

b. Benign Prostatic Hypertrophy

c. Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus

d. Non infective Arthritis, Treatment of Spondylosis / Spondilytis, Gout & Rheumatism

e. Surgery of Genitourinary tract

f. Calculus Diseases

g. Sinusitis, nasal disorders and related disorders

h. Surgery for prolapsed intervertebral disc unless arising from accident

i. Vertebro-spinal disorders (including disc) and knee conditions;

j. Surgery of varicose veins and varicose ulcers

k. Chronic Renal failure

Exclusions applicable to first three years of cover from commencement of the Policy, from the following Diseases / Illness and its related complications:

a. Joint replacement surgery due to degenerative condition, age related osteoarthritis and osteoporosis unless such joint replacement surgery is necessitated by Accidental Bodily Injury.

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

c. Dental treatment or surgery of any kind unless required as a result of Accidental Bodily Injury to natural teeth requiring hospitalization treatment.

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

e. Surgery to correct deviated septum and hypertrophied turbinate unless necessitated by accidental bodily injury and proved to our satisfaction that the condition is a result of an accidental injury.

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

g. Hospitalization primarily for investigation purposes, diagnosis, x-ray examination, general or routine physical or medical examinations, not incidental to treatment or diagnosis of a covered Disease or Illness or any treatment or any preventive treatments, or examinations carried out by a Medical Practitioner which are not medically necessary and which would necessarily not warrant hospitalization and the line of treatment is such that could be carried out on an outpatient basis.

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

III. **Personal Accident**

a. **Accidental Death**

If during the Policy Period Primary Insured Person sustains Bodily injury which directly and independently of all other causes results in death within 12 months of the date of loss, then the company agrees to pay the insured person's beneficiary or legal representative the compensation stated in the schedule.

b. **Permanent Total Disablement**

If during the Policy Period a Primary Insured Person sustains Bodily injury which directly and independently of all other causes results in disablement within 12 months of the date of loss, then the company agrees to pay the insured person the compensation stated in the specific table of benefits below.

Table of benefits

	% of SI
a) Loss of sight (both eyes)	100
b) Loss of two limbs	100
c) Loss of one limb and one eye	100
d) Permanent Total disablement	100
Total and irrecoverable loss of i) the sight of one eye or the actual loss by physical separation of one entire hand or one entire foot.	50% of S.I

In the above:

a) Physical separation of hand or leg means, a hand at or above the wrist or a foot above the ankle.

Specific Condition

If Primary Insured person dies as a result of bodily injury any amount claimed and paid to an Insured person under this section will be deducted from any payment under Accidental Death (3.a)

Specific Exclusions

The Company shall not be liable for any claim or claims under this Policy arising from

a) Payment of compensation in respect of injury or disablement directly or indirectly arising out of or contributed by or traceable to any disability existing on the date of issue of this Policy.

b) Infections (except pyogenic infections which shall occur through an Accidental cut or wound) or any other kind of Disease.

c) Accident while being under the influence or abuse of drugs, alcohol, or other intoxicants or hallucinogens unless properly prescribed by a physician and taken as prescribed

D. GENERAL EXCLUSIONS

Without prejudice to the exclusions mentioned elsewhere in this document, the following exclusions shall apply to the benefits admissible under this Policy. This entire Policy does not provide benefits for any loss resulting in whole or in part from, or expenses incurred, directly or indirectly in respect of

1. Pre-existing Disease Exclusion 001:

i. Expenses related to the treatment of a Pre-existing disease and its direct complication shall be excluded until the expiry of 36 months of continuous coverage after the inception of the first policy with the insurer.

ii. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase

iii. If the insured person is continuously covered without any break as defined under the portability norms of the extant IRDAI (health insurance) Regulations, then the waiting period for the same would be reduced to the extent of prior coverage.

iv. Coverage under the policy after expiry of 36 months for any PED is subject to the same being declared at the time of application and accepted by insurer.

2. 30-day waiting period exclusion 03

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

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

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

3. Investigation & Evaluation 04

i. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

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

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

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

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

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

5. Obesity/ Weight Control: Code- Excl06

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

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

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

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

iv. 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:

- Obesity-related cardiomyopathy
- Coronary heart disease
- Severe Sleep Apnea
- Uncontrolled Type2 Diabetes

6. 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.

7. 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.

8. 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.

9. Excluded Providers: Code- Excl 11

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

10. Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl12**

11. 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**

12. 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**

13. Refractive Error: Code- Excl15

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

14. 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.

15. Sterility and Infertility: Code- Excl17

Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

16. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

17. Any medical treatment outside India.

18. 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.

19. 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.

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

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

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

iii. nuclear weapons material;

iv. nuclear equipment or any part of that equipment;

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

22. Accident resulting from Suicide, attempted suicide (whether sane or insane) or intentionally self-inflicted injury, mental or nervous disorder.

23. Accident during air travel except as a fare paying passenger on a recognized airline or charter aircraft

24. Accident while operating or learning to operate any aircraft or ship or performing duties as a member of the crew on any aircraft or ship.

25. Accident arising out of and in the course of employment in any branch of the Military or Armed Forces of any country, whether in peace or War.

26. The dispersal or application of pathogenic or poisonous biological or chemical materials; The release of pathogenic or poisonous biological or chemical materials, or Congenital anomalies or any complications or conditions arising there from.

27. Expenses related to any treatment necessitated due to participation as a professional in hazardous 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.

E. GENERAL CONDITIONS

E.1) Conditions Precedent to the Contract:

1. **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 the age of 91 days to 25 years.

2. **Currency**

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

3. **Non-Disclosure or Misrepresentation**

If at the time of issuance of policy or during continuation of the policy, the information provided to us in the proposal form either physically or electronically or otherwise, by you or the insured person or anyone acting on behalf of you or an insured Person is found to be incorrect, incomplete, suppressed or not disclosed, willfully or otherwise, the policy shall be:

i. cancelled ab initio i.e. from the inception date or the renewal date (as the case may be),

ii. or the policy may be modified by us, at our sole discretion, upon 30 days' notice by sending an endorsement to your address shown in the schedule / certificate of insurance;

iii. the claim under such policy if any, shall be rejected/ repudiated forthwith.

4. **Electronic Transactions**

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

5. **Insured Person**

Only those persons named as an insured person in the policy schedule/certificate of insurance shall be covered under this policy.

6. **No Constructive Notice**

Any knowledge or information of any circumstance or condition in relation to the Policyholder/Insured Person which is in Our possession or in the possession of any of Our official shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve the Policyholder /Insured Person from their duty of disclosure, notwithstanding subsequent acceptance of any premium.

7. **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.

8. **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.

9. **Nominee**

   You can, at the inception or at any time before the expiry of the policy, make a nomination for the purpose of payment of claims under the policy. This is paid in the event of death of the insured.

   Any change of nomination should be communicated to us in writing and such change shall apply only when an endorsement on the policy is made by us.

   In case of any insured person other than you under the policy, for the purpose of payment of claims in the event of death, the default nominee would be you.

E.2) Conditions Applicable During the Contract:

1. **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.

2. **Cancellation:**

i. For Yearly premium paying mode.

You can choose to cancel the policy, giving us a 15-day notice period by recorded delivery. Provided there is no claim under the policy. The insured shall be entitled for premium refund at the company's Short Period Scale provided in table 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

For Quarterly and Half yearly premium paying mode.

For Quarterly and Half yearly Premium Payment options, 50% of current instalment premium will be refunded when the current period is less than 6 months into the policy year. For instalment after 6 months, no refund will be payable.

No refund of any premium in case of any claim during policy year.

ii. 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.

3. **Geography**

   In Policy, Personal Accident Section Applies to events or occurrences taking place anywhere in the world. However, teleconsultation and hospital daily cash section are restricted to India only.

   All admitted or payable claims under this Policy shall be settled in India in Indian rupees.

4. **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

5. **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

6. **Special Conditions applicable for policies issued with premium payment on instalment basis -**

   If the Insured Person has opted for Payment of Premium on an instalment basis i.e. Single, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

   i. Grace Period would be given to pay the instalment premium due for the Policy. In case of monthly instalment option, a Grace Period of 15 days is applicable. Whereas, in case of Single, Half Yearly, Quarterly instalment options, a Grace Period of 30 days is applicable.

ii. During such Grace Period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the Sum Insured, No Claim Bonus, Specific Waiting Periods, Waiting Periods for Pre-existing Diseases, Moratorium period etc in the event of payment of premium within the stipulated Grace Period

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the Grace Period, the Policy will get cancelled.

vi. In the event of a Claim, all subsequent premium instalments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending instalments from the Claim amount due under the Policy.

E.3) Conditions applicable during renewal of the Policy:

1. **Renewal conditions:**

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.

2. **Portability and Continuity Benefits-**

The Insured Person will have the option to port the Policy to other Insurers by applying to such Insurer to port the entire Policy along with all the members of the Family, if any, at least 45 days before, but not earlier than 60 days from the Policy Renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance Policy with an Indian General/Health Insurer, the proposed Insured Person 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

3. **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

E.4) Conditions when a claim arises:

Claim Intimation

Upon the discovery or occurrence of an event or Hospitalisation that may give rise to a claim under this Policy, Insured Person or the Nominee as the case may be, shall undertake the following:

- In case of Teleconsultation, Customer can call to the Toll free numbers of SBI GI's empaneled Tele- Consultation Service Provider from his/her registered mobile number to get the limited set of health care services, basis the chosen plan.

  Service Timings- Tele Consultation will be available for 12 hrs* in a day, 8 AM to 8 PM on all seven days in week.

  * Timings and duration of tele-consultation service subject to change on the sole discretion of the company. Any such changes or technical disruption leading to unavailability of service, will be communicated to customers.

- In case of Hospitalisation, notify Us either at Our call centre or in writing within 48 hours of the Hospitalization but not later than discharge from the Hospital. The following details are to be provided to Us at the time of intimation of Claim:
  - Policy Number
  - Name of the Policyholder
  - Date and Time of Loss Location of Accident /illness for which insured is hospitalized.
  - Name of the Insured Person in whose relation the claim is being lodged
  - Nature of claims, Accidental death, Permanent Total Disablement, Hospital Daily Cash
  - Name and address of the attending Medical Practitioner and Hospital (if admission has taken place)
  - Any other information, documentation as requested by Us.

  Intimation about an event or occurrence that may give rise to a claim under this Policy must be given within 30 days of it's happening. We will examine and relax this time limit mentioned herein depending upon the merits of the case.

Claim Notification

It is a condition precedent to Our liability hereunder that written notice of claim must be given by You Us within seven (7) days after an actual or potential loss begins or as soon as reasonably possible and in any event no later than (30) Days after an actual or potential loss begins. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if you can satisfy us that it was not reasonably possible for you to give proof within such time.

We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

Claim Documents

1. **In case of Teleconsultation claim:**

- For Teleconsultation claim, Call need to be made by the primary insured from his/her registered mobile no. in the toll-free no. provided by the insurer.
- Every call made by the customer for consultation irrespective of whether it is a follow up call or otherwise, will be treated as a new call /claim.

- If in a single call, the Primary Insured Person seeks consultation for other Insured Persons mentioned in the Policy Schedule / Certificate of Insurance, then queries pertaining to each Insured Person will be treated as a separate call/claim

2. In case of Hospital Daily Cash claim, following is the document list for claim submission:

- Duly filled and signed claim form
- Certified copy of Hospital discharge Summary with pre & post hospitalization consultation details (if any)
- Certified copy of Diagnostic report confirming diagnosis.
- Certified copy of final hospital bill with detailed break up

Nominee / Beneficiary details

- Beneficiary (Primary Insured) 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.

Case specific additional documents may be requested if required for justified claim decision & processing.

3. **In case of Personal Accident claim, following is the document list for claim submission:**

A. **Personal Accident – Death**

- Duly filled and signed claim form
- Certified copy of Death certificate issued by municipal authority
- Certified copy of FIR, MLC Copy, Spot Panchnama.
- Certified copy of Postmortem examination report, if done.

Nominee / Beneficiary details

- Duly filled and signed Central KYC Registry form
- Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card/ Driving license / Passport / Aadhar Card / Election Card, etc.) for address mentioned in claim form
- 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.

B. **Personal Accident – Permanent Total Disability**

- Duly filled and signed claim form
- Certified copy of Disability certificate issued by Appropriate Govt/Medical authority
- Certified copies of hospital treatment records and diagnostic reports
- Certified copy of FIR, MLC Copy, Spot Panchnama.
- Photograph of insured showing disability

Beneficiary details

- Duly filled and signed Central KYC Registry form (applicable for benefit of ₹1,00,000 & above)
- Self-attested Copy of PAN card & Aadhar card, photo id & address Proof of the nominee / beneficiary (Pan card / Driving license / Passport / Aadhar Card / Election Card, etc) for address mentioned in claim form (applicable for benefit of ₹1,00,000 & above)
- Insured 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.

On receipt of intimation from Insured regarding a claim under the Policy, Insurer is entitled to carry out examination and obtain information and may seek further clarification.

Scrutiny of Claim Documents

We shall scrutinize the claim and accompanying documents. Any deficiency of documents shall be intimated to Insured Person, within 15 days of their receipt. If the deficiency in the necessary claim documents is not met or are partially met 2 periodic reminders will be sent. If no response received to requirement communications claim will be rejected post 60 days of deficiency communication date.

Claim Assessment

We will pay fixed amounts as specified in the applicable Sections for Basic or Optional Benefits in accordance with the terms of this Policy.

We are not liable to make any payments that are not specified in the Policy.

Re-opening of Claim

The claim would be rejected if shortfall documents are not received within stipulated timelines as communicated through deficiency & reminder letters.

However, such rejected claim shall be reviewed for settlement if, Requisite document sufficient for settlement are received.

Claims Investigation

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. In such cases, We will settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

Settlement & Repudiation of a Claim

We shall settle a claim including its rejection within 30 days of the receipt of the last "necessary" documents.

In case of suspected frauds, the last "necessary" document shall mean the receipt of verification/ investigation report to determine the validity of the claim.

In the cases of delay in the payment, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by Us.

Representation against Rejection

Where a rejection is communicated by Us, the claimant may if so desired within 15 days of the communication of the rejection, represent to Us for reconsideration of the decision.

Payment Terms

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

Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy then this Policy shall be void in respect of such Insured Person and all claims in respect of such Insured Person shall be forfeited. All sums paid under this Policy shall be repaid to Us by You on behalf of such Insured Person who shall be jointly liable for

such repayment.

Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within thirty six months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

Any claim for which the notification of claim is received 12 calendar months after the event or occurrence giving rise to the claim shall not be admissible, unless it is proved to Our satisfaction that the delay in reporting of the claim was for reasons beyond Your or the Insured Persons control.

Complete Discharge

We will not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy except in case of assignment of the Benefit in respect of an Insured Person where the Policyholder is a creditor of the Insured Person. The payment made by Us to the Insured Person or to their Nominee/ legal representative or to the valid assignee, as the case may be, of the compensation or Benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

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.

E.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)

LIST OF OMBUDSMEN OFFICES

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu	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
Karnataka	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
Madhya Pradesh, Chattisgarh	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
Odhisa	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
Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	Mr Atul Jerath Insurance Ombudsman Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).	Shri Segar Sampathkumar Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018. Tel.: 044 - 24333668 / 24335284 Email: bimalokpal.chennai@cioins.co.in

Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	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
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	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
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Pondicherry.	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
Rajasthan	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
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	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
West Bengal, Sikkim, Andaman & Nicobar Islands.	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
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	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
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).	Ms Susmita Mukherjee Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Bulandshehar, Budaun, Etah, Etawah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	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
Bihar, Jharkhand.	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
Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).	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
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	

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