Group Mediclaim Policy Wordings

Preamble

WHEREAS the policyholder designated in the Schedule to this Group Mediclaim having by a proposal and declaration together with any statement, report or other document which shall be the basis of the contract and shall be deemed to be incorporated herein, has applied to Reliance General Insurance Company Limited (hereinafter called "the Company") for the insurance hereinafter set forth and paid appropriate premium for the period as specified in the Schedule.

NOW THIS POLICY WITNESSETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon the Company, undertakes, that if during the Policy Period as specified in the Schedule, any claim is incurred which becomes admissible and payable under this Policy then the Company shall pay for such claim, as per terms conditions and benefits and exclusions and the limit of Sum insured as set forth in this policy

Definitions

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meanings set forth:

1. **"Accident"** is a sudden, unforeseen and involuntary event caused by external visible and violent means.
2. **Acute Condition** is a disease, Illness and 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 th disease/illness/injury which lead to full recovery.
3. **"Any one illness"** means continuous Period of illness/ Injury and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken
4. **"Cashless Facility"** means a facility extended by the company to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider/TPA by the insurer to the extent of pre-authorization approved.
5. **"Chronic Condition"** is defined as a disease, illness, or injury that has one or more of the following characteristics – it needs ongoing or long term monitoring through consultation, examination, check-ups, and /or or tests – it needs ongoing or long-term control or relief of symptoms – it requires insured rehabilitation or for you to be specially trained to cope with it – it continues indefinitely – it comes back ot is likely to come back.
6. **"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 "Internal Congenital Anomaly" means 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.
7. **"Co-Payment"** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage o f the admissible claim amount. A co-payment does not reduce the sum insured
8. **"Day Care Treatment"** refers to medical treatment, and /or surgical procedure which is :
   I. Undertaken under General or Local Anesthesia in a hospital/ day care centre in less than 24 hours because of technological advancement, and
   ii. Which would have otherwise required a hospitalisation of more than 24 hours.
   iii. Treatment normally taken on an out-patient basis is not included in scope of this definition.
   iv. Day care treatment shall include only procedures listed in Annexure I.
9. **"Day care centre"** means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
   - has qualified nursing staff under its employment;
   - has qualified medical practitioner/s in charge;
   - has a fully equipped operation theatre of its own where surgical procedures are carried out;
   - maintains daily records of patients and will make there accessible to the insurance company's authorized personnel
10. **"Deductible"** is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount which will apply before any benefits are payable by the insurer, A deductible does not reduce the sum insured.
11. **"Domicilliary hospitalisation"** means medical treatment for an illness/injury which in the normal course require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    a. the condition of the patient is such that he/she cannot be removed to Hospital/or
    b. the patient takes treatment at home on account of non availability of room in a hospital.

12. **"Emergency Care"** means management for severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate hospitalization by a medical practitioner to prevent death or serious long term impairment of the insured person's death.
13. **"Family"** means as defined in the policy schedule
14. **"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 inpatient beds, in those towns having a population of less than 10,00,000 and 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 will make these accessible to the Insurance company's authorized personnel.
15. **"Hospitalisation"** means admission in a hospital for a minimum period of 24 Inpatient care consecutive hours except for specified procedures/treatments where such admission could be for a period of less than 24 consecutive hours.
16. **"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.
17. **"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.
18. **"Intensive Care Unit"** means an indentified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
19. **"In-patient care"** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
20. **"Insurer/Company"** means i.e Reliance General Insurance Company Limited.
21. **Insured/Insured Person/Insured beneficiary:** A person accepted by the Company to be insured under this Policy and who meets and continues to meet all the eligibility requirements and whose name specifically appears under Insured (Insured Person) in the Policy Schedule and with respect to whom the premium has been received by the Company.
22. **"Medical Advise"** means any consultation or advice from a medical practitioner including the issue of any prescription or repeat prescription.
23. **"Medical Expenses"** means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or injury 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 Medical Practitioners in the same locality would have charged for the same medical treatment.
24. **"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 Govt 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 his license and should not be the insured or close family member.
25. **"Medically necessary treatment"** is defined as any treatment, tests, medication, or stay in hospital or part of stay in a hospital which
    I. Is required for the medical management of the illness or injury suffered by the insured;
    ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii. Must have been prescribed by a medical practitioner;
    iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
26. **"Network Provider"** means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.
27. **"Non- Network"** any hospital, day care centre or other provider that is not part of the network provider.
28. **"New Born Baby"** means baby born during the policy period and is aged between 1 day and 90 days, both days inclusive.
29. **"Policy"** is the Company's contract of insurance with the policyholder providing cover as detailed in this Policy Terms & conditions, the Proposal Form, Policy Schedule, Endorsements, if any and Annexures, form part of the contract and must be read together.
30. **Policyholder:** The person who is the Proposer and whose name specifically appears in the Policy Schedule as policy holder
31. **"Policy period"** means the period between the inception date/date of joining and the expiry date/date of exit as specified in the Schedule to this Policy or the cancellation of this policy, whichever is earlier.
32. **"Post hospitalisation medical expenses"** Medical expenses incurred immediately after the insured person is discharged from the hospital provided that:
    I. Such medical expenses are incurred for the same condition for which the Insured Person's hospitalisation was required, and

ii. the in-patient hospitalisation claims for such hospitalisation is admissible by the Company.

33. **"Pre-existing Disease"** means any condition, illness or injury or related condition(s) for which the Insured/Insured person had signs or symptoms and/or were diagnosed and/or received medical advice/ treatment, within 48 months prior to the first policy issued by the Company.

34. **"Pre-hospitalisation medical expenses"** means Medical expenses incurred immediately before the Insured person is hospitalized, provided that:

I. Such medical expenses are incurred for the same condition for which the Insured Person's hospitalisation was required, and

ii. The in-patient hospitalisation claims for such hospitalisation is admissible by the Insurance Company..

35. **"Qualified Nurse"** is a person who holds a valid registration from the Nursing council of India or the Nursing council of any state in India.

36. **"Reasonable and customary charges"** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.

37. **"Room Rent"** means the amount charged by a hospital for the occupancy of a bed on per day (24 hour) basis and shall include associated medical expenses.

38. **"Schedule"** means the document attached name so and to and the forming part of this Policy mentioning the details of the Insured/ Insured Person/s, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

39. **"Sum Insured"** means the sum as specified in the Schedule to this Policy against the name of Insured/Insured Person/s, which sum represents the Company's maximum liability for any or all claims pertaining to that insured person & his/her family members, if insured, under this Policy during the Policy period.

40. **"Surgery"** Surgery or Surgical procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

41. **Third party administrator (TPA)**: - Third party administrator or TPA means any person who is licensed under the IRDA (Third Party Administrators - Health Services) Regulations 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company to service this policy, for the purposes of providing health services.

42. **"Unproven/ Experimental treatment"** is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

2. Scope Of Cover

The Company undertakes, subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon that if during the Policy Period, the Insured/Insured Person shall contract any illness or injury and if such illness or injury shall upon the written medical advise of a Medical Practitioner require any such Insured/Insured Person within the policy period, to incur hospitalisation at any Hospital, day care treatment at any day care centre or domiciliary hospitalisation, in India for the medically necessary treatment of the Insured/Insured Person, under any of the benefits as mentioned hereunder, then the Company will indemnify the Insured/Insured Person, as the case may be, for the amount of such medical expenses, which should be reasonable and customary charges, as would fall under the different heads mentioned below and are incurred by or on behalf of such Insured/Insured Person for

- Hospital (Room Rent and Operation theatre) charges
- Fees of Surgeon, Anesthetist, Specialists etc.
- Cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs etc.
- Pre hospitalisation medical expenses and post hospitalisation medical expenses
- Medical expenses on day care treatment
- Medical expenses on Domiciliary hospitalisation

in manner, for the period and to the extent of the Sum Insured as specified in this Policy. The Company's total liability in aggregate for all claims paid under the policy shall not exceed the Sum Insured of the respective Insured Person

Benefits

1. Hospitalisation

This benefit covers payment of medical expenses incurred for medically necessary treatment taken for Hospitalization of the Insured/Insured Person for illness/injury contracted or sustained by the Insured/Insured Person during the Policy period in a Hospital, which, includes, Hospital (Room & Boarding and Operation theatre) charges, fees of Surgeon, Anesthetist, Specialists, the cost of diagnostic tests, medicines, blood, oxygen, appliances like pacemaker, artificial limbs and organs.

2. Domiciliary Hospitalisation

Domiciliary Hospitalisation means medical treatment for a period exceeding three days for disease/injury which in the normal course would require care and treatment at a hospital/nursing home but is actually taken whilst confined at home in India under any of the following circumstances namely

1. The condition of the patient is such that he/she cannot be removed to Hospital/Nursing home, or
2. The patient cannot be admitted to Hospital/Nursing Home for lack of accommodation therein.

Domiciliary hospitalisation benefits shall be subject to the Sum Insured as specified in the Schedule, and shall, in no case cover expenses incurred for:

a. Pre hospitalisation medical expenses and Post Hospitalisation medical expenses.

b. Treatment of any of the following diseases/illness/injury:

I. Asthma

ii. Bronchitis

iii. Chronic nephritis and nephritic syndrome

iv. Diarrhea & all types of dysenteries including gastroenteritis.

v. Diabetes mellitus and insipidus

vi. Epilepsy

vii. Hypertension

viii. Influenza, cough and cold

ix. All psychiatric or psychosomatic disorders

x. Pyrexia of unknown origin for less than 10 days

xi. Tonsillitis and upper respiratory tract infection including laryngitis & pharangitis

xii. Arthritis, gout and rheumatism.

3. Day Care Treatment

This benefit covers payment of medical expenses incurred for medically necessary treatment pertaining to Day care treatment of the Insured/Insured person.

4. Pre-Hospitalisation medical expenses

This benefit covers relevant Pre-hospitalization medical expenses incurred by the Insured/ Insured Person during a period as specified in Schedule, prior to hospitalization.

5. Post-Hospitalisation medical expenses

This benefit covers relevant Post-hospitalization medical expenses incurred by the Insured/ Insured Person during a period as specified in Schedule, post hospitalization.

3. Policy Exclusions

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. All diseases/injuries which are pre-existing when the cover incepts for the first time.
2. Any disease other than those stated in exclusion 3 hereunder, contracted by an Insured Person during the first 30 days from the date of commencement of the policy. Provided that the above exclusion shall not apply:
   a. If in the opinion of a panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company; or
   b. In case of the Insured Person having been covered under this scheme or a group insurance scheme with any of the Insurance Companies in India for a continuous period of preceding 12 months without any break.
3. During the first year of operation of the insurance cover, expenses on treatment of diseases such as cataract, benign prostatic hypertrophy, hysterectomy or menorrhagia or fibromyoma, hernia, hydrocele, congenital internal diseases/anomalies, fistula in anus, piles, sinusitis and related disorders are not payable. If these diseases are pre-existing at the time of proposal, they will not be covered even during period of subsequent renewals.
4. Circumcision unless necessary for treatment of a disease not excluded hereinabove or as may be necessitated due to an accident, vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
5. Cost of spectacles, contact lenses and hearing aids.
6. Dental treatment or surgery of any kind unless requiring hospitalisation.
7. Convalescence, general debility, 'run-down' condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury and use of intoxicating drugs/alcohol.
8. All expenses arising out of any condition, directly or indirectly, caused to or associated with human T-Cell Lymphotropic Virus type III (HTLV III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.
9. Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home or at home under domiciliary hospitalisation as defined.
10. Expenses on vitamins and tonics unless forming part of treatment for disease or injury as certified by the medical practitioner.
11. Treatment arising from or traceable to pregnancy, childbirth including caesarean section. Voluntary medical termination of pregnancy during the first 12 weeks from the date of conception.
12. Naturopathy treatment.
13. Disease or injury directly or indirectly caused by or arising from attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not).
14. Disease or injury directly or indirectly caused by or contributed to by nuclear weapons/materials.
15. Unproven/Experimental Treatment.
16. Any non-medical charges as mentioned in "List of Medical Expenses Excluded" as appended

4. Claims Procedure

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, including complying with the following steps, shall be the condition precedent to the admissibility of the Claim.

Upon the discovery or happening of any Illness / Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admissibility of the Claim, the Policyholder/ Insured Person shall undertake the following:

4.1 Claims Intimation

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a Claim covered under the Policy, the

Policyholder/ Insured Person, must notify to the TPA/Company either at the call center or in writing immediately.

In the event of

- Planned Hospitalization, the Policyholder /Insured Person will intimate such admission at least 48 hours prior to the planned date of admission.
- Emergency Hospitalization, the Policyholder /Insured Person will intimate such admission within 24 hours of such admission.

The following details are to be provided to the TPA/Company at the time of intimation of Claim:

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital
- Date of Admission
- Any other information as requested by the Company

4.2 Claims Procedure

4.2.1 Cashless: Cashless facility is available only at a Network Hospital. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital, by presenting the health card as provided by the TPA/Company with this Policy, along with a valid photo identification proof (Voter ID card / Driving License / Passport / PAN Card / any other identity proof as approved by the Company).

To avail Cashless facility, the following procedure must be followed by the Policyholder/ Insured Person:

a. Pre-authorization: Prior to Hospitalization, the Policyholder/ Insured Person must call the call center of the TPA/Company and request authorization by way of submission of a completed Pre-authorization form at least 48 hours before a planned Hospitalization and in case of an Emergency situation, within 24 hours of Hospitalization.

b. The TPA/Company will process the Policyholder's/ Insured Person's request for authorization after having obtained accurate and complete information for the Illness/ Injury for which Cashless facility for Hospitalization is sought by the Policyholder/ Insured Person and the TPA/Company will confirm such Cashless authorization / rejection in writing or by other means.

c. If the procedure above is followed and the Policyholder's/ Insured Person's request for Cashless facility is authorized, the Policyholder/ Insured Person will not be required to pay for the Hospitalization Expenses which are covered under this Policy and fall within the Company's liability (within the authorized limit).Original bills and evidence of treatment in respect of the same shall be left with the Network Hospital.

d. The Company/TPA (On behalf of Company) reserves the right to review each Claim for Hospitalization Expenses and coverage will be determined according to the terms and conditions of this Policy. The Policyholder/ Insured Person shall, in any event, be required to settle all other expenses, co-payment and / or deductibles (if applicable), directly with the Hospital.

e. Cashless facility for Hospitalization Expenses shall be limited exclusively to Medical Expenses incurred for treatment undertaken in a Network Hospital for Illness or Injury which are covered under the Policy.

f. There can be instances where the TPA/Company may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case the Policyholder/ Insured Person may be required to pay for the treatment and submit the Claim for reimbursement to the TPA/Company which will be considered subject to the Policy Terms &Conditions.

g. The Policyholder/ Insured Person shall be required to submit the documents as mentioned in Clause 4.4 with the Network Hospital.

Note: Under Cashless facility, the TPA/Company may authorize upon the Policyholder's / Insured Person's request for direct settlement of admissible Claim as per agreed charges & terms and conditions between Network Hospital and the TPA/Company. In such cases, the TPA/Company will directly settle all eligible amounts as per the Policy Terms &Conditions with the Network Hospital to the extent the Claim is covered under the Policy.

The Company, at its sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable list of Network Hospital on the Company's website.

4.2.2 Re-imbursement :

In case of any Claim under the Benefits, where cashless facility is not availed, the list of documents as mentioned in Clause 4.4 shall be provided by the Policyholder/Insured Person, to TPA/Company immediately but not later than 30 days of discharge from the Hospital, at the Policyholder's/ Insured Person's expense to avail the Claim.

4.3 Policyholder's / Insured Person's duty at the time of Claim

a. The Policyholder / Insured Person must take reasonable steps or measure to avoid or minimize the quantum of any Claim that may be made under this Policy.

b. Forthwith intimate / file / submit a Claim in accordance with Clause 4 of this Policy.

c. If so requested by the TPA/Company, the Insured Person will have to submit himself for a medical examination by the TPA/Company's nominated Medical Practitioner as often as it considers reasonable and necessary. The cost of such

examination will be borne by the Company.

d. The Policyholder/ Insured Person is required to check the applicable list of Network Hospitalization the TPA/Company's website or call center before availing the Cashless services.

e. On occurrence of an event which will lead to a Claim under this Policy, the Policyholder/ Insured Person shall :

- Allow the Medical Practitioner or any of the Company's representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person.
- Assist and not hinder or prevent the Company's representatives in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

If the Policyholder / Insured Person does not comply with the provisions of these conditions all benefits under this Policy shall be forfeited at the Company's option.

4.4 Claim Documents

The Policyholder / Insured Person shall submit to the TPA/Company/ Network Hospital (as applicable) the following documents for or in support of the Claim:

- Duly completed and signed Claim Form, in original
- Medical Practitioner's referral letter advising Hospitalization
- Medical Practitioner's prescription advising drugs / diagnostic tests / consultation
- Original bills, receipts and discharge card from the Hospital / Medical Practitioner
- Original bills from pharmacy / chemists
- Original pathological / diagnostic test reports and payment receipts
- Indoor case papers
- Ambulance receipt and bill
- First Information Report/ Final Police Report, if applicable
- Post mortem report, if available
- Any other document as required by the Company to assess the Claim

When original bills, receipts, prescriptions, reports and other documents are given to any other insurer or to the reimbursement provider, verified photocopies attested by such other insurer/reimbursement provider along with an original certificate of the extent of payment received from them needs to be submitted.

Note :

- Claim once paid under one Benefit cannot be paid again under any other Benefit.
- All invoices / bills should be in Insured Person's name.

4.5 Payment Terms

4.5.1. This Policy covers medical treatment taken within India, and payments under this Policy shall be made in Indian Rupees within India.

4.5.2. Claims shall not be admissible under this Policy unless the TPA/Company has been provided with the complete documentation / information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum unless the Policyholder / Insured Person have complied with the obligations under this Policy.

4.5.3. The Company shall not indemnify the Policyholder / Insured Person for any period of Hospitalization of less than 24 hours except for the Day Care Treatment, the list of which is annexed as per Annexure 1 (List of Day Care Treatments).

4.5.4. The Sum Insured of the Insured Person shall be reduced by the amount payable / paid under the Benefit(s) and the balance shall be available as the Sum Insured for the unexpired Policy Period.

4.5.5. For Cashless Claims, the payment shall be made to the Network Hospital / TPA whose discharge would be complete and final.

4.5.6. For the Reimbursement Claims, the TPA/Company will pay the Policyholder/Insured Person.

4.5.7. The Company will only be liable to pay for such Benefits for which the Policyholder has specifically claimed in the Claim Form.

5. Terms And Conditions

1. Duty of disclosure

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact

In the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a Claim being fraudulent or any fraudulent means or device being used by the Policyholder/ Insured Person or any one acting on his/ their behalf to obtain a benefit under this Policy, the Company may cancel this Policy at its sole discretion and the premium paid shall be forfeited in its favor.

2. Observance of Terms and Conditions

The due observance and fulfillment of the Policy Terms & Conditions and Endorsements of this Policy 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 any of the Company's liability to make any payment under this Policy.

3. Reasonable Care

The Policyholder/ Insured Person shall take all reasonable steps to safeguard the interests against any Illness / Injury that may give rise to a Claim.

4. Material Change

The Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation / business at his own expense and the Company may adjust the scope of cover and/or

premium, if necessary, accordingly.

5. Records to be maintained

The Policyholder/ Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representative(s) to inspect such records. The Policyholder/ Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period and up to three years after the policy expiration, or until final adjustment (if any) and resolution of all Claims 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 possession of the Company and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

7. Complete discharge

Payment made by the Company to the Policyholder/ adult Insured Person or the Nominee of the Policyholder or the legal representative of the Policyholder or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

8. Subrogation

Subrogation shall mean the right of the Company to assume the rights of the Insured Person/Policyholder to recover expenses paid out under the Policy that may be recovered from any other source

The Policyholder/ Insured Person shall at his own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and/or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which the Company is/or would become entitled upon the Company paying for a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after its payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at his own expense provide the Company with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and any costs and expenses incurred by the Company of effecting a recovery, where after the Company shall pay any balance remaining to the Policyholder. This clause shall not apply to any Benefit offered on fixed benefit basis.

9. Contribution

Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured.

If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company shall not be liable to pay or contribute more than its ratable proportion of any Claim.

This clause shall not apply to any Benefit offered on fixed benefit basis.

10. Fraudulent Claims

If a Claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a Claim, or if any fraudulent means or devices are used by the Policyholder / Insured Person or anyone acting on his/ their behalf to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to the Company by the Policyholder / all Insured Persons who shall be jointly liable for such repayment.

11. Policy Disputes

Any and all disputes or differences under or in relation to validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and subject to Indian law.

12. Renewal Notice

a. This Policy will automatically terminate at the end of the Policy Period. All renewal applications should reach the Company before the end of the Policy Period.

b. Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein prior mentioned and that nothing is known to the Policyholder/ Insured Person(s) that may result in enhancing the Company's risk.

c. This Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of this Policy

d. Renewal premium may vary.

13. Cancellation / Termination

- The Company may at any time, cancel this Policy on grounds as specified in Clause 1 of Terms and Conditions, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address.
- The Policyholder may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy by the Policyholder/ Insured Person.

  No refund of premium shall be made on Policy where premium is paid in installments.

Refund % to be applied on Policy Premium

Policy Tenure ->	1 year
Cancellation date up to (x months) from Policy Period Start Date	Refund
Up to 1 month	75.0%
Up to 3 months	50.0%
Up to 6 months	25.0%

14. Limitation Period

In no case whatsoever the Company shall be liable for any Claim under this Policy, if the requirement of Clause 4 above are not complied with, unless the Claim is the subject of pending action; it being expressly agreed and declared that if the Company shall disclaim liability for any Claim hereunder and such Claim shall not within 12 calendar months from the date of the disclaimer have been made the subject matter of a suit in court of law then the Claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

15. Communication

Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule. Any communication meant for the Policyholder will be sent by the Company to his last known address or the address as shown in the Policy Schedule.

All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule. Agents are not authorized to receive notices and declarations on the Company's behalf.

Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

16. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company.

17. Cause of Action

Claims shall be payable under this Policy only if the cause of action arises in India.

18. Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

19. Special Provisions

Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

20. Low Claim Ratio Discount (Bonus)

Low claim ratio discount at the following scale will be allowed on the total premium at renewal only depending upon the incurred claims ratio for the entire group insured under any Group Mediclaim Policy for the preceding 3 completed years excluding the year immediately preceding the date of renewal, Where the Group Mediclaim Insurance policy has not been in force for 3 completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

Incurred claims ratio under the Policy	Discount upto %
Not exceeding 60%	5
Not exceeding 50%	15
Not exceeding 40%	25
Not exceeding 30%	35
Not exceeding 25%	25.0%

21. High Claim Ratio Loading (Malus)

The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under any Group Mediclaim policy for the preceding

Incurred claims ratio under the Policy	Loading % upto
Between 80% and 100%	25
Between 101% and 125%	55
Between 126% and 150%	90
Between 151% and 175%	120
Between 176% and 200%	150
Over 200%	Cover to be reviewed

Incurred claims means claims paid plus claims outstanding at the end of the policy period minus the claims outstanding at the beginning of the policy period in respect of the entire group insured under the policy.

22. Withdrawal/Revision/Modification of the Product

The Company reserves the right to withdraw, revise or modify this product /policy in future. The revision/modification may be in respect of Benefits, coverage, premiums, policy terms and conditions &/or exclusions.

In the event of any such withdrawal of product/terms of policy, premium the company would give a 3 months notice in advance to the policyholder.

In the event of any revision or modification of the product the company will notify the policyholder in advance of such changes.

24. Payment of Interest

In case of delay of seven days or more in payment of claim after the acceptance by the insured, the Company will pay interest on the claim amount at a rate which is 2% above the bank rate for the period of delay

25. 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 independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto or if they cannot agree upon a single arbitrator within 30 days of

any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act,1996.

It is clearly agreed and understood that no difference or dispute shall be preferable 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.

26. Portability

Portability means transfer by an individual having health insurance Policy holder (including family cover) of the credit gained for pre-existing conditions and time bound exclusions if he/she chooses to switch from One Insurer to another.

Insured has a right to migrate from Group policy to an individual health insurance policy or a family floater policy with the same insurer provided he/she is covered under this policy as per portability guidelines.

Portability to any of our Individual Health Insurance products will be subject to applicable product features and prevailing Underwriting guidelines of the company.

27. Grievances

If the Policyholder has a grievance that the Policyholder wishes the Company to redress, the Policyholder may contact the Company with the details of his grievance through:

Website	:	https://reliancegeneral.co.in
e-mail	:	rgicl.services@relianceada.com
Telephone	:	1800-3009
Post/Courier	:	Any branch office, the correspondence address, during normal business hours
Write to us at (Correspondence Only)	:	Reliance General Insurance, Correspondence Unit, 301-302, Corporate House RNT Marg, Opp. Jhabua Tower, Indore, Madhya Pradesh, India – 452001

For further details on Grievance redressal procedure please refer: https://reliancegeneral.co.in/Insurance/About-Us/Grievance-Redressal.aspx

If the Policyholder is not satisfied with the Company's redressal of the Policyholder's grievance through one of the above methods, the Policyholder may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned below:

Address of the Ombudsman Offices
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@gbic.co.in
BENGALURU 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@gbic.co.in
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@gbic.co.in
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@gbic.co.in
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@gbic.co.in
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@gbic.co.in
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@gbic.co.in
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@gbic.co.in
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@gbic.co.in
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@gbic.co.in
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@gbic.co.in

Address of the Ombudsman Offices
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@gbic.co.in
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@gbic.co.in
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@gbic.co.in
PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna-800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@gbic.co.in
PUNE 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@gbic.co.in

The details of Insurance Ombudsman are available on IRDA website: www.irda.gov.in, on the website of General Insurance Council: www.gbic.co.in, the Company's website www.reliancegeneral.co.in or from any of the Company's offices. Address and contact number of Governing Body of Insurance Council –

(Monitoring Body for Offices of Insurance Ombudsman)
3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz(West), Mumbai – 400054, Tel: 022 - 26106889 / 671

Email id: inscoun@gbic.co.in

RGI/MCOM/CO/HL-01/GM-PW/Ver.1.2/010317

IRDAI Registration No. 103. UIN: IRDA/NL-HLT/RGI/P-H/V.I/317/13-14