Spectra Health Insurance Policy (SHIP)

Terms & Conditions

I. PREAMBLE

This Policy is a contract of insurance issued by UNITED INDIA INSURANCE COMPANY (hereinafter called the COMPANY) to the Proposer mentioned in the Schedule (hereinafter called the 'Policyholder') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The Policy is based on the statements and declaration provided in the Proposal Form by the Proposer and is subject to

i. The receipt of full premium,
ii. Disclosure to information norm including the information provided in the Proposal Form by the proposer on behalf of themselves and all persons to be Insured which is incorporated in the policy and is the basis of it; and
iii. The terms, conditions and exclusions of this Policy.

A. Operative Clause

If during the Policy Period the Insured Person(s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital /Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner/Mental Health Professional, the Company shall indemnify Medically Necessary, Reasonable and Customary Medical Expenses towards the Coverage mentioned hereunder, provided that the admission date of the hospitalisation due to illness or injury is within the policy period.

Provided further that, any amount payable under the Policy shall be subject to the terms of coverage (including any limits/sub limits), exclusions, conditions and definitions contained herein. The Company's maximum liability under all such Claims during each Policy Year shall be the Total Sum Insured opted and the applicable Cumulative Bonus, if any, as specified in the Schedule.

II. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy. Where the context so requires, references to the singular include references to the plural; reference to any gender includes all genders and reference to any statutory enactment includes subsequent changes to the same.

A. Standard Definitions

1. Accident

   means a sudden, unforeseen, and involuntary event caused by external, visible, and violent means.

2. Any One Illness

   will be deemed to mean a continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment has been taken.

3. AYUSH Day Care Centre

   means and includes Community Health Care Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered

AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner (s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the Insurance Company's authorized representative.

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:

i. Central or State Government AYUSH Hospital; or
ii. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
iii. 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 all 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 AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    d. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

5. AYUSH Treatment

refers to the hospitalisation treatment given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of Medicine.

6. Break in policy

means the period of a 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. Cashless Facility

means a facility extended by the insurer 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 by the insurer to the extent pre-authorization is approved.

8. Condition Precedent

shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

9. Congenital Anomaly

refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

Internal Congenital Anomaly – Congenital anomaly which is not in the visible and accessible parts of the body.

External Congenital Anomaly – Congenital anomaly which is in the visible and accessible parts of the body.

10. Co-Payment
means a cost sharing requirement under a health insurance policy that provides that the Policyholder/ Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

11. Cumulative Bonus
means any increase or addition in the Sum Insured granted by Us without an associated increase in premium.

12. Day Care Centre
means any institution established for day care treatment of illness and/or injuries or a medical set-up 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:
    i. Has qualified nursing staff under its employment;
    ii. Has qualified Medical Practitioner(s) in charge;
    iii. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
    iv. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

13. Day Care Treatment
means medical treatment, and/or surgical procedure which is:
    i. undertaken under general or local anesthesia in a hospital/Day Care Centre in less than twenty-four hours because of technological advancement, and
    ii. which would have otherwise required hospitalisation of more than twenty-four hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

14. 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 in case of Indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the Insurer. A deductible does not reduce the sum insured.

15. Dental Treatment
means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

16. Domiciliary Hospitalisation
means medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

    i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii. the patient takes treatment at home on account of the non-availability of room in a hospital.

17. Emergency Care
means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the Insured person's health.

18. 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.

19. Hospital/Nursing Home

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:

i. Has qualified nursing staff under its employment round the clock;
ii. Has at least 10 in-patient beds in towns having a population of less than 10 lakhs and at least 15 in-patient beds in all other places;
iii. Has qualified Medical Practitioner(s) in charge round the clock;
iv. Has a fully equipped Operation Theatre of its own where surgical procedures are carried out;
v. Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel

20. Hospitalisation

means admission in a Hospital/Nursing Home for a minimum period of 24 in-patient care consecutive hours except for the standard day care procedures/treatments as defined above, where such admission could be for a period of less than 24 consecutive hours.

21. Illness

means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

i. 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 the disease/ illness/ injury which leads to full recovery.
ii. Chronic Condition – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
    a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    b. it needs ongoing or long-term control or relief of symptoms
    c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    d. it continues indefinitely
    e. it recurs or is likely to recur.

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

23. 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.

24. Intensive Care Unit
means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

25. Intensive Care Unit (ICU) Charges
means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

26. Maternity Expenses
Means:
i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation);
ii. expenses towards lawful medical termination of pregnancy during the policy period.

27. Medical Advice
means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

28. 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.

29. Medically Necessary Treatment
means any treatment, tests, medication, or stay in hospital or part of a stay in 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.

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

and is acting within its scope and jurisdiction of license. The term Medical Practitioner would include Physician, Specialist and Surgeon.

31. 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.

32. Network Provider
means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

33. Non-Network Provider
means any hospital, day care Centre or other provider that is not part of the network.

34. Notification Of Claim
means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

35. Out-Patient (OPD) Treatment
means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

36. 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.

37. 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 the commencement of policy or its reinstatement.

38. Pre-Hospitalisation Medical Expenses
means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person 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 claim for such Hospitalisation is admissible by Us.

39. Post-Hospitalisation Medical Expenses
means medical expenses incurred during pre-defined number of days 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 claim for such Hospitalisation is admissible by Us.

40. Qualified Nurse
means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

41. Reasonable And Customary Charges
mean 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 illness/injury involved.

42. Renewal
means the terms on which the contract of insurance can be renewed on mutual consent with a provision of a grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

43. Room Rent
means the amount charged by a Hospital towards room and boarding expenses and shall include the Associated Medical Expenses.

44. 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 from suffering and prolongation of life, performed in a hospital or day care Centre by a medical practitioner.

45. Third-Party Administrator (TPA)
means a company registered with the IRDAI and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services as mentioned under the IRDAI (Third Party Administrators – Health Services) Regulations, 2016 and its amendment regulations as notified from time to time.

46. Unproven/Experimental Treatment
means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

B. Specific Definitions

1. Age
means completed age in years on the Policy Commencement Date.

2. Associated Medical Expenses
means hospitalisation-related expenses on Surgeon, Anesthetist, Medical Practitioner, Consultants and Specialist Fees (whether paid directly to the treating doctor/surgeon or to the hospital), Anesthetics, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances and such other similar expenses which vary based on the room category occupied by the Insured Person whilst undergoing treatment in a hospital. Such Associated Medical expenses do not include:

i. cost of pharmacy and consumables medicines
ii. cost of implants/medical devices
iii. cost of diagnostics

The scope of this definition is limited to admissible claims where a proportionate deduction is applicable.

3. Cancellation
   defines the terms on which the policy contract can be terminated either by the Insurer or the Insured person by giving sufficient notice to the other which is not lower than a period of seven days.

4. Clinical Psychologist
   means a person— (i) having a recognised qualification in Clinical Psychology from an institution approved and recognised, by the Rehabilitation Council of India, constituted under section 3 of the Rehabilitation Council of India Act, 1992 (34 of 1992); or (ii) having a Post-Graduate degree in Psychology or Clinical Psychology or Applied Psychology and a Master of Philosophy in Clinical Psychology or Medical and Social Psychology obtained after completion of a full time course of two years which includes supervised clinical training from any University recognised by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956) and approved and recognised by the Rehabilitation Council of India Act, 1992 (34 of 1992) or such recognised qualifications as may be prescribed.

5. Continuous Coverage
   means uninterrupted coverage of the Insured Person under the Health Insurance Policy from the date of inception of policy for the first time as mentioned in the policy schedule. However, for the purpose of applying waiting periods, the break in insurance period for which the premium was not received shall be excluded from it.

6. Epidemic
   means the occurrence of more cases of a disease than would be expected in a community or region spreading rapidly during a given time period; and declared as such by the appropriate Government Authority in India.

7. Family
   means the persons named in the Policy Schedule who are the Insured Person, his/her legal spouse, Children, Parents, Parents-in-law, or Siblings.

8. Insured Person
   means person(s) named in the schedule of the Policy.

9. Lending Partner
   shall mean an entity engaged in the business of providing credit facilities, such as Non-Banking Financial Companies (NBFCs), to the proposers of insurance, for payment of Premium for availing health insurance cover.

10. Letter to the insurer
    means a digitally authenticated or signed declaration by the Proposer or Policyholder at the time of purchasing or renewing the policy, availing the service of *Premium Financing* through the Lending Partner, containing his/her instructions on cancellation of the Policy and refund of premium.

11. Material Fact
    means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take an informed decision in the context of underwriting the risk.

12. Mental Illness
    means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary

demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, especially characterised by subnormality of intelligence.

13. Mental Health Professional
means— (i) a psychiatrist (ii) a professional registered with the concerned State Authority or (iii) a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam or (iv) a clinical psychologist.

14. Nominee
means the person named in the Policy Schedule, Policy certificate and/or endorsement (if any) who is nominated by the Policy Holder/Insured Person, to receive the benefits under this Policy as per the terms of the Policy if the Insured Person deceases.

15. Organ Donor
means any person whose organ has been made available in accordance and compliance with The Transplantation of Human Organs (Amendment) Act, 1994 and relevant rules and amendments thereof. The donated organ must be for the use of the Insured Person.

16. Pandemic
means an epidemic of disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of people; and declared as such by the appropriate Government Authority in India

17. Policy
means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to and/or forming part thereof. The Policy contains details of the benefits, exclusions, and applicable terms & conditions.

18. Policy Period
means the period for which this policy is taken and is in force as specified in the Schedule.

19. Preferred Provider Network (PPN):
means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the Insured Person. The updated list of network providers/PPN is available on our website (https://uiic.co.in/en/tpa-ppn-network-hospitals) and the website of the TPA mentioned in the schedule and is subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

20. Proposal Form
means the form to be filled in by the prospect in written or electronic or any other format as requested by the Company and approved by the IRDAI, for furnishing all material information as required by the Insurer, to:

i. Enable the Insurer to take an informed decision in the context of underwriting the risk
ii. And in the event of acceptance of the risk, to determine the rates, benefits, terms and conditions of the cover to be granted.

21. Psychiatrist
means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956), or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956 (102 of 1956), or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act.

22. Single Occupancy Standard Air-Conditioned Room
means an individual air-conditioned room for accommodating a single patient with attached wash room. This room may have a television, telephone, and a couch. Such room must be the most economical of all such air-conditioned accommodations available in that hospital as single occupancy. This does not include deluxe room / suite or room with additional facilities other than those stated herein.

23. Sub-Limit
means a cost sharing requirement under a health insurance policy in which an Insurer would not be liable to pay any amount in excess of the pre-defined limit.

24. Sum Insured
means the pre-defined limit specified in the Policy Schedule.

25. Total Sum Insured
means the aggregate limit of Indemnity which consists of the Sum Insured and Cumulative Bonus (if any). It represents Our maximum, total, and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person(s) (on Individual Sum Insured basis) or for all Insured Persons (on Family Floater Sum Insured basis) during the policy period.

26. Waiting Period
means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

27. We/Our/Us/Company/Insurer
means **United India Insurance Company Limited.**

28. You/Your
means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one person covered in the policy) in the Schedule.

III. BENEFITS COVERED

The coverages available under this Policy are described below:

A. Base Covers

The Policy provides base coverage as described below in this section provided that the expenses are incurred on the written Medical Advice of a Medical Practitioner/Mental Health Professional (in case of mental illness) and are incurred on Medically Necessary Treatment of the Insured Person.

1. In-patient Hospitalisation Expenses Cover

i. Room, Boarding and Nursing expenses (all inclusive) incurred as provided by the Hospital/Nursing Home up to the limits provided below:

Sum Insured	**Limit (Rs.) per day**
< Rs. 5 Lakhs	1% of Sum Insured
Rs. 5 Lakhs and Above	1% of Sum Insured or Single Occupancy Standard AC Room Charges whichever is higher

These expenses will include nursing care, RMO charges, patient's diet charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

ii. Charges for accommodation in Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) up to the limits provided below:

Sum Insured	**Limit (Rs.) per day**
< Rs. 5 Lakhs	2% of Sum Insured
Rs. 5 Lakhs and Above	Actuals

iii. The fees charged by the Medical Practitioner, Surgeon, Specialists, Consultants and Anesthetists treating the Insured Person.

iv. Operation theatre charges;

v. Expenses incurred for Anesthetics, Blood, Oxygen, Surgical Appliances and/or Medical Appliances; Medicines and Drugs, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory/ diagnostic tests, X-Ray, Dialysis and such other similar medical expenses related to the treatment.

vi. All day care treatments as per definition in Clause II.A.13 are covered.

1.1. Note

i. PROPORTIONATE PAYMENT CLAUSE: In case of admission to a room at rates exceeding the aforesaid limits in Clause III.A.1.i, the reimbursement/payment of all associated medical expenses incurred at the Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent.
Proportionate Deductions shall not be applied in respect of those hospitals where differential billing is not followed or for those expenses where differential billing is not adopted based on the room category.

ii. No payment shall be made under clause III.A.1.iii other than as part of the hospitalisation bill. However, the bills raised by Surgeon, Anesthetist directly and not forming part of the hospital bill shall be paid provided a pre-numbered bill/receipt is produced in support thereof, when such payment is made ONLY by cheque/ credit card/debit card or digital/online transfer.

1.2. Sub-limit:

Surgery / Disease	**Maximum Limits**
Cataract	10% of S.I or 50,000 per eye

2. Pre-Hospitalisation and Post-Hospitalisation Expenses –

We will cover, on a reimbursement basis, the Insured Person's

i. Pre-hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 30 days prior to hospitalisation; and
ii. Post- hospitalisation Medical Expenses incurred due to an Illness or Injury during the period up to 60 days after the discharge from the hospital,

Subject to a maximum of 10% of Sum Insured for Pre- and Post-Hospitalisation combined, provided that:

a. We have accepted a claim for primary In-patient Hospitalisation under Clause III.A.1 above.
b. The Pre-hospitalisation and Post-hospitalisation Medical Expenses are related to the same Illness or Injury.
c. Home Care Treatment also will be deemed as hospitalisation for this cover.

3. Donor Expenses Cover

We will cover the In-patient Hospitalisation Medical Expenses incurred for an organ donor's treatment during the Policy Period for the harvesting of the organ donated provided that:

i. The donation conforms to The Transplantation of Human Organs Act 1994 and the organ is for the use of the Insured Person;
ii. We have admitted a claim towards In-patient Hospitalisation under Clause III.A.1 and it is related to the same condition; organ donated is for the use of the Insured Person as certified in writing by a Medical Practitioner;
iii. We will not cover:
    a. Pre-hospitalisation Medical Expenses or Post-hospitalisation Medical Expenses of the organ donor;
    b. Screening expenses of the organ donor;
    c. Costs directly or indirectly associated with the acquisition of the donor's organ;
    d. Transplant of any organ/tissue where the transplant is experimental or investigational;
    e. Expenses related to organ transportation or preservation;
    f. Any other medical treatment or complication in respect of the donor, consequent to harvesting.

4. Modern Treatment Methods & Advancement in Technologies:

In case of an admissible claim under Clause III.A.1, expenses incurred on the following procedures (wherever medically indicated) shall be covered.

i. Uterine Artery Embolization and HIFU (High Intensity focused ultrasound)
ii. Balloon Sinuplasty
iii. Deep Brain Stimulation
iv. Oral Chemotherapy
v. Immunotherapy - Monoclonal Antibody to be given as an injection
vi. Intra-vitreal injections
vii. Robotic Surgeries
viii. Stereotactic Radio Surgeries
ix. Bronchial Thermoplasty
x. Vaporization of the Prostrate (Green Laser Treatment or Holmium Laser Treatment)
xi. IONM - (Intra Operative Neuro Monitoring)
xii. Stem Cell Therapy; Hematopoietic stem cells for bone marrow transplant for hematological conditions to be covered

5. Home care Treatment

We will indemnify the Reasonable and Customary Charges for Home Care Treatment for any epidemic/ pandemic subject to a maximum of 10% of Sum Insured or Rs. 30, 000 per person per policy period, whichever is lower.

Home Care Treatment means Treatment availed by the Insured Person at home for any epidemic/ pandemic on positive diagnosis of the epidemic/ pandemic in a Government authorised diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:

i. The Medical Practitioner advises the Insured Person to undergo treatment at home
ii. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day throughout the duration of the home care treatment
iii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.
iv. In case the insured intends to avail the services of non-network provider claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.

In this benefit, the following shall be covered if prescribed by the treating Medical Practitioner and is related to treatment of epidemic/ pandemic,

a. Diagnostic tests undergone at home or at diagnostics centre
b. Medicines prescribed in writing
c. Consultation charges of the medical practitioner
d. Nursing charges related to medical staff
e. Medical procedures limited to parenteral administration of medicines
f. Cost of Pulse oximeter, Nebulizer and Rental cost for Oxygen cylinder, oxygen concentrator, if needed

6. Road Ambulance Cover

We will cover the costs incurred up to:

i. Rs. 2,500 per event and
ii. Rs. 5,000 per policy period

on transportation of the Insured Person by road Ambulance to a Hospital for treatment in an Emergency following an Illness or Injury which occurs during the Policy Period. The necessity of use of an Ambulance must be certified by the treating Medical Practitioner and becomes payable if a claim has been admitted under Clause III.A.1 and the expenses are related to the same Illness or Injury.

We will also cover the costs incurred on transportation of the Insured Person by road Ambulance in the following circumstances up to the limits specified above under this cover, if:

a. it is medically required to transfer the Insured Person to another Hospital or diagnostic Centre during the course of Hospitalisation for advanced diagnostic treatment in circumstances where such facility is not available in the existing Hospital;
b. it is medically required to transfer the Insured Person to another Hospital during the course of Hospitalisation due to lack of super specialty treatment in the existing Hospital.

7. Cost of Health Check-up

Expenses incurred towards cost of health check-up up to 1% of average Sum Insured of preceding 3 policy years, subject to a maximum of Rs. 5,000 per person for policies issued on individual sum insured basis/ Rs. 10,000 per policy period for policies issued on family floater basis for a block of every three claim-free years provided the health check-up is done at

hospitals/diagnostic Centre authorised by us within a year from the date when it got due and the policy is in force. Payment under this benefit does not reduce the Total Sum Insured.
In case of the policy on family floater Sum Insured basis, if a claim is made by any of the Insured Persons, the health check-up benefits will not be available under the policy.
Note: Payment of expenses towards cost of health check-up will not prejudice the company's right to deal with a claim in case of non-disclosure of material fact and /or Pre-Existing Diseases in terms of the policy.

B. Optional Cover

1. Daily Cash Allowance on Hospitalisation

We will pay Daily Cash Allowance to the Insured Person for every continuous and completed period of 24 hours of Hospitalisation, subject to the hospitalisation claim being admissible under the policy, as per the table below:

Sum Insured	Limit (Rs.) per day
Up to Rs. 5 Lakhs	Rs. 500 per day subject to a maximum of Rs. 5,000 per policy period
Above Rs. 5 Lakhs and up to Rs. 15 Lakhs	Rs. 1,000 per day subject to a maximum of Rs. 10,000 per policy period
Above Rs. 15 Lakhs	Rs. 2,000 per day subject to a maximum of Rs. 20,000 per policy period

The aggregate of Daily Cash Allowance during the policy period shall not exceed 'per policy period limits' as mentioned in the table above.
Daily Cash Allowance will not be payable for Day Care Treatment claims. Deductible equivalent to Daily Cash Allowance for the first 24 hours Hospitalisation will be levied on each Hospitalisation during the Policy Period.
Payment under this benefit does not reduce the Total Sum Insured

IV. EXCLUSIONS

A. Waiting Periods

The Company shall not be liable to make any payment under the policy in connection with or in respect of the following expenses till the expiry of waiting period mentioned below:

1. Pre-Existing Diseases (Code – Excl01)

i. Expenses related to the treatment of a disclosed pre-existing disease (PED) disclosed by the insured person and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
ii. In case of enhancement of the Sum Insured, the exclusion shall apply afresh to the extent of the Sum Insured increase.
iii. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Insurance Products) Regulations, then the waiting period for the same would be reduced to the extent of prior coverage.
iv. Coverage under the policy after the expiry of 36months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. Specified Disease/Procedure Waiting Period (Code – Excl02)

i. Expenses related to the treatment of the listed Conditions, surgeries/treatments as per Table A and Table B below shall be excluded until the expiry of 24 months and 36 months respectively 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.

ii. In case of enhancement of the sum insured the exclusion shall apply afresh to the extent of the sum insured increase.
iii. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.
iv. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
v. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then the waiting period for the same would be reduced to the extent of prior coverage.
vi. List of specific diseases/procedures:

Table A. 24 months waiting period

All internal and external benign tumours, cysts (including Polycystic ovarian disease), polyps of any kind, including benign breast lumps	Amyotropic lateral sclerosis
All type of transplant and related surgeries, including Hematopoietic stem cell transplantation	Calculus diseases
All Neurodegenerative disorders	Disease related to thyroid excluding malignancy
Benign Prostatic hyperplasia	Cataract and diseases of the anterior and posterior chamber of the Eye, correction of refractive index,
Benign ENT disorders including Sinusitis	Gastric/ Duodenal Ulcer
Cardiac surgeries	Mastoidectomy
Chronic obstructive pulmonary disease	Hernia of all types
Connective tissue disorders	Piles (Haemorrhoids), Fissures and Fistula in anus, Pilonidal sinus, Rectal prolapse
Gout and Rheumatism, Non infective arthritis	Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident,
Internal Congenital Disorders	Skin diseases
Liver Cirrhosis- NASH	Sleep Apnoea Syndrome
Morbid Obesity and its complications	Surgery of gall bladder and bile duct excluding malignancy
Renal Failure	Autoimmune Disorders
Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders	Menopause related Disorders excluding malignancy
Tympanoplasty	Treatment for Menorrhagia/Fibromyoma, Myoma and Prolapsed uterus

Varicose veins and Varicose ulcers

Table B. 36 months waiting period

Joint Replacement due to Degenerative condition, unless necessitated due to an accident.
Age-related Osteoarthritis & Osteoporosis
Age-related Macular Degeneration (ARMD)

3. 30-Day Waiting Period (Code – Excl03)

i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within-referred waiting period is made applicable to the enhanced sum insured in the event of granting a higher sum insured subsequently.

B. Standard Permanent Exclusions

The Company shall not be liable to make any payment under the policy in connection with or in respect of the following expenses till the expiry of waiting period mentioned below:

4. Investigation & Evaluation (Code – Excl04)

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.

5. Rest Cure, Rehabilitation and Respite Care (Code – Excl05)

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

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, and moving around either by skilled nurses or assistants or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. 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:
    b.1 Obesity-related cardiomyopathy
    b.2. Coronary heart disease

b.3 Severe Sleep Apnea
b.4. Uncontrolled Type2 Diabetes

7. Change-of-Gender treatments (Code – Excl07)
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
8. 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.
9. Hazardous or Adventure Sports (Code – Excl09)
   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
10. 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.
11. Excluded Providers (Code – Excl11)
    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed on 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.
12. (Code – Excl12)
    Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
13. (Code – Excl13)
    Treatments received in health 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.
14. (Code – Excl14)
    Dietary supplements and substances that can be purchased without a prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of a hospitalisation claim or day care procedure.
15. Refractive Error (Code – Excl15)
    Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.
16. 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.
17. 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

18. Maternity (Code- Excl18)

i Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
ii Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

C. Specific Permanent Exclusions

1. All expenses caused by or arising from or attributable to foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped power.
2. All Illnesses/expenses caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or any nuclear waste from the combustion of nuclear fuel, nuclear/chemical/biological attack.
3. Any expenses incurred on Domiciliary Hospitalisation .
4. Any expense incurred on multi-focal or toric lenses during cataract or any other eye-related surgery, except to the extent of the cost of a unifocal lens.
5. Any expenses incurred on out-patient treatment (OPD treatment). Procedures/treatments usually done in out-patient department are not payable under the policy even if admitted/converted as an in-patient in the hospital for more than 24 hours.
6. Any item(s) or treatment specified in 'List of Non-Medical Expenses under this Policy' as per clauses in Annexure – 1, unless specifically covered under the Policy.
7. Any treatment related to sleep disorder or Sleep Apnoea Syndrome.
8. Artificial life maintenance including life support machine use, from the date of confirmation by the treating doctor that the patient is in a vegetative state.
9. Change of treatment from one system of medicine to another system unless recommended by the consultant/hospital under whom the treatment is taken.
10. Circumcision, unless necessary for the Treatment of an Illness or Injury not excluded hereunder or due to an Accident.
11. Congenital External Diseases or Defects or anomalies.
12. Cost of hearing aids.
13. Cost of routine medical examination and preventive health check-up unless as provided for in clause III.A.7.
14. Dental treatment or surgery of any kind unless necessitated by disease or accident and requiring hospitalisation.
15. External and or durable Medical/ Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support including instruments used in treatment of sleep apnoea syndrome; Infusion pump, Oxygen concentrator, Ambulatory devices, subcutaneous insulin pump and also any medical equipment, which are subsequently

used at home. This is an indicative list. Please refer to clauses in Annexure-1 for the complete list of non-payable items.

16. Intentional self-inflicted Injury or attempted suicide.
17. Routine eye-examination expenses, cost of spectacles, contact lenses, including optometric therapy.
18. Stem cell implantation/Surgery/Therapy, harvesting, storage or any kind of treatment using stem cells except Hematopoietic stem cells for bone marrow transplant for haematological conditions; growth hormone therapy.
19. Treatments including Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy, chondrocyte or osteocyte implantation, procedures using platelet rich plasma, Trans Cutaneous Electric Nerve Stimulation; Use of oral immunomodulatory/ supplemental drugs.
20. Unless used intra-operatively, any expenses incurred on prosthesis, corrective devices;
21. Vaccinations or inoculations of any kind, except when required as part of hospitalisation or a daycare procedure for treatment following an animal bite.
22. In respect of the existing condition(s)/disease(s), disclosed by the insured and mentioned in the policy schedule (based on insured's consent), Insured Person is not entitled to get the coverage for specified medical condition and its complications.

V. GENERAL TERMS AND CLAUSES

A. Standard Terms and Clauses

1. Cancellation

i. The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall refund proportionate premium for unexpired policy period, if there is no claim (s) reported during the policy period.

ii. The Company may cancel the policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

2. Claim Settlement (provision for Penal Interest)

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

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

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

v. "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBl) at the beginning of the financial year in which claim has fallen due.

3. Complete Discharge

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

4. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

5. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

6. Fraud

If any claim made by the Insured Person is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/ Policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance policy:

i. the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
ii. the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
iii. any other act fitted to deceive; and
iv. any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the claim and/ or forfeit the policy benefits on the ground of fraud, if the Insured Person/Beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

7. Free Look Period

i. The free look period shall be applicable on new Spectra Health Insurance Policy and not on renewals or at the time of porting/migrating the policy. The Insured Person shall be allowed free look period of 30days from date of receipt of the policy document, whether received electronically or otherwise, to review the terms and conditions of the policy and to return the same if not acceptable.
ii. If the Insured has not made any claim during the free look period, the insured 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.

8. Migration

The Insured Person will be provided a facility to migrate the policy (including all members) to other health insurance products/plans offered by the company. 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 will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

9. Moratorium Period

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

10. Multiple Policies

i. In case of multiple policies taken by an Insured Person during a period from one or more Insurers to indemnify treatment costs, the Insured Person can file for claim settlement as per his/her choice under any policy. The Insurer of that chosen policy shall be treated as the primary Insurer.
ii. In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, provided a written request for same has been submitted by the Insured Person.

11. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the policy is made. ln the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

12. Portability

The Insured Person will be provided facility 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, 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 will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

13. Possibility of Revision of Terms of the Policy including the Premium Rates

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

14. Redressal of Grievance

In case of any grievance, the Insured Person may contact the company through:

- Website : www.uiic.co.in
- Toll free : 1800 425 333 33
- E-mail : customercare@uiic.co.in
- Courier : Customer Care Department, Head Office,
  United India Insurance Co. Ltd.,
  24, Whites Road, Chennai, Tamil Nadu- 600014

The insured person may also approach the grievance cell at any of the Company's branches with the details of the grievance. If Insured Person is not satisfied with the redressal of the grievance through one of the above methods, the insured Person may contact the grievance officer at customercare@uiic.co.in.

- For updated details of grievance officer, kindly refer the link
- https//uiic.co.in/en/customercare/grievance.
- If an Insured Person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the Office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017 and its amended from time to time. The contact details of the Insurance Ombudsman offices have been provided as Annexure-2.
- Grievance may also be lodged at IRDAI Integrated Grievance Management System: https://bimabharosa.irdai.gov.in/

15. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, non-disclosure or misrepresentation by the Insured Person.

i. The Company will give notice for renewal.
ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured.
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 except when premium is paid in instalments
vi. No loading shall apply on renewals based on individual claims experience.

16. Premium Payment in Installment

If the insured person has opted for payment of premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (not withstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy if the premium is paid as monthly installments. For other installment basis, the grace period will be 30 days.
ii. During such grace period, coverage will be available.

iii. The Benefits provided under – "Waiting Periods", "Specific Waiting Periods" clause shall continue in the event of payment of premium within the stipulated grace period.
iv. No interest will be charged if the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace period, the Policy will get cancelled.
vi. In the event of a claim, all subsequent premium installment shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

17. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Policyholders about the same 90 days prior to expiry of the policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

B. Specific Terms and Clauses

1. Automatic change in Coverage under the Policy

The coverage for the Insured Person(s) shall automatically terminate:

i. In the case of his/her/their (Insured Person(s)) demise;

However, the cover shall continue for the remaining Insured Persons till the end of the Policy Period. The other Insured Person(s) may also apply to renew the policy. In case, the other Insured Person(s) is/are minor, the policy shall be renewed only through any one of his/her/their natural guardian or a guardian appointed by the court. All relevant particulars in respect of such person(s) (including his/her/their relationship with the Insured Person(s)) must be submitted to the company along with the application. Provided no claim has been made, and termination takes place on account of death of the Insured Person(s), pro-rata refund of premium of the deceased Insured Person(s) for the balance period of the policy will be effective.

ii. Upon exhaustion of Total Sum Insured for the policy period. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

2. Basis of Insurance

i. This policy is issued based on the truth and accuracy of statements in the Proposal.
ii. This policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of fraud, misrepresentation or misdescription or non-disclosure of any material fact.
iii. The Proposal Form, Pre-acceptance Health check-up report (if carried out) and the Policy issued shall constitute complete contract of insurance.

3. Change of Sum Insured

i. The Insured can apply for change of Sum Insured at the time of renewal, by submitting a fresh proposal form/written request to the company.
ii. Any request for enhancement of Sum Insured must be accompanied by a declaration that the Insured or any other Insured Person(s) in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. The Company may require such Insured Person/s to undergo a medical

examination to enable the Company to take a decision on accepting the request for enhancement in the Sum Insured.

iii. The acceptance of enhancement of Sum Insured would be at the discretion of the company, subject to underwriting, based on the health condition of the Insured Persons & claim history of the policy.

iv. All waiting periods as defined in the Policy shall apply for the incremental portion of the Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy with the Company.

4. Claim Procedure

i. Notification of Claim

Upon the happening of any event which may give rise to a claim under this Policy, the Insured Person/Insured Person's representative shall notify the TPA/company in writing providing all relevant information relating to claim including plan of treatment, policy number etc. within the prescribed time limit as under:

a. Within 24 hours from the date of emergency hospitalisation required or before the Insured Person's discharge from Hospital, whichever is earlier.
b. At least 48 hours prior to admission in Hospital in case of a planned Hospitalisation.

ii. Procedure for Cashless Claims

a. Cashless facility for treatment taken in a hospital is subject to pre-authorization by the TPA.
b. Treatment may be taken in a network provider/PPN hospital and is subject to pre authorization by the TPA. Booklet containing list of network provider/PPN hospitals shall be provided by the TPA. Updated list of network provider/PPN is available on website of the company and the TPA mentioned in the schedule.
c. The customer may call the TPA's toll free phone number provided in the policy copy/on the health ID card for intimation of claim and related assistance. Please keep the ID number handy for easy reference.
d. On admission in the network provider/PPN hospital, please produce the ID card issued by the TPA at the Hospital Helpdesk. Cashless request form available with the network provider/PPN and TPA shall be filled and submitted to the TPA for authorization.
e. The TPA upon getting cashless request form and related medical information from the Insured Person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification.
f. At the time of discharge, the Insured Person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.
g. The TPA reserves the right to deny pre-authorization in case the Insured Person is unable to provide the relevant medical details.
h. Denial of a Pre-authorization request is in no way to be construed as denial of treatment or denial of coverage. The Insured Person may get the treatment as per treating doctor's advice and submit the claim documents to the TPA for possible reimbursement.

iii. Procedure for reimbursement of Claims

a. In non-network hospitals payment must be made up-front and for reimbursement of claims the Insured Person may submit the necessary documents to TPA/company within the prescribed time limit.
b. Claims for Pre- and Post-Hospitalisation will be settled on reimbursement basis on production of relevant claim papers and cash receipts within the prescribed time limit.

c. Claims for Cost of Health Check-up will be settled on reimbursement basis on production of test reports and cash receipts within the prescribed time limit.

iv. Documents

The claim is to be supported with the following original documents and submitted within the prescribed time limit:

a. Duly completed claim form
b. Attending medical practitioner's / surgeon's certificate regarding diagnosis/ nature of operation performed, along with date of diagnosis, advise for admission, investigation test reports etc. supported by the prescription from attending medical practitioner.
c. Medical history of the patient as recorded, bills (including break up of charges) and payment receipts duly supported by the prescription from attending medical practitioner/ hospital.
d. Discharge certificate/ summary from the hospital.
e. Cash-memos from the Diagnostic Centre(s)/ hospital(s)/ chemist(s) supported by proper prescription.
f. Payment receipts from doctors, surgeons and anesthetists.
g. Bills, receipts, Stickers of the Implants.
h. Any other document required by company/ TPA

Note: In the event of a claim lodged as per Settlement under multiple policies clause and the original documents having been submitted to the other Insurer, the company may accept the duly certified documents listed under Clause V.B.4.iv and claim settlement advice duly certified by the other Insurer subject to satisfaction of the company.

v. Time Limit for submission of documents

Type of Claim	Time Limit for submission of documents to company/TPA
Reimbursement of hospitalisation, daycare and pre-hospitalisation expenses	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses	Within 15 (fifteen) days from completion of post-hospitalisation treatment.
Reimbursement of Cost of Health Check-up	Within 15 (fifteen) days from Health Check-up

Notes:

a. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
b. Waiver of clause V.B.4.v may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time-limit.
c. The Insured Person shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim including an authorisation to obtain Medical and other records from the hospital, lab, etc.
d. All the documents submitted to TPA shall be electronically collected by us for settlement/denial of the claims by the appropriate authority.

e. Any medical practitioner or Authorised Person authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease leading to Hospitalisation if so required.

5. Co-Payment

For persons with age of entry above 60 years in Spectra Health Insurance Policy, every admissible claim under *Clause III.A.1-III.A.6* shall be subject to a Co-payment of 10% on the admissible claim amount.

6. Endorsements (Changes in Policy)

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the Company. Any change made by the Company shall be evidenced by a written endorsement signed and stamped.

7. Limitation of Liability

If a claim is rejected and is not the subject of any pending suit or other proceeding within twelve months from the date of such rejection, the claim shall be deemed to have been abandoned. Our liability shall be extinguished and the claim shall not be recoverable thereafter.

8. Notice & Communication

i. Any notice, direction, instruction, or other communication related to the Policy must be made in writing.
ii. All communications related to claims, ID cards, or PPN/network providers should be directed to the TPA at the contact details provided in the Policy Schedule.
iii. The Insured must notify the policy issuing office in writing of any material changes, such as changes in occupation, address, nominee, or choice of No Claims Reward, during the policy period or at the time of policy renewal, as applicable.
iv. The Company or TPA will communicate with the Insured Person at the address mentioned in the Policy Schedule.
v. No insurance agents, brokers, or any other persons or entities are authorized to receive any notice on behalf of Us unless explicitly stated in writing by Us.
vi. No waiver of any terms, provisions, conditions, or endorsements of this Policy shall be valid unless made in writing and signed by an authorized official of the Company.

9. Policy cancellation for Premium payment through Lending Partner

If the premium tendered/paid towards the policy has been financed through a Lending Partner, and the policy is cancelled by invocation of the terms stated by the policy holder in the "*Letter* to the Insurer" or If the refund of premium is due for any reason whatsoever, the refund will be effected to the *a*ccount which is mentioned by the policy holder in the "Letter to the Insurer" submitted by the policy holder.

10. Services offered by TPA

Servicing of claims i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims, as per the terms and conditions of the policy.

The services offered by a TPA shall not include:

a. Claim settlement and claim rejection;
b. Any services directly to any Insured Person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

11. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the policy shall be determined by the Indian court and according to Indian law.

12. Territorial Limit

The geographical scope of this Policy applies to events limited to India. All medical treatment for the purpose of this insurance will have to be taken in India only and all admitted or payable claims shall be settled in India in Indian currency only.

VI. OTHER TERMS AND CONDITIONS

1. Discounts, Loadings and No Claim Rewards

i. No Claim Rewards

The Insured Person(s) shall be eligible for a No Claim Reward if no claim is reported under the expiring policy and the policy is renewed with Us without any break in policy. The No Claim Reward may either be a No Claim Discount (NCD), calculated as a percentage of the renewal premium, or a Cumulative Bonus (CB), calculated as a percentage of the expiring policy's Sum Insured. There are a maximum of 2 slabs of NCR, with each slab representing one claim-free year.

If no claim is reported, the Policyholder must choose one of the following options at the time of renewal. If no choice is explicitly made as per clause V.B.8, the option selected in the expiring policy will be deemed chosen. If the option to choose an NCR is not exercised at the first renewal, the policyholder will automatically be entitled to the Cumulative Bonus.

a. No Claim Discount (NCD):

The Insured Person(s) shall receive a 2.5% discount on the renewal premium for each slab, up to a maximum of 5%.

b. Cumulative Bonus (CB):

The Cumulative Bonus shall increase by 10% for each slab, up to a maximum of 20% of the Sum Insured under the current policy year.

Notes on Cumulative Bonus (CB):

i. If the Insured Person(s) were covered under the expiring policy on an Individual Sum Insured Basis and had accumulated a CB, but renew on a Floater Sum Insured Basis, only the lowest CB slab among the insured persons will be carried forward in the renewed policy.
ii. If the Insured Person(s) covered under a floater policy with an accumulated CB choose to split the policy into two or more floater or individual policies upon renewal, the CB from the expiring policy will be apportioned among the renewed policies in proportion to their respective Sum Insured.
iii. If there is an enhancement of Sum Insured at the time of renewal, the CB will be calculated on the Sum Insured from the last completed policy year.
iv. If the Sum Insured is reduced at the time of renewal, the CB will be reduced in the same proportion as the decrease in the Sum Insured in the current policy.

Notes on No Claim Rewards (NCR):

i. If a claim is reported in any particular year, the NCR accrued shall be reduced at the same rate at which it has accrued.

ii. Where the policy is on individual sum insured basis, the NCR shall be available to each insured person separately. If a claim is reported, the NCR will reduce by one slab as it was accrued for that person only.
iii. Where the policy is on floater sum insured basis, the NCR shall be available for the entire family. If a claim is reported from any insured person, the NCR will reduce by one slab as it was accrued for the entire family.
iv. If the policyholder opts to switch from the No Claim Discount (NCD) to the Cumulative Bonus (CB) or vice versa at the time of renewal, the premium and sum insured shall be suitably adjusted to ensure that the policyholder gets the benefit of either of the options only.
v. If a claim is reported in the expiring policy and notified to us after acceptance of the renewal premium, applicable No Claim Rewards will be adjusted accordingly.

ii. Family Discount

In case of policies issued on Individual Sum Insured Basis, 5% family discount will be allowed if more than one person of a family is covered.

iii. Floater Discount

If the policy is issued on Family Floater Sum Insured basis, a Family Floater Discount will be allowed based on the family composition.

iv. Direct Channel Discount

A discount is applicable for fresh policies purchased online through the Company's website or directly from United India's office, without any agent or an intermediary.

For renewals, the discount shall be offered provided that both the renewing policy and expiring policy are without any agent or an intermediary.

v. Underwriting Loading for Pre-existing Conditions

We may apply a risk loading on the premium payable (excluding statutory levies and taxes) based on your health status if accepted at the time of underwriting. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s).
The loadings are applicable on individual ailments only. In case of loading on two or more ailments, the loadings shall apply in conjunction on additive basis.

Note: The application of loading does not mean that the illness/ condition, for which loading has been applied, would be covered from inception. Any waiting period as mentioned above in Clause IV.A.1 shall be applied on illness/condition, as applicable.

2. IRDAI Regulations

This policy is subject to Provisions of Insurance Act, 1938, IRDAI (Insurance Products) Regulations 2024 and IRDAI (Protection of Policyholders' Interest) Regulations 2024 as amended from time to time.

ANNEXURE – 1

List of Non-Medical Expenses under this Policy:

- List I – Optional Items - Indicated whether payable or not under the Policy
- List II – Items that are to be subsumed into Room Charges
- List III – Items that are to be subsumed into Procedure Charges
- List IV – Items that are to be subsumed into costs of treatment

List 1		
1	Baby Food	Not Payable
2	Baby Utilities Charges	Not Payable
3	Beauty Services	Not Payable
4	Belts/ Braces	Payable for cases who have undergone surgery of thoracic or lumbar spine.
5	Buds	Not Payable
6	Cold Pack/Hot Pack	Not Payable
7	Carry Bags	Not Payable
8	Email / Internet Charges	Not Payable
9	Food Charges (Other Than Patient's Diet Provided By Hospital)	Not Payable
10	Leggings	Payable in case of varicose vein surgery
11	Laundry Charges	Not Payable
12	Mineral Water	Not Payable
13	Sanitary Pad	Not Payable
14	Telephone Charges	Not Payable
15	Guest Services	Not Payable
16	Crepe Bandage	Not Payable
17	Diaper Of Any Type	Not Payable
18	Eyelet Collar	Not Payable
19	Slings	Reasonable costs for one sling in case of upper arm fractures is payable
20	Blood Grouping and Cross Matching Of Donors Samples	Part of Cost of Blood, not payable
21	Service Charges Where Nursing Charge Also Charged	Part of room charge not payable separately
22	Television Charges	Payable under room charges not if separately levied
23	Surcharges	Part of Room Charge, not payable separately
24	Attendant Charges	Not Payable - Part of Room Charges
25	Extra Diet of Patient (Other Than That Which Forms Part Of Bed Charge)	Not Payable
26	Birth Certificate	Not Payable
27	Certificate Charges	Not Payable
28	Courier Charges	Not Payable
29	Conveyance Charges	Not Payable
30	Medical Certificate	Not Payable
31	Medical Records	Not Payable
32	Photocopies Charges	Not Payable
33	Mortuary Charges	Payable up to 24 hours, shifting charges not payable
34	Walking Aids Charges	Not Payable
35	Oxygen Cylinder (For Usage Outside the Hospital)	Not Payable
36	Spacer	Not Payable
37	Spirometer	Device not payable
38	Nebulizer Kit	Not Payable
39	Steam Inhaler	Not Payable
40	Arm-sling	Not Payable
41	Thermometer	Not Payable
42	Cervical Collar	Not Payable
43	Splint	Not Payable
44	Diabetic Foot Wear	Not Payable
45	Knee Braces (Long/ Short/ Hinged)	Not Payable
46	Knee Immobilizer/ Shoulder Immobilizer	Not Payable

List 1		
47	Lumbo Sacral Belt	Payable for cases who have undergone surgery of lumbar spine.
48	Nimbus Bed or Water Or Air Bed Charges	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at a reasonable cost of approximately Rs 200/- day
49	Ambulance Collar	Not Payable
50	Ambulance Equipment	Not Payable
51	Abdominal Binder	Payable for cases who have undergone surgery of lumbar spine.
52	Private Nurses Charges- Special Nursing Charges	Payable in post-hospitalisation
53	Sugar Free Tablets	Payable -Sugar free variants of admissible medicines are not excluded
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Payable when prescribed
55	ECG Electrodes	Up to 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day is payable.
56	Gloves	Sterilized Gloves payable / unsterilized gloves not payable
57	Nebulization Kit	Payable reasonably if used during hospitalisation
58	Any Kit With No Details Mentioned [Delivery Kit, Ortho-kit, Recovery Kit, Etc.]	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Payable in case of PIVD requiring traction
64	Pan Can	Not Payable
65	Trolley Cover	Not Payable
66	Urometer, Urine Jug	Not Payable
67	Ambulance	Payable
68	Vasofix Safety	Payable - maximum of 3 in 48 hours and then 1 in 24 hours

List II			
1	Baby Charges (Unless Specified/Indicated)	20	Foot Cover
2	Hand Wash	21	Gown
3	Shoe Cover	22	Slippers
4	Caps	23	Tissue Paper
5	Cradle Charges	24	Toothpaste
6	Comb	25	Toothbrush
7	Eau De-Cologne / Room Fresheners	26	Bed Pan
8	Face Mask	27	Admission Kit
9	Flexi Mask	28	Diabetic Chart Charges
10	Hand Holder	29	Documentation Charges / Administrative Expenses
11	Sputum Cup	30	Discharge Procedure Charges
12	Disinfectant Lotions	31	Daily Chart Charges
13	Luxury Tax	32	Entrance Pass / Visitor's Pass Charges
14	Hvac	33	Expenses Related To Prescription On Discharge
15	Housekeeping Charges	34	File Opening Charges
16	Air Conditioner Charges	35	Incidental Expenses / Misc. Charges (Not Explained)
17	Im Iv Injection Charges	36	Patient Identification Band / Name Tag
18	Clean Sheet	37	Pulse Oximeter Charges
19	Blanket/Warmer Blanket		

List III			
1	Hair Removal Cream	13	Surgical Drill
2	Disposables Razors Charges (For Site Preparations)	14	Eye Kit
3	Eye Pad	15	Eye Drape
4	Eye Shield	16	X-Ray Film
5	Camera Cover	17	Boyles Apparatus Charges
6	DVD, CD Charges	18	Cotton
7	Gauze Soft	19	Cotton Bandage
8	Gauze	20	Surgical
9	Ward And Theatre Booking Charges	21	Apron
10	Arthroscopy And Endoscopy Instruments	22	Tourniquet
11	Microscope Cover	23	Orthobundle, Gynaec Bundle
12	Surgical Blades, Harmonic Scalpel, Shaver		

List IV			
1	Admission / Registration Charges	10	HIV Kit
2	Hospitalisation For Evaluation/Diagnostic Purpose	11	Antiseptic Mouthwash
3	Urine Container	12	Lozenges
4	Blood Reservation Charges And Ante Natal Booking Charges	13	Mouth Paint
5	Bipap Machine	14	Vaccination Charges
6	Cpap / Capd Equipments	15	Alcohol Swabs
7	Infusion Pump-Cost	16	Scrub Solutions / Sterillium
8	Hydrogen Peroxide / Spirit / Disinfectants, Etc.	17	Glucometer & Strips
9	Nutrition Planning Charges – Dietician Charges, Diet Charges	18	Urine Bag

ANNEXURE – 2

The contact details of the **Insurance Ombudsman** offices are as below:

Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman & Diu	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	Office of the Insurance Ombudsman, Jeevan Soudha Building No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh, Chhattisgarh	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 Email: bimalokpal.bhopal@cioins.co.in
Odisha	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	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, Puducherry Town and Karaikal (which are part of Puducherry)	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	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	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Pan bazar 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 Puducherry	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	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	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	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072.

Jurisdiction	Office of the Insurance Ombudsman
	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	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)	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, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	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	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)	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 also available at:

- IRDAI website: https://www.irdai.gov.in/
- General Insurance Council website: https://www.gicouncil.in/
- Our Company Website: https://uiic.co.in/
- From any of the offices of our Company