Healthcare Plus Policy Wordings

PART II OF THE SCHEDULE

1. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth:

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

"Alternative treatments" are forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

"Break in policy" occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

"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 approved.

"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 consultations, examinations, check-ups, and / or tests-it needs ongoing or long-term control or relief of symptoms- it requires your rehabilitation or for you to be specially trained to cope with it-it continues indefinitely-it comes back or is likely to come back.

"Claim" means a demand by the Insured per episode of Hospitalisation, defined by the date of admission and discharge, for payment of Medical Charges as covered under the Policy.

"Co-payment" is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

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

"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.

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

"Company" means ICICI Lombard General Insurance Company Limited.

"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 hrs because of technological advancement, and

ii. Which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

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

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

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

"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 moved to a hospital, or

ii. The patient takes treatment at home on account of non availability of room in a hospital.

"Dental treatment" is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

"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.

The applicability of deductible is defined under '3.2 Payments of Claims' section.

Emergency Care is management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, requires immediate care by a medical practitioner to prevent death or serious long term impairment to the insured person's health

Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of Pre Existing Diseases. Coverage is not available for the period for which no premium is received.

"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:

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 10,00,000 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. Mmaintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

For the purpose of this definition, the term "Hospital" shall not include an establishment, which is a place of rest or recreation, a place for the aged, a place for drug-addicts or place of alcoholics, a hotel or any other like place.

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

"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.

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:-it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests-it needs ongoing or long-term control or relief of symptoms- it requires your rehabilitation or for you to be specially trained to cope

"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.

"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.

"Inpatient care" means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.

"Insured" means the Individual(s) whose name(s) are specifically appearing as such in Part I of the Schedule to this Policy.

"Limit of Indemnity" means the sum stated as Annual Sum Insured in Part I of the Schedule against the name of each Insured, which sum represents the Company's maximum liability, under the Policy, for any and in aggregate of all Claims for that Insured, regardless of the number of Claims made by that Insured or on his/her behalf during the Policy Year less the amount already claimed by the Insured from the Company under the Policy. However, the Limit of Indemnity will be reinstated to the extent any claim is rejected partly or wholly by the Company and there is no contingent or impending liability on the Company in respect of such Claim.

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

"Maternity Expenses" shall include-

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

ii. Expenses towards lawful medical termination of pregnancy during the policy period.

"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.

"Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.' The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude the Insured and members of his/ her immediate family. Immediate family would comprise of Insured's spouse, children, brother(s), sister(s) and parent(s).

"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.

"Non- Network " means any Hospital, day care centre or other provider that is not part of the Network.

"Notification of claim/Intimation of claims" is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

"OPD treatment" is 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.

"Period of Insurance" shall mean the period from commencement of insurance cover to the end of the insurance cover and specifically appearing as such in Part I of the Schedule to this Policy.

"Pre-hospitalization Medical Expenses" means medical expenses incurred immediately before 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 hospitalization was required and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

"Post-hospitalization Medical Expenses" means medical expenses incurred immediately after the Insured Person is Hospitalised, 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 Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"Portability" means transfer by an individual health insurance policyholder (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.

"Policy" means the Policy booklet, the Schedule, any Extension and applicable endorsements under the Policy. The Policy contains details of the extent of cover available to the Insured, the exclusions under the cover and the terms and conditions of the issue of the Policy.

"Policy Year" means a period of twelve months beginning from the Period of Insurance Start Date, as specified in Part I of the Schedule, and ending on the last day of such twelve month period. For the purpose of subsequent years, following the first year of the Period of Insurance, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve month period, till the Period of Insurance End Date as specified in Part I of the Schedule.

"Pre-existing Disease" means any condition, ailment or injury or related condition(s) for which the Insured 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.

"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.

"Renewal" defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

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

"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

"Subrogation" shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

"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.

"Senior citizen" means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy.

"Specified Treatment" means any treatment or cure by a Medical Practitioner, for any one or more of the following Illnesses:

i. Cataract
ii. Lithotripsy (Kidney stone removal)
iii. Tonsillectomy
iv. Eye Surgery
v. Dialysis
vi. Dilatation & Curettage
vii. Chemotherapy
viii. Radiotherapy
ix. Coronary Angiography
x. Cardiac catheterization

"Annual Sum Insured" means the maximum liability of the Company under the Policy for a Policy Year and as stated in Part I of the Schedule.

"Third Party Administrator (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, for the purposes of providing health services.

"Unproven/Experimental treatment" means any treatment including drug experimental therapy which is not based on established medical practice in India.

2.1 SCOPE OF THE COVER

The Company will indemnify the Insured, subject always to the Limit of Indemnity and the Deductible amount, for the Medical Charges incurred by such Insured as an in-patient in a Hospital where the Hospitalization is for a minimum period of 24 consecutive hours, as a result of suffering Illness or Bodily Injury during the Period of Insurance, which on the written advice of a Medical Practitioner requires Hospitalization.

Notwithstanding anything contained herein, this Benefit shall not apply to any Medical Charges incurred by the Insured in any place or geographical area other than in India, unless otherwise agreed by the Company in writing by way of any Endorsement.

The following charges shall be reimbursable under the policy:

i. Room rent, boarding and nursing expenses as charged by the Hospital where the Insured availed medical treatment.
ii. Intensive Care Unit (ICU) charges.
iii. Surgeon, anaesthetist, Medical Practitioner, consultants, specialist fees.
iv. Anaesthesia, blood, oxygen, operation theatre charges, surgical consumables, medicines and drugs, diagnostic materials and X-ray, dialysis, chemotherapy, radiotherapy, cost of pacemaker, cost of artificial limbs.

2.2 EXCLUSIONS APPLICABLE TO POLICY

The Company shall not be liable for the Deductible amount as specified in Part I of the Schedule.

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

i. Any Pre-existing illness - Any Pre-Existing condition(s) until 48 months of Your continuous coverage has elapsed, since Period of Insurance Start Date
ii. Any Illness contracted within 30 days of inception date of the Policy except those that are incurred as a result of Bodily Injury. This exclusion doesn't apply for subsequent renewals with the Company without a break.
iii. Expenses incurred on treatment of following diseases within the first two (2) years from the commencement of the first Healthcare Plus Policy with the Company, will not be payable:
    - Cataract
    - Benign prostatic hypertrophy
    - Myomectomy, endometriosis, hysterectomy unless because of malignancy
    - All types of hernia, hydrocele
    - Fissures &/or fistula in anus, haemorrhoids/piles
    - Arthritis, gout, rheumatism and spinal disorders
    - Joint replacements unless due to Accident
    - Sinusitis and related disorders
    - Stones in the urinary and biliary systems
    - Dilatation and curettage
    - All types of Skin and internal tumours/ cysts/nodules/ polyps of any kind including breast lumps unless malignant
    - Dialysis required for chronic renal failure
    - Surgery on tonsils, adenoids and sinuses
    - Gastric and Duodenal ulcers
    - Deviated nasal septum

In case the above Illnesses are not Pre-existing illnesses at the commencement of this Policy, then this exclusion shall cease to apply if the Insured has taken the Healthcare Plus Policy from the Company without a break, for a period of 2 consecutive years immediately preceding the Period of Insurance.

In case the above Illnesses are Pre-existing illnesses at the commencement of this Policy, then this exclusion shall cease to apply if the Insured has taken the Healthcare Plus Policy from the Company, without a break, for 4 consecutive years immediately preceding the Period of Insurance.

iv) **PERMANENT EXCLUSIONS**

i. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy in Part I of the Schedule under Special Conditions.

ii. Routine medical, eye and ear examinations, cost of spectacles, laser surgery for correction of refractory errors, contact lenses or hearing aids, vaccinations, issue of medical certificates and examinations as to suitability for employment or travel or any other such purpose.

iii. Congenital disease/ defects/ anomalies.

iv. Suicide or self-inflicted injury.

v. Alcohol or drug abuse.

vi. Treatment relating to birth defects.

vii. All dental treatment unless caused due to Accident.

viii. Treatment traceable to pregnancy and childbirth, abortion and its consequences, tests and treatment relating to infertility and invitro fertilization. However, the exclusion do not apply to ectopic pregnancy proved by diagnostic means and is certified to be life threatening by the Medical Practitioner.

ix. Birth control procedures and hormone replacement therapy.

x. Prosthesis, corrective devices, durable medical equipments and items and medical appliances/apparatus/machines, which are not required intra-operatively or for the Illness for which the Insured required Hospitalisation.

xi. Cost of cochlear implant(s) unless necessitated by an Accident.

xii. Personal comfort and convenience items and services.

xiii. Any charge incurred prior to Hospitalisation or post Hospitalisation, including but not limited to, charges for nurses/attendants, etc.

xiv. Treatment of mental Illness, stress, psychiatric or psychological disorders.

xv. Aesthetic treatment, cosmetic surgery and plastic surgery including any complications arising out of or attributable to these, unless necessitated due to Accident or as a part of any Illness.

xvi. Any treatment/surgery for change of sex or treatment/surgery /complications/Illness arising as a consequence thereof.

xvii. Circumcision unless necessary for treatment of a disease or necessitated due to an Accident.

xviii. Vaccination and inoculation of any kind.

xix. Any sexually transmitted diseases. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex Syndrome (ARCS) and all diseases caused by and/ or related to the HIV.

xx. The performance of hazardous sports of any kind.

xxi. Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

xxii. Any Injury/Illness sustained or contracted due to flying other than as a passenger on a scheduled regular carrier.

xxiii. Insured's involvement in any criminal act - whether intentional or otherwise.

xxiv. Any Injury/Illness sustained or contracted due to war invasion, act of foreign enemies, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion martial law, loot, sack or pillage.

xxv. Any losses directly or indirectly due to contamination caused by any act of terrorism, regardless of any contributory causes (if the Company alleges that by reason of these exclusion any loss is not covered by this insurance, the burden of proving the contrary shall be upon the Insured.)

xxvi. Any Injury/Illness sustained or contracted due to nuclear weapons, materials ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

xxvii. Experimental and unproven treatment, any Illness or Injury caused by or a result or consequence of undergoing of any experimental or unproven treatment, diagnostic tests and treatment not consistent with or incidental to the usual diagnosis and treatment of any Illness or Injury for which Hospitalization is required.

xxviii. Costs of donor screening or treatment including surgery to remove organs from a donor in case of transplant surgery.

xxix. Alternative treatment.

xxx. Treatment received outside the Geographical Scope of Cover mentioned in the Part I of the Policy.

xxxi. Any travel or transportation expenses including ambulance charges.

xxxii. Treatment taken from persons not registered as Medical Practitioners under respective medical councils.

xxxiii. Vitamins and tonics, treatment of obesity (including morbid obesity) and any other weight control programs, general debility, convalescence, run-down condition and rest cure.

xxxiv. Any treatment undertaken after the point at which it is certified by a Medical Practitioner that the condition is of such a nature that further medical treatment may serve to stabilize or maintain it but is unlikely to result in a material improvement within a reasonable time frame.

xxxv. Domiciliary Hospitalisation

xxxvi. Any consequential or indirect loss or expenses arising out of or related to the Hospitalization.

xxxvii. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council.

xxxviii. Any treatment related to sleep disorder or sleep apnoea syndrome.

2.3 CASHLESS HOSPITALISATION FACILITY

The Company/TPA may provide a health card to the Insured under this Policy to avail of cashless hospitalization facility. The Insured can avail of cashless hospitalization facility under this Policy at the time of admission into any Hospital which has a tie-up with the TPA/ Company by production of this health card subject to the terms and conditions for the usage of the health card as communicated to the Insured by the TPA/Company.

Cashless hospitalization facility will not be available if treatment is taken in a Hospital where the TPA/Company does not have any tie-up to provide such facility. The TPA/ Company shall have the right to deny cashless hospitalization facility in case accurate and complete

information is not forthcoming for the Illness or Bodily Injury for which cashless hospitalization facility is sought. It shall be at the sole discretion of the TPA / Company to provide this cashless hospitalization facility under the above mentioned circumstances as it so deems fit.

3. TERMS AND CONDITIONS APPLICABLE TO THE POLICY

3.1 WHEN AND HOW TO MAKE A CLAIM

It is a condition precedent to the Company's liability that upon the discovery or happening of any Illness or Bodily Injury that may give rise to a Claim under this Policy, the Insured or (if the Insured is incapacitated or a minor, then his representative) shall undertake the following:

3.1.1 CLAIM NOTIFICATION

The Insured or his representative, as the case may be, shall give immediate notice to the appointed TPA or the Company (in case no TPA is appointed) by calling the toll free number as specified in the health card/ Policy provided to the Insured and also in writing at the address of the Company with particulars as below:

i. Policy Number;
ii. Name of the Insured availing treatment;
iii. Policyholder's relation to the Insured;
iv. Nature of Illness or Bodily Injury;
v. Name and address of the attending Medical Practitioner and the Hospital; and
vi. Any other information that may be relevant to the Illness/ Bodily Injury/ Hospitalisation.

The above information needs to be provided to the TPA/Company immediately and prior to availing treatment and in any case within 7 days from date of admission/date of availing treatment

3.1.2 PRIOR AUTHORIZATION

For cashless Hospitalization, the Insured must contact the TPA /Company at least 48 hours before a planned Hospitalization. In an emergency situation the TPA should be contacted within 24 hours of Hospitalization.

3.1.3 CLAIM PROCESSING

The TPA appointed by the Company will process the Claim on behalf of the Company and make all payments.

The Policyholder or the Insured shall deliver, at their own costs, to the TPA/Company, within 90 days of the Insured's discharge from Hospital, any and all information and documentation in original concerning the Claim or the Company's liability for it, including but not limited to:

i. Duly completed claim form signed by You & Medical Practitioner. The claims form can be downloaded from our website www.icicilombard.com
ii. Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner.
iii. Original bills from chemists supported by proper prescription.
iv. Original investigation test reports and payment receipts.
v. Indoor case papers
vi. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
vii. Any other document as required by the Company or Company's TPA to investigate the Claim or Our obligation to make payment for it.

If so requested by the TPA/Company, the Insured will have to submit to a medical examination by the Company's or TPA's nominated Medical Practitioner as and when the TPA/Company considers reasonable and necessary. The cost of such examination shall be borne by the Company.

In the event of Insured's death, written notice accompanied by a copy of the post mortem report (if any) should be given to the Company within 14 days regardless of whether any prior notice has been given to the Company.

3.2 PAYMENT OF CLAIMS

3.2.1 The Deductible amount shall be applicable to each and every Claim separately

3.2.2 No indemnity under this Policy is available if the period of Hospitalization is less than 24 hours except in the case of Specified Treatment.

3.3 Settlement/Rejection of Claim

The Settlement of claims would be done by Us within 30 days after receipt of last necessary documents, any rejections if done, would be provided with proper reasons by Us. The role of the TPA (if any) would be limited to facilitate the flow of information between Insured and the Company.

Penal interest provision shall be as per Regulation 9(6) of (Protection of Policyholders' Interests) Regulations, 2002.

4. GENERAL CONDITIONS APPLICABLE TO THE POLICY

4.1 It is hereby declared and agreed that:

i. Any notice or declaration for the attention of any Insured shall be deemed served if sent by the Company to the Policyholder at his/her address given in the Schedule.
ii. Any payment due to any Insured under this Policy shall be paid by the Company to the Policyholder and the receipt by the Policyholder shall be complete discharge of the Company's liability against the Claim. The Company shall not be responsible for any liability arising out of the Policyholder's delay or default in making payment to any Insured. However, the Company reserves its right to pay the Claim directly to the Insured in whose respect the Claim has been lodged.

PART III OF THE SCHEDULE

Standard Terms and Conditions

1. Incontestability and Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or on non-disclosure in any material particular 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 devices being used by the Insured or any one acting on his behalf to obtain any benefit under this Policy.

2. Reasonable Care

The Insured shall take all reasonable steps to safeguard the interests of the Insured against Accidental loss or damage that may give rise to the Claim.

3. Observance of terms and conditions

The due observance and fulfilment of the terms, conditions and endorsement of this Policy in so far as they relate to anything to be done or complied with by the Insured, shall be a condition precedent to any liability of the Company to make any payment under this Policy.

4. Material change

The Insured shall immediately notify the Company in writing of any material change in the risk and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

5. Records to be maintained

The Insured shall keep an accurate record containing all relevant medical records and shall allow the Company to inspect such record. The Insured shall furnish such information as the Company may require in relation to the Claim within reasonable time limit and within the time limit specified in the Policy.

6. No constructive Notice

Any knowledge or information of any circumstances or condition in connection with the Insured in possession of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

7. Notice of charge etc.

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by the Company to the Insured or his legal representative of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

8. Overriding effect of Part II of the Schedule

The terms and conditions contained herein and in Part II of the Schedule shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Schedule, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part II of the Schedule and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

9. Duties of the Insured on occurrence of loss

On the occurrence of any loss, within the scope of cover under the Policy the Insured shall:

i. Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in Part II of the Schedule.

ii. Assist and not hinder or prevent the Company or any of its agents from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.

If the Insured does not comply with the provisions of this Clause or other obligations cast upon the Insured under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at the option of the Company.

10. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured's rights or recovery thereof against any person or organisation, and the Insured shall execute and deliver instruments and papers necessary to secure such rights.

The Insured and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated.

11. Fraudulent Claims

If any Claim 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 or anyone acting on his behalf to obtain any benefit under this Policy, or if a Claim is made and rejected and no court action or suit is commenced within twelve months after such rejection or, in case of arbitration taking place as provided therein, within twelve (12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

12. Terms of renewal

The Policy can be renewed under the then prevailing Healthcare Plus product or its nearest substitute (in case the product Healthcare Plus is withdrawn by the Company) approved by IRDA.

A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured

Renewal Premium - Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDA.

Maximum Renewal Age - There will be life-long renewal without any age restriction for the cover.

13. Cancellation/ termination

Disclosure to information norm-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. The Insured 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 retain the premium for the period this Policy has been in force at the Company's short period scales as mentioned herein below, provided that, no refund of premium shall be made if any Claim has been made under the Policy by or on behalf of the Insured.

PERIOD ON RISK	RATE OF PREMIUM REFUND
Up to 1 month	75% of annual rate
Up to 3 months	50% of annual rate
Up to 6 months	25% of annual rate
Exceeding six months	NIL

14. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Part I to the Schedule or Extensions to this Policy. All claims payable in India shall be in Indian Rupees only.

15. Contribution

If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would but for the existence of this Policy) and the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, in the same Claim (in whole or in part), then We shall not be liable to pay or

contribute more than Our rateable proportion of any Claim.

However, this condition shall not be applicable for all the benefit based covers under the Policy, as applicable

16. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both the Insured and the Company to be adjudicated or interpreted in accordance with the Laws of India and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

17. 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 to the dispute/difference, 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. 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 referable to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

18. Renewal notice:

i. **Renewal notice for policies not issued on Auto Renewal Basis:**

The Company shall ordinarily renew the policy except on grounds of moral hazard, misrepresentation or fraud or non cooperation by the Insured. The Company shall not be bound to give notice that such renewal premium is due. 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 before mentioned and that nothing is known to the Insured that may result to enhance the risk of the company under the guarantee hereby given. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorised official of the Company. Any change in the risk will be intimated to the Company by the Insured. Nothing herein or otherwise shall affect the Company's right to impose any additional terms and conditions on renewal or restrict any renewal terms as to premium or otherwise.

The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to Us on or before the date of expiry of the Policy and in no case later than Grace Period of 30 days from the expiry of the Policy.

ii. **Renewal notice for policies issued on Auto Renewal Basis:**

The Company shall automatically renew the Policy annually for the period it has been issued for. However on expiry of the Policy after completing its entire auto renewal period the Company shall not be bound to give notice that such renewal premium is due. 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 before mentioned and that nothing is known to the Insured that may result to enhance the risk of the company under the guarantee hereby given. No renewal receipt shall be valid unless it is on the printed form of the Company and signed by an authorised official of the Company. Any change in the risk will be intimated to the Company by the Insured. Nothing herein or otherwise shall affect the Company's right to impose any additional terms and conditions on renewal or restrict any renewal terms as to premium or otherwise.

19. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In case of the Insured, at the address specified in Part 1 of the Schedule.

In case of the Company:

ICICI Lombard General Insurance Company Limited

ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025, Toll-free number: 1800-2666

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

20. Free Look Period: In case of all policies a free look period of 15 days would be available to You from the date of receipt of the Policy document, for reviewing its terms & conditions. If You disagree with any of its conditions, You may return the Policy within this free look period and We will refund You the premium subject only to a deduction of expenses incurred on medical examination and stamp duty charges.

21. Customer Service

If at any time the Insured requires any clarification or assistance, the Insured may contact the offices of the Company at the address specified, during normal business hours.

22. Grievances

In case You are aggrieved in any way, the Insured should do the following:

i. Call the Company at toll free number: 1800 2666 or email us at customersupport@icicilombard.com

ii. If You are not satisfied with the resolution then You may successively write to the manager- service quality, corporate manager- service quality, national manager- operations & finally director-services and business development at the following address:

ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

If the issue still remains unresolved, You may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of Your grievance.

The details of Insurance Ombudsman are available below:

Ombudsman Offices	
Delhi, Rajasthan	2/2 A, 1st Floor, Universal Insurance Bldg., Asaf Ali Road, New Delhi - 110 002
West Bengal, Bihar	29, N. S. Road, 3rd Fl., North British Bldg. Kolkata -700 001
Maharashtra	3rd Flr., Jeevan Seva Annexe, S.v. Road, Santa Cruz (w), Mumbai - 400 054
Tamil Nadu, Pondicherry	Fatima Akhtar Court, 4th Flr., 453(old 312), Anna Salai, Teynampet, Chennai -600 018
Andhra Pradesh	6-2-46, 1st Floor, Moin Court, Lane Opp. Saleem Function Palace A.c. Guards, Lakdi-ka-pool, Hyderabad - 500 004.
Gujarat	2nd Flr., Ambica House, Nr.c.u. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad - 380 014
Kerla, Karnataka	2nd Flr., Cc 27/ 2603, Pulinat Building, Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015
North Eastern States	Aquarius, Bhaskar Nagar, R.g. Baruah Rd. Guwahati
Uttar Pradesh	Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Rd., Hazartganj, Lucknow - 226 001
Madhya Pradesh	1st Floor, 117, Zone Ii, (above D.m. Motors Pvt. Ltd.) Maharana Pratap Nagar, Bhopal - 462 011
Punjab, Haryana, Himachal Pradesh, J & K, Chandigarh	S.c.o. No. 101,102 & 103, 2nd Floor, Batra Building, Sector 17-d, Chandigarh-160 017
Orissa	62, Forest Park, Bhubaneswar - 751 009

The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: www.generalinsurancecouncil.org.in, website of the company www.icicilombard.com or from any of the offices of the Company

ICICI Lombard
Nibhaye Vaade

Mailing Address: ICICI Lombard General Insurance Company Limited Interface Building No.11, 401/402 4th Floor, New Link Road Malad (W), Mumbai - 400064.
Corporate Address :ICICI Lombard General Insurance Company Limited,
ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at www.icicilombard.com Mail us at **customersupport@icicilombard.com**
Now One Number for all your Insurance needs **1800 2666 (Toll Free also accessible from your mobile)**

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