



UNITED INDIA INSURANCE COMPANY LIMITED
REGD.& HEAD OFFICE : No.24, WHITES ROAD, CHENNAI-600014

UIN NO.IRDA/NL-HLT/UII/P-H/V.1/231/13-14

INDIVIDUAL MEDICLAIM POLICY

WHEREAS the insured designated in the Schedule herein has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated has applied to UNITED INDIA INSURANCE COMPANY LTD. (hereinafter called the COMPANY) for the insurance hereinafter set forth in respect of person(s) named in the Schedule herein (hereinafter called the INSURED PERSON) and has paid premium as consideration for such insurance.

NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed, or otherwise expressed hereon the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any insured person shall contract any disease or suffer from any illness (hereinafter called DISEASE) or sustain any bodily injury through accident (hereinafter called INJURY) and if such disease or injury shall require any such insured Person, upon the advice of a duly qualified Physician/Medical Specialist/Medical practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called SURGEON) to incur hospitalisation/domiciliary hospitalisation expenses for medical/surgical treatment at any Nursing Home/Hospital in India as herein defined (hereinafter called HOSPITAL) as an inpatient, the Company will pay through TPA to the Hospital / Nursing Home or the Insured Person the amount of such expenses incurred as are Medically Necessary and reasonable and customary in respect thereof by or on behalf of such Insured Person but not exceeding the Sum Insured in aggregate in any one period of insurance stated in the schedule herein.

In the event of any claim/s becoming admissible under this scheme, the company will pay through TPA to the Hospital/ Nursing Home or the insured person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person, but not exceeding the Sum Insured in aggregate mentioned in the schedule herein.

- A) Room, Boarding Expenses as provided by the Hospital / nursing home
- B) Nursing Expenses
- C) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees
- D) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray.
- E) Dialysis, Chemotherapy, Radiotherapy, Cost of Peacemaker, Artificial Limbs & Cost of organs and similar expenses.

(N.B: Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured per person as mentioned in the schedule)

2 Expenses on Hospitalisation for minimum period of 24 hours are admissible. However, this time limit is not applied to specific treatments, such as

1. Adenoidectomy	13. Radiotherapy	24. Inguinal/ventral/Umbilical/femoral hernia
2. Appendectomy	14. Lithotripsy	25. Parenteral chemotherapy
3. Ascitic/Pleural tapping	15. Incision and drainage of abscess	26. Polypectomy
4. Auroplasty	16. Varicocelelectomy	27. Septoplasty
5. Coronary angiography	17. Wound suturing	28. Piles/fistula
6. Coronary angioplasty	18. FESS	29. Prostate
7. Dental surgery	19. Haemo dialysis	30. Sinusitis
8. D & C	20. Fissurectomy/Fistulectomy	31. Tonsillectomy
9. Endoscopies	21. Mastoidectomy	32. Liver aspiration
10. Excision of Cyst/granuloma /Lump	22. Hydrocele	33. Sclerotherapy
11. Eye surgery	23. Hysterectomy	34. Varicose Vein Ligation
12. Fracture/dislocation excluding hairline fracture		

This condition will also not apply in case of stay in hospital of less than 24 hours provided -

- a. **The treatment is undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement and**
- b. **Which would have otherwise required a hospitalisation of more than 24 hours.**

Procedures/treatments usually done on out patient basis are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in Day Care Centres.

2.2 DOMICILIARY HOSPITALISATION BENEFIT means:- Medical treatment for a period exceeding three days for such illness / disease / injury which in the normal course would require care and treatment at a hospital / nursing home but actually taken whilst confined at home in India under any of the following circumstances namely:-

- i) The condition of the patient is such that he / she cannot be removed to the hospital / nursing home or
- ii) The patient cannot be removed to Hospital / Nursing home for lack of accommodation therein

Subject however that domiciliary hospitalisation benefits shall not cover:

- I) Expenses incurred for pre and post hospital treatment and
- II) Expenses incurred for treatment for any of the following diseases:-
 - 1) Asthma
 - 2) Bronchitis
 - 3) Chronic Nephritis and Nephritic Syndrome
 - 4) Diarrhoea and all type of Dysenteries including Gastroenteritis
 - 5) Diabetes Mellitus and Insipidus
 - 6) Epilepsy
 - 7) Hypertension
 - 8) Influenza, Cough and Cold
 - 9) All Psychiatric or Psychosomatic Disorders
 - 10) Pyrexia of unknown Origin for less than 10 days
 - 11) Tonsillitis and Upper Respiratory Tract infection including Laryngitis and pharangitis
 - 12) Arthritis, Gout and Rheumatism

Liability of the company under this clause is restricted as stated in the Schedule attached herein.

2.3 For Ayurvedic Treatment, hospitalisation expenses are admissible only when the treatment has been undergone in a Government Hospital or in any Institute recognised by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health .

MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

3. DEFINITIONS:

3.1 ACCIDENT

Accident – An accident is a sudden, unforeseen and involuntary event caused by external and visible and violent means

3.2 A. “Acute condition” – Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

B. “Chronic condition” – A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics –

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

b.3 ALTERNATIVE TREATMENT

Alternative treatments are forms of treatments other than treatment “Allopathy” or “modern medicine” and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

b.4 ANY ONE ILLNESS

Any one illness will be deemed to mean 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.

3.5 CASHLESS FACILITY

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-authorisation approved.

3.6 CONGENITAL ANOMALY

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

- a. Internal Congenital Anomaly-Which is not in the visible and accessible parts of the body.
- b. External Congenital Anomaly-Which is in the visible and accessible parts of the body.

3.7 CONDITION PRECEDENT

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

3.8 CONTRIBUTION

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

3.9 CUMULATIVE BONUS

Cumulative Bonus shall mean any increase in the sum insured/Malus granted by the insurer without an associated increase in premium.

3.10 DAY CARE CENTRE

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 :

- a. Has qualified nursing staff under its employment
- b. Has qualified Medical Practitioner(s) in charge
- c. Has a fully equipped operation theatre of its own where surgical procedures are carried out-
- d. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

3.11 DAY CARE TREATMENT - Day Care treatment means the 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 and (ii) which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.12 DEDUCTIBLE

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.

3.13 DOMICILIARY HOSPITALISATION

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 :

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

3.14 GRACE PERIOD

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.

3.15 HOSPITAL/NURSING HOME

A 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

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

3.16 HOSPITALISATION

Means admission in a Hospital/Nursing Home 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.

3.17 ID CARD

ID card means the identity card issued to the insured person by the TPA to avail cashless facility in network hospitals.

3.18 ILLNESS

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 required medical treatment.

3.19 INJURY 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.

3.20 IN-PATIENT CARE

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.

3.21 INTENSIVE CARE UNIT

The term "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.

3.22 MEDICAL ADVISE

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

3.23 MEDICAL EXPENSES

Medical expenses – 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.

3.24 MEDICALLY NECESSARY

Medically Necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

- a. Is required for the medical management of the illness or injury suffered by the insured;
- b. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
- c. Must have been prescribed by a Medical Practitioner;
- d. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

3.25 MEDICAL PRACTITIONER

A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State of India 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 and Surgeon. (The Registered Practitioner should not be the insured or close family members such as parents, in-laws, spouse and children).

3.26 NETWORK PROVIDER

Network Provider means the hospital/nursing home 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. The list of Network Hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

Preferred Provider Network means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the company/TPA and 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.

3.27 NON-NETWORK HOSPITALS

Non-Network – Any hospital, day care centre or other provider that is not part of the network.

3.28 NOTIFICATION OF CLAIM

Notification of claim 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.

3.29 PORTABILITY

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.

3.30 PRE-EXISTING DISEASE

Any condition, ailment or injury or relation condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months to prior to the first policy issued by the insurer.

3.31 PRE – HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 30 days before the Insured person is hospitalised provided that ;

- a. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
- b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company

3.32 POST HOSPITALISATION MEDICAL EXPENSES

Relevant medical expenses incurred immediately 60 days after the Insured person is discharged from the hospital provided that ;

- a. Such Medical expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
- b. The In-patient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

3.33 QUALIFIED NURSE

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.

3.34 REASONABLE AND CUSTOMARY CHARGES

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 illness/injury involved.

3.35 RENEWAL

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.

3.36 ROOM RENT

Room rent shall mean the amount charged by a hospital for the Occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

3.37 SUBROGATION

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.

3.38 SURGERY OR SURGICAL PROCEDURE

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.

3.39 THIRD PARTY ADMINISTRATOR

TPA means a Third Party Administrator who holds a valid License from Insurance Regulatory and Development Authority to act as a **THIRD PARTY ADMINISTRATOR** and is engaged by the Company for the provision of health services as specified in the agreement between the Company and TPA.

3.40 UNPROVEN/EXPERIMENTAL TREATMENT

Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

4 EXCLUSIONS:

The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 All diseases/injuries which are pre-existing when the cover incepts for the first time. For the purpose of applying this condition, the date of inception of the initial mediclaim policy taken from any of the Indian Insurance Companies shall be taken, provided the renewals have been continuous and without any break.

4.2 Any disease other than those stated in clause 4.3, contracted by the Insured person during the first 30 days from the commencement date of the policy. This condition 4.2 shall not however, apply in case of the Insured person having been covered for a continuous period of preceding 12 months without any break.

Note: These exclusions 4.1 and 4.2 shall not however apply if,

a. In the opinion of a Panel of Medical Practitioners constituted by the Company for the purpose, the Insured Person could not have known of the existence of the disease or any symptoms or complaints thereof at the time of making the proposal for insurance to the Company.

AND

b. The insured had not taken any consultation, treatment or medication, in respect of the hospitalisation for which claim has been lodged under the policy prior to taking the insurance.

4.3 During the first year of the operation of the policy, the expenses on treatment of diseases such as Cataract, Benign, Prostatic, Hypertrophy, Hysterectomy for Menorrhagia, or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders are not payable. If these diseases (other than congenital internal disease) are pre-existing at the time of proposal they will not be covered even during subsequent period of renewal. If the insured is aware of the existence of congenital internal disease before inception of policy, the same will be treated as pre-existing.

4.4 Injury / disease directly or indirectly caused by or arising from or attributable to invasion, Act of Foreign enemy, War like operations (whether war be declared or not)

- 4.5 Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident, vaccination or inoculation of any kind unless it is post animal bite, change of life or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as apart of any illness.
- 4.6 Cost of spectacles and contact lenses, hearing aids.
- 4.7 Dental treatment or surgery of any kind unless requiring hospitalisation.
- 4.8 Convalescence, general debility; run-down condition or rest cure, Congenital external disease or defects or anomalies, Sterility, Venereal disease, intentional self injury and use of intoxication drugs / alcohol
- 4.9 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.
- 4.10 Charges incurred at Hospital or Nursing Home primarily for diagnosis x-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home
- 4.11 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician
- 4.12 Injury or Disease directly or indirectly caused by or contributed to by nuclear weapon / materials
- 4.13 Treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy) and childbirth, (including caesarean section)
- 4.14 Naturopathy Treatment

5. CONDITIONS:

- 5.1 Every notice or communication to be given or made under this Policy shall be delivered in writing at the address of the TPA office as shown in the Schedule.
- 5.2 The premium payable under this Policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorised official of the company. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid unless made in writing and signed by an authorised official of the Company.
- 5.3 Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to the TPA named in the schedule immediately and in case of emergency Hospitalisation within 24 hours from the time of Hospitalisation / Domiciliary Hospitalisation.
- 5.4 All supporting documents relating to the claim must be filed with TPA within 15 days from the date of discharge from the hospital. In case of post-hospitalisation, treatment (limited to 60 days), all claim documents should be submitted within 7 days after completion of such treatment.

Note: Waiver of this Condition 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.

- 5.5 The Insured Person shall obtain and furnish the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA / Company such additional information and assistance as the TPA / Company may require in dealing with the claim.
- 5.6 Any medical practitioner authorised by the TPA / Company shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the TPA/Company.
- 5.7 The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.
- 5.8 If at the time when a claim arises under the policy, there is in existence any other insurance taken by the insured to indemnify the treatment costs, the insured person shall have the right to require a settlement of the claim in terms of any of his policies. If the amount to be claimed exceeds the sum insured under a single policy, after considering deductibles or co-pay, the insured person shall have the right to choose the insurers by whom the claim is to be settled. In such cases, the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation costs or expenses.

Note: The insured person must disclose such other insurance at the time of making the claim under this policy.

5.9 This insurance may be terminated at any time at the request of the Insured, in which case the Company will retain the premium at customary short period rate for the time the policy has been in force. This insurance may also at any time be terminated at the option of the Company, on 15 days' notice to that effect being given to the Insured, in which case the Company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of the cancellation. In either case premium will be refunded only if there is no claim under the policy

5.10 If any dispute or difference shall arise as to the quantum to be paid under the 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 or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this policy that award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained.

It is also hereby expressly agreed and declared that If the Company shall disclaim liability to the Insured for any claim herein under, and such claim shall not, within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.11 If the TPA, as per terms and conditions of the policy or the Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date or receipt of the notice of such disclaimer notify the TPA/ Company in writing that he does not accept such disclaimer and intends to recover his claim from the TPA/Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.12 All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

6. PAYMENT OF CLAIM

All claims under this policy shall be payable in Indian currency. All medical treatments for the purpose of this insurance will have to be taken in India only. Payment of claim shall be made through TPA to the Hospital/Nursing Home or the Insured Person as the case may be

Upon acceptance of an offer of settlement, the payment of amount due shall be made within 7 days from the date of acceptance of offer by the Insured. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

7. CUMULATIVE BONUS

Sum Insured under the policy shall be progressively increased by 5% in respect of each claim free year of insurance, subject to maximum accumulation of 10 claim free years of insurance.

If a claim is made in a particular year, the cumulative bonus accrued will be reduced at the same rate at which it accrued.

N.B: Cumulative bonus will be lost if policy is not renewed on the date of expiry

Waiver: In exceptional circumstances the seven days extension in period of renewal is permissible to be entitled for cumulative bonus although the policy is renewed only subject to Medical Examination and exclusion of diseases.

8. COST OF HEALTH CHECK UP

In addition to Cumulative Bonus, the insured shall be entitled for reimbursement of the cost medical check-up once at the end of block of every four underwriting years provided there are no claims reported during the block. The cost so reimbursable shall not exceed the amount equal to 1% of the amount of average sum insured during the block of four claim free underwriting years.

IMPORTANT

For Cumulative Bonus and Health Check up Provisions as aforesaid-

Both Health Check up and Cumulative Bonus provisions are applicable only in respect of continuous insurance without break excepting however, where in exceptional circumstances the break in period for a maximum of seven days is approved as a special case subject to medical examination and exclusion of disease contracted during the break period.

Health check up benefit will be accrued after completion of four years continuous claim free insurance.

9. **IRDA REGULATIONS** : This policy is subject to IRDA (Health Insurance) Regulations 2013 and IRDA (Protection of Policyholders' Interest) Regulations 2002 as amended from time to time.
10. **GRIEVANCE REDRESSAL** : In the event of the policyholder having any grievance relating to the insurance, the insured person may submit in writing to the Policy Issuing Office or Grievance cells at Regional Office of the Company for redressal. If the grievance remains unaddressed, the insured person may contact the Officer, Uni-Customer Care Department, Head Office.
11. **OMBUDSMAN**
The Insured person can also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The updated list of Office of Insurance Ombudsman are available on the website of IRDA www.irda.gov.in and on the website of General Insurance Council www.gicouncil.in

IMPORTANT NOTICE

1. The Company may revise any of the terms, conditions and exceptions of this insurance including the premium payable on renewal in accordance with the guidelines/rules framed by the Insurance Regulatory and Development Authority (IRDA) and after obtaining prior approval from the Authority. We shall notify you of such changes at least three months before the revision are to take effect.
2. The Company may also withdraw the insurance as offered hereunder after following the due process as laid down by the IRDA and after obtaining prior approval of the IRDA and we shall offer to cover you under such revised/new terms, conditions, exceptions and premium for which we shall have obtained prior approval from the Authority.