UNIVERSAL SOMPO GENERAL INSURANCE COMPANY,
GROUP MASHAK RAKSHAK

A. SCHEDULE

B.1. PREAMBLE

This Policy is a contract of insurance issued by Universal Sompo General Insurance Co Ltd (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') 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 receipt of the requisite premium.

B.2. OPERATIVE CLAUSE

If during the policy period the Insured Person is diagnosed (through laboratory examination and confirmed by the medical practitioner) with any Vector Borne Disease covered in this policy and hospitalized for a minimum period of seventy-two (72) consecutive hours at a Hospital following Medical Advice of a duly qualified Medical Practitioner, the Company shall pay the agreed sum insured as mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during the Policy Period shall be the Sum Insured (Individual or Floater) opted and specified in the Schedule.

C. DEFINITIONS

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

C.1. Standard Definitions:

1. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2. Condition Precedent means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

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

4. Disclosure to information norm: The policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or nondisclosure of any material fact

5. 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. Grace coverage need not be available during the period for which no premium is received.

6 Hospital means any institution established for in-patient care and day care treatment of disease/ 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 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 ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient 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 shall make these accessible to the Company's authorized personnel.

7Hospitalization means admission in a hospital for a minimum period of seventy-two (72) consecutive hours of 'In-patient care', provided it will not include procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

8In-Patient Care means treatment for which the insured person has to stay in a hospital for more than 72hours for a covered event.

9.Medical Advice means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

10.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 the scope and jurisdiction of the licence.

11.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 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.

12."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.

13.Notification of Claim means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

14.Out-Patient (OPD) Treatment means treatment 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.

15.Pre-Existing Disease (PED): Pre existing disease means any condition, ailment, injury or disease:

a) That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement

b) For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy issued by the Insurer or its reinstatement.

16.“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

17. Renewal means 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 gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

18. 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..

C.2. Specific Definitions:

1. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
2. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.

3. **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:

   i. Legally wedded spouse.
   ii. Parents and Parents-in-law.
   iii. Dependent Children (i.e. natural or legally adopted) between the day 1 of ageto25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage.

4. **Insured Person** means person(s) named in the schedule of the Policy.
5. **Nominee** means the person nominated by the insured to receive the insurance benefits under this policy payable on the death of the insured.

6. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.

7. **Policy period** means period of one policy year as mentioned in the schedule for which the Policy is issued.

8. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy.

9. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum and total liability for any claim made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Period.

10. **Third Party Administrator (TPA)** means a Company registered with the Authority, 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.

11. **Waiting Period** means a period from the inception of this Policy during which specified vector borne disease (s) is/are not covered.

D. Benefits:

The cover listed below is in-built Policy benefit and shall be available to all Insured Persons as mentioned in policy schedule and in accordance with the procedures set out in this Policy.

4.1 Hospitalization Benefit:

Lump sum benefit up to 100% of the Sum Insured (excluding the amount paid under diagnosis cover referred at clause 4.2, if any) shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of any of the following vector borne disease (s) if insured is hospitalized for a minimum period of seventy-two (72) consecutive hours.

i. Dengue fever
ii. Malaria
iii. Filaria (Lymphatic Filariasis)
iv. Kala-azar
v. Chikungunya
vi. Japanese Encephalitis
vii. Zika Virus

4.2 Diagnosis Cover:

2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under "diagnosis cover" for each disease only once in each of the policy year.

Note:

i. The total amount payable in respect of Covers 4.1 and 4.2 shall not exceed 100% of the Sum Insured during a policy period.

ii. Any laboratory test not recognized/ approved in India for diagnosis of the covered vector borne diseases is not covered.

iii. On payment of 100% of sum insured, the policy shall be terminated for the policy year. In case where a policy is issued to a family with individual sum insured for each member, policy will continue for the rest of the insured members.

iv. Once the Sum Insured is paid under the policy for any Insured Beneficiary for **Filaria (Lymphatic Filariasis)**, notwithstanding the terms and conditions, no other claim for this particular condition shall be paid to the Named Insured Beneficiary in his/her entire lifetime.

E. EXCLUSIONS:

E.1. Standard Exclusions:

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.

E.2. Specific Exclusions:

i. First fifteen-days waiting period

The Company shall not be liable to make any payment under the policy if the covered vector borne disease is diagnosed or hospitalization takes place during first fifteen days (15 days) from the commencement date of this Policy unless insured person is covered under this Policy continuously and without any break in the previous Policy Year.

ii. Cooling Off Period:

If the Policy is renewed within 30 days from the date of discharge of the previously paid claim for the named insured a 30 days cooling off period shall apply for the same ailment in the renewed Policy. However, there would be no waiting period for other listed vector borne diseases.

iii. Hospitalization for treatment other than allopathy.

iv. Hospitalization for less than a minimum period of seventy-two (72) consecutive hours.

v. Claim for any illness/disease other than for vector borne diseases covered under the policy.

vi. Diagnosis / Treatment outside the geographical limits of India.

vii. Any laboratory test not recognized/ approved by the state or central government.

Exclusions specific to Section 4.1:

i. Domiciliary Hospitalization, Day care OPD treatment.

ii. **Investigation & Evaluation**

a) Expenses related to any admission primarily for diagnostics and evaluation purposes.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

iii. **Rest Cure, rehabilitation and respite care**

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

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

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

iv. **Excluded Providers**

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

v. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

vi. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

F. GENERAL TERMS & CLAUSES

F.1. Standard General Terms and Clauses:

1. Disclosure of Information

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

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. 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.

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, 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. 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:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) 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.

5. Cancellation

The Insured may cancel this Policy by giving 7 days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

a) If no claim has been made during the policy period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of cancellation request will be considered as expiry date of coverage

b) If the claim has been made in the current policy year, the premium for the remaining policy year(s) will be refunded on cancellation

6. Renewal of Policy

The policy shall ordinarily be renewable established fraud or non- disclosure or misrepresentation by the insured person.

i. The Company shall will endeavor to give notice for renewal.
ii. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. No loading shall apply on renewals based on individual claims experience.

7. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person 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.

8. Possibility of Revision of Terms of the Policy Including the Premium Rates

9. 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 affected.

Free look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of **30 days** from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or;

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or;

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

10. 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. In 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.

11. Redressal Of Grievance

If You have a grievance about any matter relating to the Policy, or Our decision on any matter, or the claim, you can address Your grievance as follows:

Step 1: Contact us

Write us at:

Customer Service Universal Sompo General Insurance Co. Ltd.
Unit No. 601 & 602, 6th Floor, Reliable Tech Park, Thane- Belapur Road, Airoli, Navi Mumbai, Maharashtra – 400708

E- mail Address
contactus@universalsompo.com
For more details:
www.universalsompo.com
Toll Free Numbers: 1800-22-4030 or 1800-200-4030
Senior Citizen toll free number: 1800-267-4030

Step 2: Grievance Cell

If the resolution you received, does not meet your expectations, you can directly write to our Grievance Id. After examining the matter, the final response would be conveyed within two weeks from the date of receipt of your complaint on this email id.

Customer Service Universal Sompo General Insurance Co. Ltd.
Unit No. 601 & 602, 6th Floor, Reliable Tech Park, Thane- Belapur Road, Airoli, Navi Mumbai, Maharashtra – 400708

E- mail Address:
grievance@universalsompo.com
For more details:
www.universalsompo.com

Visit Branch Grievance Redressal Officer (GRO) - Walk into any of our nearest branches and request to meet the GRO.

- We will acknowledge receipt of your concern Immediately
- Seek and obtain further details, if any, from the complainant (permitted only once) Within one week
- Within 2 weeks of receiving your grievance, we will respond to you with the best solution.
- We shall regard the complaint as closed incase on non-receipt of reply from the complainant Within 8 weeks from the date of registration of the grievance

Step 3: Chief Grievance Redressal Officer

In case, you are not satisfied with the decision/resolution of the above office or have not received any response within 15 working days, you may write or email to:

Customer Service Universal Sompo General Insurance Co. Ltd.	**E- mail Address:** gro@universalsompo.com
Unit No. 601 & 602, 6th Floor, Reliable Tech Park, Thane- Belapur Road, Airoli, Navi Mumbai, Maharashtra – 400708	**For more details:** www.universalsompo.com

For updated details of grievance officer, kindly refer the link https://www.universalsompo.com/resourse-grievance-redressal

Step 4: Insurance Ombudsman

Bima Bharosa Portal link: https://bimabharosa.irdai.gov.in/

You can approach the Insurance Ombudsman depending on the nature of grievance and financial implication, if any.

Information about Insurance Ombudsmen, their jurisdiction and powers is available on the website of the Insurance Regulatory and Development Authority of India (IRDAI) at www.irdai.gov.in, or of the General Insurance Council at https://www.gicouncil.in/, the Consumer Education Website of the IRDAI at http://www.policyholder.gov.in, or from any of Our Offices.

The updated contact details of the Insurance Ombudsman offices can be referred by clicking on the Insurance ombudsman official site**: https://www.cioins.co.in/Ombudsman.**

Note: Grievance may also be lodged at IRDAI- **https://bimabharosa.irdai.gov.in/.**

Note: Please refer the Contact details of the Insurance Ombudsman mentioned in Annexure B.

F.2. Specific Terms and Clauses:

1. **Material Change**

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

2. **Records to be maintained**

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

3. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule. iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

4. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

5. Automatic change in Coverage under the policy is permitted:

i. In the case of Insured Person's demise. However, the cover shall continue for the remaining Insured Person (s) till the end of Policy Period. The other insured person (s) may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of natural guardian or guardian appointed by court for the minor insured person. All relevant particulars in respect of such person (including his/her relationship with the insured person) 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, pro-rata refund of premium of the deceased insured person for the balance period of the policy will be effective.

ii. Upon exhaustion of sum insured for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

6. 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.

7. Arbitration

The parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this policy.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.
(This clause does not apply to Group policies where premium is paid by members)

8. Endorsements (Changes in Policy)

i. 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.

ii. The policyholder may be changed during the Policy Period only in case of his/her demise or him/her moving out of India. The new policyholder must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any).

9. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal or at any time, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh only for the enhanced portion of the sum insured.

10. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

G. CLAIM PROCEDURE

7.1 Notification of claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

7.2 Procedure for reimbursement of claims:

Follow below steps to avail reimbursement facility through our In house Health Claims Management:

Step I: Visit our Web Portal to register claim or Call our Health Helpline 1800 200 4030 or email us at healthserve@universalsompo.com and inform about your claim.

Step II: Visit hospital and undergo your treatment. Settle your hospitalization bill and collect all the documents after discharge from the hospital.

Step III: Fill in Reimbursement Claim Form and submit all original documents to our below mention office for reimbursement.
Universal Sompo General Insurance Company Limited,
Health Claims Management Office,
1st FloorC-56- A/13,
Block- C Sector- 62,
Noida,
Uttar Pradesh, Pincode: 201309

Step IV: On receipt of document your claim will processed as per Terms & Conditions of policy and the same will be communicated over SMS & Email.

Step V: Outcome of the claim will be communicated within 15 days from date of Submission of claim.

7.3 Documents to be submitted:

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

Benefits	Claims Documents Required

1. Hospitalization Benefit	i. Duly filled and signed Claim Form ii. Photo Identity proof of the patient iii. Medical practitioner's prescription advising admission iv. Discharge summary including complete medical history of the patient along with other details. v. Laboratory report(s) confirming the diagnosis vi. OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable vii. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque. viii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs one (1) Lakh or as per extant AML Guidelines. ix. Legal heir/succession certificate, wherever applicable x. Any other relevant document required by Company/TPA for assessment of the claim.
2. Diagnosis Cover	i. Duly filled and signed Claim Form ii. Photo Identity proof of the patient iii. Laboratory report(s) confirming the diagnosis iv. Payment receipt (s) v. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque

	vi.	Legal heir/succession certificate, wherever applicable
	vii.	Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

7.4 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 submission of the claim.

ii In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt date of receipt of intimation to till the date of payment.

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 15 days from the date of submission of claim.

iv In case of delay beyond stipulated 15 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of intimation to till the date of payment.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

7.5 Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim assessment, under this Policy by way of processing of claims, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection; ii. 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.

7.6 Payment of Claim

All claims under the policy shall be payable in Indian currency only.

Insurance Ombudsman – If 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.The contact details of the Insurance Ombudsman offices have been provided as Annexure-A.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

H. TABLE OF BENEFITS

Name	Universal Sompo General Insurance Company, Group Mashak Rakshak
Product Type	Individual/ Floater
Category of Cover	Benefit
Sum insured	Rs 10,000/- (Ten Thousand) to 2,00,000/- (Two Lakh) (in the multiples of ten thousand) On Individual basis – SI shall apply to each individual family member On Floater basis – SI shall apply to the entire family
Policy Period	Standard Product shall be offered with a policy tenure of one year (12 Months).
Eligibility	Minimum entry age shall be 18 years for principal insured and maximum age at entry shall not be less than 65 years for all the insured members including principal insured. Policy can be availed for Self and the following family members i. legally wedded spouse. ii. Parents and Parents-in-law. iii. Dependent Children (i.e. natural or legally adopted) between the day 1 of age to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible.
Hospitalization Benefit	Lump sum benefit equal to 100% of the Sum Insured (excluding the amount paid under diagnosis cover, if any) shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of any of the following vector borne disease (s) if insured is hospitalized for a minimum period of seventy-two (72) consecutive hours.

Diagnosis Cover	2% of the sum insured shall be payable on positive diagnosis (through laboratory examination and confirmed by the medical practitioner) of every covered vector borne disease on the first diagnosis during the Cover Period, subject to policy terms and conditions. The Policyholder is entitled for payments under "diagnosis cover" for each disease only once in each of the policy years.
Sub-limits	Diagnosis cover: 2% of sum insured

Annexure-A

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

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu	**AHMEDABAD** Shri Collu Vikas Rao Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka.	**BENGALURU** Mr Vipin Anand Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh **Chattisgarh.**	**BHOPAL** Shri R. M. Singh

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Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.	**CHANDIGARH** Mr Atul Jerath Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).	**CHENNAI** Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in

Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	**DELHI** Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 46013992/23213504/23232481 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura	**GUWAHATI** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	**HYDERABAD** Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan.	JAIPUR Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: bimalokpal.jaipur@cioins.co.in

Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry	**KOCHI** Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	**KOLKATA** Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 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.	**LUCKNOW** Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane)	**MUMBAI** Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33

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State of Uttaranchal and the following Districts of Uttar Pradesh: **Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.**	**NOIDA** Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
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Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region)	**PUNE** Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in

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