RASHTRIYA SWASTHYA BIMA YOJANA POLICY

TATA AIG General Insurance Company Limited (We, Our or Us) will provide the insurance described in this Policy and any endorsements thereto for the Insured Period as defined in this Policy, to the Insured Persons described in the Policy Schedule and in reliance as provided in the Scheme as defined herein which shall be the basis of this Policy and are deemed to be incorporated herein in return for the payment of the required premium when due and compliance with all applicable provisions of this Policy.

NOW THIS POLICY WITNESSESETH that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, We undertake that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person/s 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 injured Person, upon the advice of the duly Qualified Physician/Medical Specialist /**Medical Practitioner** (hereinafter called MEDICAL PRACTITIONER) or of duly Qualified Surgeon (hereinafter called SURGEON) to incur Hospitalization 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 to the Insured Person the amount of such expenses as are reasonably and necessarily incurred in respect thereof by or on behalf such Insured Person up-to the limits indicated but not exceeding the sum insured in aggregate in any one policy period stated in the schedule hereto.

The insurance provided under this Policy is only with respect to such and so many of the benefits as are indicated by a specific amount set opposite in the Policy Schedule.

This Policy will only be valid and in force if the Policy Schedule is signed by a person We have authorized.

Part A: GENERAL DEFINITIONS

We use certain words in this Policy and Policy Schedule, which have a specific meaning and are shown under the heading of General Definitions in the Policy. They have this meaning wherever they appear in the Policy or Policy Schedule. Where the context so permits, references to the singular shall also include references to the plural and references to the male gender shall also include references to the female gender, and vice-versa in both cases.

Accident, Accidental - means a sudden, unforeseen, uncontrollable and unexpected physical event to the Insured Person caused by external, violent and visible means.

Acquired Immune Deficiency Syndrome - means the meanings assigned to it by the World Health Organization. Acquired Immune Deficiency Syndrome shall include HIV (Human Immune-deficiency Virus), encephalopathy (dementia), HIV Wasting Syndrome, and ARC (AIDS Related Condition).

Age - means the Age of the Insured Person on his / her most recent birthday as per the English calendar, regardless of the actual time of birth.

Benefits – mean the health services that the BPL beneficiaries are entitled to receive based on the contract between the Government and the Insurer under Rashtriya Swasthya Bima Yojana subject to terms, conditions, limitations and exclusions of the Policy.

Beneficiary (ies)- mean BPL beneficiaries in participating districts under Rashtriya Swasthya Bima Yojana who have paid their contribution towards the health insurance premium and are enrolled in the scheme.

Covered Illness – means those illnesses that are sought to be covered by the Scheme under which this policy is issued.

Diagnosis – means Diagnosis by a registered practitioner, supported by clinical, radiological, and histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable, acceptable to the Company.

Hospital, means any institution established for *in- patient care* and *day care treatment* of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified *medical practitioner* AND must comply with all minimum criteria as under:
- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- 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.

Insured Period(s) - means with respect to the Policy, the period commencing with the Effective Date of the Policy / Identity Cards, whichever is later and terminating with the Expiration Date of the Policy as stated in the Policy Schedule and any subsequent period for which the Policy may be renewed.

Insured Person - means the Insured Person who is/are detailed in the Policy Schedule or identified by the smart card or as provided for in the Scheme as being eligible to become insured under this Policy.

Family- The maximum size is five consisting of Household Head, Spouse and upto three dependants. The dependants would include members who are listed as part of the family in the BPL Database. Head of the Household will need to identify three members (In case where spouse is not in the BPL List, four members can be identified) who will be enrolled in the scheme.

Physician - means a licensed medical practitioner acting within the scope of his license and who holds a degree of a recognized institution and is registered by the Authorized Medical Council in the Republic of India. The term Physician would include surgeon.

Policy – shall mean the health insurance policy of the Insurer provided to the Government covering BPL beneficiaries under Rashtriya Swasthya Bima Yojana.

Policyholder - means the Government which has paid the premium on behalf of the BPL beneficiaries to Insurer for availing the Health Insurance Policy

Policy Schedule - means the Policy Schedule attached to and forming part of the Policy.

Pre-existing Condition - Any condition, ailment or injury or related condition(s) for which the Insured Persons had signs or symptoms, and / or were diagnosed, and / or received medical advice/ treatment, within 48 months prior to your first policy with Us.

Reasonable and Customary Charges - means a charge which: (a) is charged for medical treatment, supplies or medical services that are Medically Necessary to treat Your condition; (b) does not exceed the usual level of charges for similar medical treatment, supplies or medical services in the locality where the expense is incurred; and (c) does not include charges that would not have been made if no insurance existed.

Scheme – Rashtriya Swasthya Bima Yojana

Smart Card- means Identification Card for BPL beneficiaries issued under Rashtriya Swasthya Bima Yojana by the Insurer as per specifications given by Government.

Third Party Administrator (TPA) – means a TPA licensed by the Regulator whose services may be engaged by Us for enabling cashless treatment under this insurance.

War - means war, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

We/Us/Our - means TATA AIG General Insurance Company Limited.

You/Your/Yourself - means the Policy Holder and/or Insured Person(s) who is named in the Policy Schedule.

GENERAL CONDITION

The terms and conditions of the Scheme, Tender Documents, Gazette Notification, if any, under which this policy of insurance is issued, are deemed to be included in this policy.

THE BENEFITS

The scheme shall provide coverage for meeting expenses of hospitalization for medical and/or surgical procedures **including maternity benefit,** to the enrolled BPL families up to Rs.30,000 per family per year subject to limits, in any of the network hospitals. The benefit to the family will be on floater basis, i.e., the total reimbursement of Rs.30,000 can be availed of individually or collectively by members of the family per year as per the Annexure A attached.

Pre-existing conditions/diseases are covered from day one, subject to the exclusions in the Policy.

Coverage of health services related to surgical nature also provided on a day care basis. Given the advances made in the treatment techniques, many health services, formerly requiring hospitalization, can now be treated on a day care basis. A list of the minimum day care surgeries which shall be part of package is as below.

- **i)** Haemo-Dialysis
- **ii)** Parenteral Chemotherapy
- **iii)** Radiotherapy
- **iv)** Eye Surgery
- **v)** Lithotripsy (kidney stone removal)
- **vi)** Tonsillectomy
- **vii)** D&C
- **viii)** Dental surgery following an accident
- **ix)** Surgery of Hydrocele
- **x)** Surgery of Prostrate
- **xi)** Few Gastrointestinal Surgery
- **xii)** Genital Surgery
- **xiii)** Surgery of Nose
- **xiv)** Surgery of Throat
- **xv)** Surgery of Ear
- **xvi)** Surgery of Urinary System

xvii) Treatment of fractures/dislocation (excluding hair line fracture), Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation

xviii) Laparoscopic therapeutic surgeries that can be done in day care

xix) Identified surgeries under General Anaesthesia

xx) Any disease/procedure mutually agreed upon.

Provision for transport allowance (actual with limit of Rs. 100 per hospitalisation) subject to an annual ceiling of Rs. 1000 shall be a part of the package.

Pre and post hospitalization up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital shall be part of the package rates.

Maternity and Newborn Child Coverage will be covered as per details provided below:

This means treatment taken in hospital/nursing home arising from childbirth including normal delivery / caesarean section and / or miscarriage or abortion induced by accident or other medical emergency subject to exclusions.

Newborn child shall also be covered from day one upto the expiry of the policy and expenses incurred for treatment taken in hospital as in-patient. This benefit shall be a part of basic sum insured and new born will be considered as a part of insured family member till the expiry of the policy subject to exclusions.

Above shall be covered from day one of the inception of the scheme and normal hospitalisation period *for both mother and child* should not be less than 48 hours *post delivery*.

The maximum benefit allowable under this clause will be upto Rs. 4.500/- subject to limits under table of benefits including transportation charge of Rs. 100/- per hospitalization. This benefit shall be a part of basic sum insured.

Note:

For the policy period, new born will be provided all benefits under RSBY and will NOT be counted as a separate member.

Verification for the new born can be done by any of the existing family members who are getting the RSBY benefits.

Domiciliary treatment: Not covered.

Part B: GENERAL EXCLUSIONS

EXCLUSIONS: (IPD & DAY CARE PROCEDURES)

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:

1. **Conditions that do not require hospitalization:** Condition that do not require hospitalization and can be treated under Out Patient Care. Out patient Diagnostic, Medical and Surgical procedures or treatments unless necessary for treatment of a disease covered under day care procedures will not be covered.

2. Further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.

3. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalisation for treatment.

4. **Congenital external diseases:** Congenital external diseases or defects or anomalies, Convalescence, general debility, "run down" condition or rest cure.

5. **Drug and Alcohol Induced illness:** Diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.

6. **Sterilization and Fertility related procedures:** Sterility, any fertility, sub-fertility or assisted conception procedure. Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

7. **Vaccination:** Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),

8. **War, Nuclear invasion:** Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons / materials.

9. **Suicide:** Intentional self-injury/suicide, all psychiatric and psychosomatic and related disorders

10. Naturopathy, Homeopathy, Unani, Siddha, Ayurveda: Naturopathy, Homeopathy, Unani, Siddha, Ayurveda treatment, unproven procedure or treatment, experimental or

alternative medicine including acupressure, acupuncture, magnetic and such other therapies etc. Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.

EXCLUSIONS UNDER MATERNITY BENEFIT CLAUSE:

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:

1. Expenses incurred in connection with voluntary medical termination of pregnancy are not covered except induced by accident or other medical emergency to save the life of mother.

2. Normal hospitalisation period is less than 48 hours from the time of delivery/ operations associated therewith for this benefit.

3. Those insured persons who are already having two or more living children will not be eligible for this benefit. Claim in respect of only first two living children will be considered in respect of any one insured person covered under the policy or any renewal thereof.

4. Pre-natal expenses under this benefit; however treatment in respect of any complications requiring hospitalisation prior to delivery shall be covered **under medical procedures.**

Part C: UNIFORM PROVISIONS

1. ENTIRE CONTRACT - CHANGES: This Policy, together with the Proposal Form, as well as any forms, riders and endorsements and papers hereto, constitutes the entire contract of insurance.

No change in this Policy shall be valid until approved by Our authorized officer and such approval is endorsed hereon. No agent has authority to change this Policy or to waive any of the provisions of this Policy.

2.CONSIDERATION: The premium payable for each covered person under this Policy is payable as provided for in the Scheme and the Memorandum of Understanding with the Government, as follows:

First installment of premium of Rs.30 shall be paid by the beneficiary, at the time of enrollment and delivery of smart card or at the time of renewal as the case may be, as registration fee.

Second installment shall be paid by the State Government within 30 days of the receipt of the necessary documents, in the prescribed format, from the Insurance Company. The installment will be in the nature of 25% of premium amount after deduction of Rs30 paid by beneficiary.

Third installment of balance premium shall be paid by the State Nodal Agency on the receipt of the share of the Central Government This amount shall be paid within 60 days of receipt of necessary documents from the insurance company as mentioned above.

Note:
It will be the responsibility of the Government to ensure that the premium payment to the Insurance Company is done according to the schedule mentioned above to ensure adherence to compliance of 64 VB or IRDA Act.

3.EFFECTIVE DATE: The insurance coverage under the scheme shall be in force for a period of one year from the date of commencement of the policy. A BPL family who is issued smart card in the district for a new policy will be able to avail facilities from the first of the succeeding month in which the smart card is issued.

4.RENEWAL: In the case of renewal, the policy will start from first of the next month in which the earlier policy will finish. If the policy has already expired in such cases, this will be treated as fresh policy and for this new policy for the first set of cards, the coverage would begin from the 1st of the month subsequent to the card issuance month. All cards issued thereafter in the district shall have the same Policy beginning and end date as the 1st set of cards. At the time of renewal, Insured will have the option to change the details regarding dependent beneficiaries in the smart card; however the total number of dependents cannot be more than the number in the uploaded data at the time of renewal.

5.CANCELLATION CLAUSE: We may cancel the Policy in the event of material breach of the terms by giving the Policyholder 60 Days notice delivered or mailed to the last address of the Policyholder as shown by our records, stating when such cancellation shall be effective. In the event of cancellation, we will return promptly the pro-rata unearned portion of any premium paid by the policyholder. Such cancellation shall be without prejudice to any claim originating prior thereto. We play the total package amount for all the cases for which amount has already been blocked.

If Policyholder cancels the Policy, the earned premium shall be computed in accordance with Our short rate table given below, for the period the Policy has been in force, provided no claim has occurred up to the date of cancellation in which case the whole premium shall be fully earned and no return of premium will be made.

Period at risk	***Retention of Premium***
Up to 1 week	12.5 % OF annual Premium
Up to 1 month	25 % OF annual Premium
Up to 3 months	37.5 % OF annual Premium
Up to 4 months	50 % OF annual Premium
Up to 6 months	62.5 % OF annual Premium
Up to 8 months	87.5 % OF annual Premium
Above 8 months	100 % OF annual Premium

6.TERRITORY: The coverage is limited to Geographical territory within India

7. CONCEALMENT OR FRAUD: The entire Policy/ Certificate of Insurance will be void if, whether before or after a loss, You have, related to this insurance:

a) intentionally or recklessly or otherwise concealed, not disclosed or misrepresented any material fact or circumstance;
b) engaged in fraudulent, dishonest or deceitful conduct; or
c) made false statements.

8. CLAIMS PROCEDURE

<u>CASHLESS ACCESS SERVICE</u>

We shall ensure that all the Beneficiaries are provided with adequate facilities so that they do not have to pay any deposits at the commencement of the treatment or at the end of treatment to the extent as the Services are covered under the Rashtriya Swasthya Bima Yojana. This service provided by the Insurer along with subject to responsibilities of the Insurer as detailed in this clause is collectively referred to as the **"Cashless Access Service."**

The services have to be provided to the beneficiary based on Smart card & fingerprint authentication only with the minimum of delay for pre authorization. Reimbursement to hospitals should be based on the electronic transaction data received from hospitals. Each hospital/ health service provider shall posses a machine which can read the smart card to ascertain the balance available from the insurance amount.

The beneficiaries shall be provided treatment free of cost for all such ailments covered under the scheme within the limits/ sub-limits and sum insured, i.e., not specifically excluded under the scheme. The hospital shall be reimbursed as per the package cost specified in the tender agreed for specified packages or as mutually agreed with hospitals in case of unspecified packages. The hospital, at the time of discharge, shall debit the amount indicated in the package list. The machines and the equipment to be installed in the hospitals for usage of smart card shall conform to the guidelines issued by the Central Government. The software to be used thereon shall be the one approved by the Central Government.

(1) Cashless Access in case package is fixed

Once the identity of the beneficiary and or his family member is established by verifying the fingerprint of the patient and the smart card following procedure shall be followed for providing the health care facility under package rates:

- It has to be seen that patient is admitted for covered procedure and package for such intervention is available.
- Beneficiary has balance in his account.

- Provisional entry shall be made for carrying out such procedure. It has to be ensured that no procedure is carried out unless provisional entry is completed on the smart card through blocking of claim amount.
- At the time of discharge final entry shall be made on the smart card after verification of patient's fingerprint (any other enrolled family member in case of death) to complete the transaction**.**
- All the payment shall be made electronically within 15 days of the receipt of electronic claim documents.

(2) Pre-Authorization for Cashless Access in case no package is fixed

24 hour Pre-authorization service for procedures not listed in the standard RSBY lists. The Insurer undertakes, under the terms of its agreements with empanelled Providers, to ensure a timely pre-authorization service for all procedures not included in the standard package lists provided under the scheme . Detailed provisions on the pre-authorization procedure are given below

Once the identity of the beneficiary and or his family member is established by verifying the fingerprint of the patient and the smart card, following procedure shall be followed for providing the health care facility not listed in packages:

- Request for hospitalization shall be forwarded by the provider after obtaining due details from the treating doctor in the prescribed format i.e. "request for authorization letter" (RAL). The RAL needs to be faxed to the 24-hour authorization /cashless department at fax number of the insurer along with contact details of treating physician, as it would ease the process. The medical team of insurer would get in touch with treating physician, if necessary.

- The RAL should reach the authorization department of insurer within 6 hrs of admission in case of emergency or within 7 days prior to the expected date of admission, in case of planned admission.

- In failure of the above "clause b", the clarification needs to be forwarded with the request for authorization.

- The RAL form should be dully filled with clearly mentioned Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.

- Insurer guarantees payment only after receipt of RAL and the necessary medical details. Only after Insurer has ascertained and negotiated the package with provider, shall issue the Authorization Letter (AL). This shall be completed within 12 hours of receiving the RAL.

- In case the ailment is not covered or given medical data is not sufficient for the medical team of authorization dept to confirm the eligibility, insurer can deny the authorization.

- Denial of authorization (DAL)/guarantee of payment is by no means denial of treatment. The provider is requested to deal with such case as per their normal rules and regulations.

- Authorisation letter [AL] will mention the authorization number and the amount guaranteed as a package rate for such procedure for which package has not been fixed earlier. Provider must see that these rules are strictly followed.

- The guarantee of payment is given only for the necessary treatment cost of the ailment covered and mentioned in the request for Authorisation letter (RAL) for hospitalization as a package only.

- The entry on the smart card for blocking as well at discharge would record the authorization number as well as package amount agreed upon by the hospital and insurer. Since this would not be available in the package list on the computer, it would be entered manually by the hospital.

- In case the balance sum available is considerably less than the Package, provider should follow their norms of deposit/running bills etc. However provider shall only charge the balance amount against the package from the beneficiary. Insurer upon receipt of the bills and documents would release the guaranteed amount.

- Insurer will not be liable for payments in case the information provided in the "request for authorization letter" and subsequent documents during the course of authorization, is found incorrect or not disclosed.

9. ARBITRATION: If any dispute or difference shall arise as to the quantum of claim 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 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 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 Indian 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 denied, disputed or not accepted liability under or in respect of this Policy.

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

10. MEDICAL EXAMINATION: We, at Our own expense, shall have the right and opportunity to obtain a post mortem report and any other medical Reports as permitted by law. Your or Your estate's compliance with the need for such examination report is a condition precedent to establishing liability under the Policy.

11. LEGAL ACTIONS: Without prejudice to Uniform Provision 9 above, no action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) Days after written evidence has been furnished in accordance with the requirements of this Policy. If no evidence has been furnished within one (1) year of the date upon which it should have been furnished then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

If We disclaim liability to You for any claim, and if You do not notify Us in writing within one (1) year from the date of receipt of the notice of such disclaimer that You do not accept such disclaimer and intend to recover this claim from Us, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable under this Policy.

12. COMPLIANCE WITH POLICY PROVISIONS: Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

13. INTEREST ON THE BENEFIT WE PAY: We will not pay any interest on any benefit We pay, unless provided elsewhere as per the Insurance Act/ IRDA Guidelines.

14. OTHER INTEREST: No person(s) other than you and/or your nominee (s) named by you in this application form can claim or sue us under this policy.

15. SUBROGATION: In the event of any payment under this Policy, We shall be subrogated to all Your rights of recovery thereof against any person or organization or You shall execute and deliver instruments and papers to us and do whatever else is necessary to secure such rights and provide whatever assistance We might reasonably required from You in the pursuance of Our subrogation rights. You shall take no action after the loss to prejudice such rights.

16. REASONABLE CARE AND ASSISTANCE: You and each Insured Person must take all reasonable steps to avoid or reduce, as far as possible, any loss or damage.

In addition, You and each Insured Person must assist Us in any manner We may reasonably require in relation to the investigation or settlement of a claim or the preservation or enforcement of any rights of subrogation to which we may be entitled.

17. Contribution Clause: In case there exists more than one insurance policy covering the same health condition of the respective covered person, the amount payable under this insurance will be in proportion to the respective sum insured of such policies.

18. **DISPUTE RESOLUTION**

If any dispute arises between the parties during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision

of the scheme, it will be settled in the following way:

Dispute between Beneficiary and Health Care Provider

The parties shall refer such dispute to the redressal committee constituted at the District level under the chairmanship of concerned District magistrate and authorized representative of the insurance company as members. This committee will settle the dispute.

If either of the parties is not satisfied with the decision, they can go to the State level committee which will be Chaired by the Principal Secretary/Secretary, Department of Health and Family Welfare, with representative of the Insurance Company as a member.

Dispute between Health Care Provider and the Insurance Company

The parties shall refer such dispute to the redressal committee constituted at the District level under the chairmanship of concerned District magistrate, authorized representative of the insurance company and a representative of the health care providers as members. This committee will settle the dispute.

If either of the parties is not satisfied with the decision, they can go to the State level committee which will be chaired by the Principal Secretary/Secretary, Department of Health and Family Welfare, with representative of the Insurance Company as a member.

Note: If State redressal committee is unable to resolve the dispute, mentioned in 21a and 21b, within 60 days of it being referred to them, then it will be settled as per procedure given in para **21c** below.

Dispute between Insurance Company and the State Government

A dispute between the State Government/Nodal Agency and Insurance Company shall be referred to the respective Chairmen/CEO's/CMD's of the Insurer for resolution.

In the event that the Chairmen/CEO's /CMD's are unable to resolve the dispute within {60} days of it being referred to them, then either Party may refer the dispute for resolution to a sole arbitrator who shall be jointly appointed by both parties, or, in the event that the parties are unable to agree on the person to act as the sole arbitrator within {30} days after any party has claimed for an arbitration in written form, by three arbitrators, one to be appointed by each party with power to the two arbitrators so appointed, to appoint a third arbitrator.

Customer Grievance Redressal Procedure

The Company is committed to extend the best possible services to its customers. However, if **you** are not satisfied with **our** services and wish to lodge a complaint, please feel free to call **our** 24X7 Toll free number 1800-266-7780/022-66939500 (tolled) or **you** may email to the customer service desk at customersupport@tata-aig.com.

Nodal Officer

Please visit **our** website at www.tataaiginsurance.in to know the contact details of the nodal officer for **your** servicing branch.

After investigating the grievance internally and subsequent closure, **We** will send **Our** response within a period of 10 days from the date of receipt of the complaint by the Company or its office in Mumbai. In case the resolution is likely to take longer time, **We** will inform **you** of the same through an interim reply.

Escalation Level 1

For lack of a response or if the resolution still does not meet **your** expectations, **you** can write to manager.customersupport@tata-aig.com. After investigating the matter internally and subsequent closure, **We** will send **Our** response within a period of 8 days from the date of receipt at this email id.

Escalation Level 2

For lack of a response or if the resolution still does not meet **your** expectations, **you** can write to the Head - Customer Services at head.customerservices@tata-aig.com. After examining the matter, **We** will send **you** our final response within a period of 7 days from the date of receipt of **your** complaint on this email id.

Within 30 days of lodging a complaint with **us**, if **you** do not get a satisfactory response from **us** and **you** wish to pursue other avenues for redressal of grievances, **you** may approach Insurance Ombudsman appointed by IRDAI under the Insurance Ombudsman Scheme.

Jurisdiction territory	**Office of the Ombudsman**
State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.	6th Floor, Jeevan Prakash Bldg,Tilak Marg, Relief Road, Ahmedabad - 380001.Tel : 079-25501201/02/05/06 Email: bimalokpal.ahmedabad@gbic.co.in
State of Karnataka.	24th Main Road, Jeevan Soudha Bldg, JP Nagar, 1st Phase, Bengaluru – 560 025. Tel.: 080-22222049/22222048 Fax: 080 - Email: bimalokpal.bengaluru@gbic.co.in
States of Madhya Pradesh and Chattisgarh.	2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@gbic.co.in

State of Orissa.	62, Forest Park, BHUBANESHWAR-751 009. Tel.:- 0674-2596455/2596003 Fax : 0674-2596429 Email : bimalokpal.bhubaneswar@gbic.co.in
States of Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Union territory of Chandigarh.	SCO No.101-103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706468/2772101 Fax : 0172-2708274 Email : bimalokpal.chandigarh@gbic.co.in
State of Tamil Nadu and Union Territories - Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).	Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.: 044 - 24333668 / 24335284 Fax : 044-24333664 Email : bimalokpal.chennai@gbic.co.in
States of Delhi.	2/2 A, Universal Insurance Building, Asaf Ali Road, NEW DELHI-110 002. Tel.: 011-23234057/23232037 Fax : 011-23230858 Email : bimalokpal.delhi@gbic.co.in
States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	"Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax : 0361-2732937 Email : bimalokpal.guwahati@gbic.co.in
States of Andhra Pradesh, Telangana and Union Territory of Yanam and a part of the Union Territory of Pondicherry.	6-2-46, 1st Floor, Moin Court, A. C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040-23376599 Email : bimalokpal.hyderabad@gbic.co.in
State of Rajasthan	Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Road, Jaipur - 302 005. Tel.: 0141-2740363 Fax: 0141 - Email : bimalokpal.jaipur@gbic.co.in
State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Pondicherry.	2nd Floor, CC 27/2603, Pulinat Bldg., M. G. Road, ERNAKULAM-682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email : bimalokpal.ernakulam@gbic.co.in

States of West Bengal, Sikkim and Union Territories of Andaman and Nicobar Islands.	Hindustan Building. Annexe, 4th Floor, C.R. Avenue, Kolkatta – 700 072. Tel.: 033 - 22124339 / 22124346 Fax : 033 - 22124341 Email : bimalokpal.kolkata@gbic.co.in
Districts of Uttar Pradesh : Laitpur, Jhasi, 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	Jeevan Bhawan, Phase-2,6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email : bimalokpal.lucknow@gbic.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel.: 022-26106960/26106552 Fax: 022 - 26106052 Email : bimalokpal.mumbai@gbic.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	3rd Floor,Jeevan Darshan, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-32341320 Fax: 020 -2 Email : bimalokpal.pune@gbic.co.in
State of Bihar and Jharkhand.	1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel No: 0612-2680952 Email: bimalokpal.patna@gbic.co.in
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, Ghazaibad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur	Bhagwan Sahai Palace , 4th Floor, Main Road, Naya Bans, Sector 15, G.B. Nagar, Noida. NOIDA – 201301 Tel: 0120-2514250/51/53 Email: bimalokpal.noida@gbic.co.in

This Policy is subject to IRDAI (Protection of Policyholder's Interests) Regulation, 2017.