Introduction

We all want to give the best of facilities to our families and their sound health is of supreme importance to us hence we want to have the best when it comes to Health Insurance.
Bajaj Allianz's Health Infinity Policy comes with new comprehensive benefits at competitive premiums and is a perfect product to take care of medical expenses for you and your family in case of unfortunate event of hospitalization for illness/ injury.

Special features of Health Infinity

- Indemnity Health Insurance Plan without any limit on Sum Insured
- Introducing the concept of choosing health insurance as the per day room rent
- In-patient Hospitalization Treatment without any sublimit
- Pre- Hospitalization 60 days
- Post- Hospitalization 90 days
- Road Ambulance up to Rs. 5000 per hospitalization
- Coverage for Day Care Procedures
- Preventive Health Check Up at the end of every 3 policy years, equal to per day room rent opted max. up to INR 5,000 per person whichever is less
- Individual policy for Self, Spouse, Children and Parents
- No pre-policy medical tests up to 45 years of age (subject to clean proposal form)
- Pre-existing disease covered after 36 months from your first Health Policy
- Income tax benefit under 80 D of the IT Act on premiums paid for this policy

What are the per day Room Rent options available under the policy?

INR 3000 per day	INR 20000 per day
INR 4000 per day	INR 25000 per day
INR 5000 per day	INR 30000 per day
INR 8000 per day	INR 35000 per day
INR 10000 per day	INR 40000 per day
INR 15000 per day	INR 50000 per day

What is Entry age under this policy?

- Minimum Entry age for proposer/ spouse/ dependent parents - 18 years
- Maximum Entry Age for proposer/ spouse/ dependent parents - 65 years
- Minimum Entry age for dependent Children - 3 months
- Maximum Entry Age for dependent Children - 25 years

What is Renewal Age?

Under normal circumstances, lifetime renewal benefit is available under the policy, except on the grounds of Your moral hazard, misrepresentation, non- cooperation or fraud(Subject to policy is renewed annually with us within the Grace period of 30 days from date of Expiry).

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Eligibility

- Indian nationals.
- This policy can be opted by Non-Resident Indians including PIOs (Persons of Indian Origin) and OCIs (Overseas citizens of India) also, however the Policy will be issued during their stay in India and premium is paid in Indian currency & by Indian Account only
- We will cover Insured for treatment availed in India. Our liability shall be to make payment within India and in Indian Rupees only.

What is the Policy period?

- Policy can be taken for 1year/ 2years OR 3years.

What is Premium paying term?

Annual Premium payment for 1 year policy and for long term policies of 2/ 3 years the total long term premium would be collected at the time of risk inception and renewal as well.

Is this a floater policy / individual policy?

- This is an Individual policy

Who can be covered under Health Infinity Policy?

- Self, Spouse, Dependent Children, Parents can be covered under individual option

COVERAGE

1. In-patient Hospitalization Treatment

If the Insured is hospitalized on the advice of a Medical Practitioner as defined under policy because of Illness or Accidental Bodily Injury sustained or contracted during the Policy Period, then the Company will pay the Insured, Reasonable and Customary Medical Expenses incurred subject to

i. Room rent expenses as provided by the Hospital/ Nursing Home maximum up to the per day room rent limit opted
ii. If admitted in ICU, the Company will pay up to ICU actual expenses provided by Hospital.
iii. Nursing Expenses as provided by the hospital
iv. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.
v. Anesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances,
vi. Dialysis, Chemotherapy, Radiotherapy, physiotherapy
vii. Medicines, Drugs and consumables
viii. Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents
ix. Relevant laboratory diagnostic tests, X-ray and such similar expenses that are medically prescribed by the treating Medical Practitioner.

2. Pre-Hospitalization

The Medical Expenses incurred during the 60 days immediately before the Insured was Hospitalized, provided that: Such Medical Expenses were incurred for the same illness/injury for which subsequent Hospitalization was required, and the Company has accepted an In-patient Hospitalization claim under "In-patient Hospitalization Treatment" (Point no. 1).

3. Post-Hospitalization

The Medical Expenses incurred during the 90 days immediately after the Insured was discharged post Hospitalization provided that: Such costs are incurred in respect of the same illness/injury for which the earlier Hospitalization was required, and the Company has accepted an In-patient Hospitalization claim under Inpatient Hospitalization Treatment (Point no. 1).

4. Road Ambulance

a. The Company will pay the reasonable cost upto a maximum of Rs 5000/- per Hospitalization incurred on an ambulance offered by a healthcare or ambulance service provider for transferring the Insured to the nearest Hospital with adequate emergency facilities for the provision of health services following an Emergency.
b. The Company will also reimburse the expenses incurred on an ambulance offered by a healthcare or ambulance service provider for transferring the Insured from the Hospital where he/ she was admitted initially to another hospital with higher medical facilities.

Claim under this section shall be payable by the Company only when:

i. Such life threatening emergency condition is certified by the Medical Practitioner, and
ii. The Company has accepted Insured's Claim under "In-patient Hospitalization Treatment" (Point No. 1) or "Day Care Procedures" section (Point No. 5) of the Policy.

Subject otherwise to the terms, conditions and exclusions of the Policy.

5. Day Care Procedures

The Company will pay the Insured medical expenses as listed above under "In-patient Hospitalization Treatment" (Point No. 1) for Day care procedures / Surgeries taken as an inpatient in a hospital or day care centre but not in the outpatient department.

6. Preventive Health Check Up

At the end of block of every continuous period of 3 years during which You have held Our Health Infinity Policy, You are eligible for a free Preventive Health checkup. We will reimburse the amount equal to per day room rent opted (maximum up to Rs. 5000/- whichever is lower) for each member in Individual policy during the block of 3 years.

You may approach us for the arrangement of the Health Check up. For the avoidance of doubt, We shall not be liable for any other ancillary or peripheral costs or expenses (including but not limited to those for transportation, accommodation or sustenance). Contact Email id- healthcheck@bajajallianz.co.in.

Special terms and conditions

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

A. Waiting Period

1. Pre-existing Diseases waiting period (Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first Health Infinity Policy with Us.
b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
c. If the Insured is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. Specified disease/procedure waiting period (Excl02)

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Health Infinity Policy with Us. This exclusion shall not be applicable for claims arising due to an accident.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.

d. The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e. If the Insured is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. After completion of 24 months of continuous coverage, the maximum limit for each claim will be restricted to 100 times per day room rent limit for below listed conditions/procedures. Please note that the limit of indemnity will be applicable only for the procedures.

g. List of specific diseases/procedures is as below

1. Any type gastrointestinal ulcers	2. Cataracts,
3. Any type of fistula	4. Macular Degeneration
5. Benign prostatic hypertrophy	6. Hernia of all types
7. All types of sinuses	8. Fissure in ano
9. Haemorrhoids, piles	10. Hydrocele
11. Dysfunctional uterine bleeding	12. Fibromyoma
13. Endometriosis	14. Hysterectomy
15. Uterine Prolapse	16. Stones in the urinary and biliary systems
17. Surgery on ears/tonsils/adenoids/ paranasal sinuses	18. Surgery on all internal or external tumours / cysts/ nodules/ polyps of any kind including breast lumps with exception of Malignant tumour or growth
19. Parkinson's Disease	20. Alzheimer's Disease

3. A waiting period of 36 months from the first Health Infinity Policy inception date will be applicable to the medical and surgical treatment of illness surgical procedures mentioned below. Even after 36 months of continuous coverage, the limit of indemnity for each claim will be restricted to 100 times per day room rent limit for the below listed conditions. Please note that the limit of indemnity will be applicable only for the procedures.

a. Joint replacement surgery

b. Surgery for vertebral column disorders (unless necessitated due to an accident)

c. Surgery to correct deviated nasal septum

d. Hypertrophied turbinate

e. Congenital internal diseases or anomalies

f. Treatment for correction of eye sight due to refractive error recommended by Ophthalmologist for medical reasons with refractive error greater or equal to 7.5

4. 30-day waiting period (Excl03)

a. Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

B. General exclusions

1. Any dental treatment that comprises of cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization.

2. Medical expenses where Inpatient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock

3. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.
   Any Medical expenses incurred due to Act of Terrorism will be covered under the Policy.

4. Circumcision unless required for the treatment of Illness or Accidental bodily injury,

5. Investigation & Evaluation (Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded even if the same requires confinement at a Hospital.

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

6. Rest Cure, rehabilitation and respite care (Excl05)

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

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

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

7. Obesity/Weight Control (Excl06)
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);

a. greater than or equal to 40 or

b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

8. Change-of-gender treatments (Excl07)
   Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

9. Cosmetic or plastic Surgery (Excl08)
   Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

10. Hazardous or Adventure Sports (Excl09)
    Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

11. The cost of spectacles, contact lenses, hearing aids, crutches, dentures, artificial teeth and all other external appliances and/or devices whether for diagnosis or treatment except for Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, orthopedic implants, infra cardiac valve replacements, vascular stents etc. .

12. External medical equipment of any kind used at home as post Hospitalization care including cost of instrument used in the treatment of Sleep Apnoea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and Oxygen concentrator for Bronchial Asthmatic condition.

13. Congenital external diseases or defects or anomalies, growth hormone therapy, stem cell implantation or surgery except for Hematopoietic stem cells for bone marrow transplant for haematological conditions.

14. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol)

15. Breach of law (Excl10)
    Expenses for treatment directly arising from or consequent upon any Insured committing or attempting to commit a breach of law with criminal intent.

16. Excluded Providers (Excl11)
    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 following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

17. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Excl12)

18. 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. (Excl13)

19. Vaccination or inoculation unless forming a part of post bite treatment or if medically necessary and forming a part of treatment recommended by the treating Medical practitioner.

20. 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. (Excl14)

21. Refractive Error (Excl15)
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

22. Unproven Treatments (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.

23. Birth control, Sterility and Infertility (Excl17)
Expenses related to Birth Control, sterility and infertility. This includes:
a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

24. Maternity (Excl 18)
a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

25. Treatment for any other system other than modern medicine (also known as Allopathy)and AYUSH therapies.

26. All non-medical Items as per Annexure II

27. Any treatment received outside India is not covered under this Policy.

• Pre-policy checkup for new business as well as portability proposals

- No Medical tests up to 45 years, subject to no adverse health conditions
- Medical tests are applicable for members 46 years and above as per grid given below.
- Pre-policy checkup would be arranged at our empanelled diagnostic centers.
- The validity of the test reports would be 30 days from date of medical examination.
- If pre-policy checkup would be conducted in our paneled diagnostic center, 100% of the medical tests charges would be reimbursed, subject to acceptance of proposal and policy issuance.

Age of the person to be insured	Room Rent	Medical Examination
Up to 45 years	All room rent options	No Medical Tests*
46 years and above	Room rent from 3000/ day to 20000/day	Medical Tests required as listed below: FMR, CBC, Urine R, ECG, Lipid profile, Fasting BSL, HBA1c, SGOT, SGPT, Sr.Creatinine, Total Protein, Sr. Albumin Sr. Globulin, A:G Ratio, USG abdomen & Pelvis
46 years and above	Room rent from 25000/ day to 50000/day	Medical Tests required as listed below: FMR, CBC, Urine R, ECG, Lipid profile, Fasting BSL, HBA1c, SGOT, SGPT, Sr.Creatinine, Total Protein, Sr. Albumin Sr. Globulin, A:G Ratio, USG abdomen & Pelvis, TMT

*Subject to no adverse health conditions

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■ Discounts under the policy

1. Wellness discount

Insured member is eligible for 5% discount at each renewal provided he / she submits the below mentioned medical test reports & if all the reports are falling within normal range.

i) ECG of Normal Sinus Rhythm
ii) Fasting Blood Sugar equal to or less than 120 Mg/dl
iii) Serum Creatinine – within normal limits as defined in test reports
iv) Lipid Profile – All parameters within normal limits
v) BMI less than or equal to 25
vi) No other adverse health conditions

2. Family Discount

5% family discount shall be offered if 2 or more eligible family members are covered under a single Policy

3. Long Term Policy Discount

i) 4 % discount is applicable if policy is opted for 2 years
ii) 8 % discount is applicable if policy is opted for 3 years

4. Employee Discount

20% discount on published premium rates to employees of Bajaj Allianz & its group companies, this discount is applicable only if the Policy is booked in direct office code.
(Note: Online/Direct Customer Discount is not applicable to Employees)

5. Online Discount

5% discount is extended for the policies purchased online/ through website/direct customers. This benefit is extended to direct customers in lieu of the commission.

■ Reduction in Waiting Period

1. If the proposed Insured is presently covered and has been continuously covered without any lapses as under:

a. any health insurance indemnity plan with an Indian non-life insurer/health insurer as per guidelines on portability,
OR

b. any other similar health insurance indemnity plan from Us, Then:

i. The waiting periods specified in Section C-I.4 of the Policy stand deleted

ii. The waiting periods specified in the Section C-I.1 to I.3 shall be reduced by the number of continuous preceding years of coverage of the Insured under the previous health insurance Policy; Continuity / Credit of waiting periods would be extended up to the Sum Insured & Cumulative bonus of the previous Policy

iii. The limits as mentioned under C-I.2 and I.3 and co-pay as mentioned in Point D 9- Cost Sharing shall also be applicable for all portability proposals
The above conditions would be applicable if the insured has applied for portability with us and the proposal is accepted and the policy is issued as per portability guidelines.

Cost Sharing

a. **Cost Sharing applicable if admission in higher room category**
If the Insured seeks admission in a room category exceeding the room rent plan opted at the time of Policy inception, then a proportionate co-payment would apply on Hospitalization expenses incurred, which includes all expenses mentioned in Section A1 (excluding A1- vii and A1- viii), A2, A3, A4, A5. of policy wordings.

b. **Cost Sharing for claims exceeding 100 times room rent opted**
The policy covers all hospitalization expenses incurred during the policy period subject to the policy coverage, terms conditions, definitions & exclusions, however if the claim approved amount exceeds 100 times the room rent limit opted (in a single claim or multiple claims) then the co -payment of 15% / 20% / 25% as opted would apply on the claim amount.
The co-payment would apply on the claim approved amount exceeding 100 times of the room rent limit and not on the complete claim.

c. The maximum limit of indemnity for ailments/conditions as mentioned in waiting period (A-3 & A-4) will be restricted to 100 times the room rent limit opted for each claim. Claim amount exceeding 100 times of the room rent limit would be not be admissible under the policy and hence the co-payment as defined in point (ii) above shall not be applicable on such amount.
In event of a claim wherein both the co-payments as defined above are applicable then co-payment as defined under point (i) would apply first followed by that defined under point (ii)
The Co-payment will be applicable for claims for both Network and Non- Network Hospitals.

ROOM RENT WISE CO-PAYMENT OPTIONS	
ROOM RENT OPTIONS	CO-PAYMENT OPTIONS
INR 3000 per day	20% / 25%
INR 4000 per day	20% / 25%
INR 5000 per day	20% / 25%
INR 8000 per day	20% / 25%
INR 10000 per day	15% / 20% / 25%
INR 15000 per day	15% / 20% / 25%
INR 20000 per day	15% / 20% / 25%
INR 25000 per day	15% / 20% / 25%
INR 30000 per day	15% / 20% / 25%
INR 35000 per day	15% / 20% / 25%
INR 40000 per day	15% / 20% / 25%
INR 50000 per day	15% / 20% / 25%

Example illustrating Cost Sharing:-
Scenario 1
Mr. Amit has opted the policy with room rent limit of 5000 INR per day with 20% co-payment option. He meets with an accident & incurs expenses of 750,000 INR during the hospitalization
He has opted for a private room with per day room rent of 4000 INR, which is within the room rent limit opted.
As per the policy condition there is no co-payment up to 100 times of room rent limit, in this case there is no co-pay up to 500000 INR.
Over & above 500,000 INR, 20% co-payment would apply for additional claim amount of 250,000 INR

Break up of Hospital Bill		
a	Room rent 4000*15 days	60,000
b	Professional Charges (Doctors, Surgeons etc.)	300,000
c	Investigations	100,000
d	OT, nursing etc. charges	100,000
e	Medicines and consumables	100,000
f	Internal implant cost	80,000
g	Other Non-Medical Expenses (Not Payable)	10,000
h	Total Bill amount	750,000
i	Total Claimed Amount after deducting Non-Medical Expenses	740,000

Application of Policy co-payment of 20% for total bill exceeding 100 times		
j	Room rent opted- 5000/- 100 times of 5000= 500,000	500,000
k	Amount exceeding 100 times room rent limit of 5,000 (i-j)	240,000
l	Policy co-payment applicable on 250,000 (final admissible amount exceeding 500,000)	20%
m	Policy co-payment applicable on 250,000 (l *k)	48,000
n	**Total amount payable by insurer (i- m)**	**692,000**

Scenario 2

Mr. Amit has opted the policy with room rent limit of 5,000 INR per day with 20% co-payment option. He meets with a major accident & incurs expenses of 750,000 INR during the hospitalization.

He has been admitted in a private room with per day room rent of 6,000 INR, which is above the room rent limit opted as per the policy condition

As per the policy condition the proportionate deductions for moving into a higher room rent category will apply first there. The co-payment of 20% will then apply on the remaining claim amount which is over and above 500,00 INR (100 times of room rent limit)

- Room rent opted at the time of proposal : 5,000 INR per day
- Room rent in which Mr Amit is hospitalized : 6,000 INR per day
- Total Claimed Amount : 750,000 INR

Break up of Hospital Bill		
a	Room rent 6000*10 days	60,000
b	Professional Charges (Doctors, Surgeons etc.)	300,000
c	Investigations	100,000
d	OT, nursing etc. charges	100,000
e	Medicines and consumables	100,000
f	Internal implant cost	80,000
g	Other Non-Medical Expenses (Not Payable)	10,000
h	Total Bill amount	750,000

Co-payment for opting higher room rent category		
i	Proportionate room rent co-payment (Room rent opted at the time of proposal/Actual Room rent at the time of hospitalization= (100% - 5000/6000)= 16.67%	16.67%
j	Room rent co-payment applicable on (a+b+c+d)	560,000
k	Room rent co-payment amount applicable (i * j)	93,333
l	Admissible amount after proportionate room rent co-payment deduction (j-k)	466,667
m	Final admissible amount (l+e+f)	646,667

Application of Policy co-payment of 20% for total bill exceeding 100 times		
n	Room rent opted- 5000/- 100 times of 5000= 500,000	500,000
o	Amount exceeding 100 times room rent limit of 5,000 (m-n)	146,667
p	Policy co-payment applicable on 146,648 (final admissible amount exceeding 500,000)	20%
q	Policy co-payment applicable on 146,648 (o * p)	29,333
r	**Total amount payable by insurer (m - q)**	**617,333**

Per day Room Rent Enhancement

- The Insured can apply for enhancement of per day room rent at the time of renewal. Insured can apply for enhancement of per day room rent by submitting a fresh proposal form to the company.
- The acceptance of enhancement of per day room rent would be at the discretion of the company, based on the health condition of the Insured & claim history of the Policy.
- All waiting periods as defined in the Policy shall apply for this enhanced per day room rent limit from the effective date of enhancement of such per day room rent considering such Policy Period as the first Policy with the Company.
- Cost sharing terms as specified above would be applicable to the enhanced room rent limit.

Free Look Period

You have a period of 30 days from the date of receipt of the first policy document to review the terms and conditions of this Policy. If You have any objections to any of the terms and conditions, You have the option of canceling the Policy stating the reasons for cancellation.

If you have not made any claim during the Free look period, you shall be entitled to refund of premium subject to,

- a deduction of the expenses incurred by Us on Your medical examination, stamp duty charges, if the risk has not commenced,
- a deduction of the stamp duty charges, medical examination charges & proportionate risk premium for period on cover, If the risk has commenced
- a deduction of such proportionate risk premium commensurating with the risk covered during such period ,where only a part of risk has commenced
- Free look period is not applicable for renewal policies.

Multiple Policies

i. In case of multiple policies which provide fixed benefits, on the occurrence of the covered event/s in accordance with the terms and conditions of the Policy, each Insurer shall make the claim payments independent of payments received under other similar polices.
ii. If two or more Policies are taken by an Insured during a period from one or more insurers to indemnify treatment costs, the Insured shall have the right to require a settlement of his/her claim in terms of any of his/her Policies.
iii. In all such cases the insurer who has issued the chosen policy shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.
iv. Claims under other Policy/ies may be made after exhaustion of Sum Insured in the earlier chosen Policy / Policies.
v. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
vi. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the medical expenses incurred in accordance with the terms, conditions and coverages of the chosen policy.
vii. If Insured has multiple Policies, he/ she has the right to prefer claims from other Policy/Policies for the amounts disallowed under the earlier chosen Policy/ Policies, even if the sum insured is not exhausted. The Company shall settle the claim subject to the terms and conditions of the Policy.

Renewal

i. Under normal circumstances, renewal will not be refused except on the grounds of Your moral hazard, misrepresentation, fraud, or your non-cooperation. (Subject to policy is renewed annually with us within the Grace period of 30 days from date of Expiry)
ii. In case of our own renewal, a grace period of 30 days is permissible and the Policy will be considered as continuous for the purpose of all waiting periods. However, any treatment availed for an Illness or Accident sustained or contracted during the break period will not be admissible under the Policy.
iii. For renewals received after completion of 30 days grace period, a fresh application of health insurance should be submitted to Us, it would be processed as per a new business proposal.
iv. Premium payable on renewal and on subsequent continuation of cover are subject to change with prior approval from IRDAI.
v. We will not apply any additional loading on your policy premium at renewal based on claim experience.

Installment Premium

If the insured person has opted for Payment of Premium on an instalment basis i.e. Annual (for long term polices only), Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the premium.

If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.

If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.

The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
No interest will be charged If the instalment premium is not paid on due date.
In case of instalment premium due not received within the grace period, the policy will get cancelled.
In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

■ Cancellation

A. Cancellation by the Policyholder

The Policyholder can cancel this Policy by providing a written notice of 7 days. In such a case, the Company will refund the premium for the unexpired policy period as detailed below:

1. Cancellation of policy where full premium received at policy inception -
   Annual Policy: The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.
   Multi-year Policy:
   For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
   For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.
2. Cancellation of policy where Premium Received on Instalment Basis
   The premium refund for the unexpired risk period will be on a pro-rata basis, provided no claim has been made during the policy year.

B. Additional Deductions

Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

C. Cancellation by the Company

The Company may cancel the Policy at any time on the grounds of misrepresentation, non-disclosure of material facts, or fraud by the Policyholder/insured person, by providing 15 days' written notice. There will be no refund of premium for cancellations on these grounds.

■ Portability Conditions

Portability shall be allowed under all individual indemnity health insurance policies issued by General Insurers and Health Insurers including family floater policies

■ Revision/ Modification of the policy

There is a possibility of revision/ modification of terms, conditions, coverages and/or premiums of this product at any time in future, with appropriate approval from IRDAI. In such an event of revision/modification of the product, intimation shall be set out to all the existing insured members at least 3 months prior to the date of such revision/ modification comes into the effect

Migration of policy

1. Every individual policy holder (including members under family floater policy) covered under indemnity based individual health insurance policy shall be provided an option of migration at the explicit option exercised by the policyholder;

a. To an individual health insurance policy or a family floater policy, or;

b. To a group health insurance policy, if members complies with the norms relating to the health insurance coverage under the concerned group insurance policy.

2. Every Individual member, including family members covered under an indemnity based group health insurance policy shall be provided an option of migration at the time of exit from group or in the event of modification of group policy (including the revision in the premium rates) or withdrawal of the group policy :

a. To an individual health insurance policy or a family floater policy.

3. Migration shall be applicable to the extent of the sum insured under the previous policy and the cumulative bonus, if any, acquired from the previous policies.

4. Only the unexpired/residual waiting period not exceeding the applicable waiting period of the previous policy with respect to pre-existing diseases and the time bound exclusions shall be made applicable on migration under the new policy.

5. Migration may be subject to underwriting as follows:

a. For individual policies, if the policyholder is continuously covered in the previous policy without any break for a period of four years or more, migration shall be allowed without subjecting the policyholder to any underwriting to the extent of the sum insured and the benefits available in the previous policy.

b. Migration from group policies to individual policy will be subject to underwriting

Withdrawal of Policy

There is possibility of withdrawal of this product at any time in future with appropriate approval from IRDAI, as We reserve Our right to do so with a intimation of 3 months to all the existing insured members. In such an event of withdrawal of this product, at the time of Your seeking renewal of this Policy, You can choose, among Our available similar and closely similar Health insurance products. Upon Your so choosing Our new product, You will be charged the Premium as per Our Underwriting Policy for such chosen new product, as approved by IRDAI.

Provided however, if You do not respond to Our intimation regarding the withdrawal of the product under which this Policy is issued, then this Policy shall be withdrawn and shall not be available to You for renewal on the renewal date and accordingly upon Your seeking renewal of this Policy, You shall have to take a Policy under available new products of Us subject to Your paying the Premium as per Our Underwriting Policy for such available new product chosen by You and also subject to Portability condition

Claim Process

All Claims will be settled by In house claims settlement team of the company and no TPA is engaged.
If the Insured meet with any Accidental Bodily Injury or suffer an Illness that may result in a claim, then as a condition precedent to the Company's liability, the Insured must comply with the following:

A. Cashless Claims Procedure

Cashless treatment is only available at Network Hospitals. In order to avail of cashless treatment, the following procedure must be followed by the Insured:

i. Prior to taking treatment and/or incurring Medical Expenses at a Network Hospital, the Insured/ his or her representative must call the Company and request pre-authorization by way of the written form.

ii. In case of Planned hospitalization, the Insured/Insured's representative shall intimate such admission 48 hours prior to such hospitalization

iii. In case of Emergency hospitalization, the Insured/Insured's representative shall intimate such admission within 24 hours of such hospitalization

iv. On receipt of Insured's pre-authorization form duly filled and signed by the Insured/ his or her representative, the Company's representative then within 2 hours will respond with Approval, Rejection or an more information

v. After considering the Insured's request and after obtaining any further information or documentation the Company has sought, the Company may, if satisfied, send the Insured or the Network Hospital, an authorization letter. The authorization letter, the ID card issued to the Insured along with this Policy and any other information or documentation that the Company has specified must be produced to the Network Hospital identified in the pre-authorization letter at the time of Insured's admission to the same.

vi. If the procedure above is followed, the Insured will not be required to directly pay for the bill amount in the Network Hospital that the Company is liable under Section A1 In-Patient Hospitalization Treatment above and the original bills and evidence of treatment in respect of the same shall be left with the Network Hospital. Pre-authorization does not guarantee that all costs and expenses will be covered. The Company reserve the right to review each claim for Medical Expenses and accordingly coverage will be determined according to the terms and conditions of this Policy.

B. Reimbursement Claims Procedure

If Pre-authorization as per Cashless Claims Procedure above is denied by the Company or if treatment is taken in a Hospital other than a Network Hospital or if the Insured do not wish to avail cashless facility, then:

i. The Insured or someone claiming on his/ her behalf must inform the Company in writing immediately within 48 hours of hospitalization in case of emergency hospitalization and 48 hours prior to hospitalization in case of planned hospitalization

ii. The Insured must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.

iii. The Insured must take reasonable steps or measures to minimize the quantum of any claim that may be made under this Policy.

iv. The Insured must have himself / herself examined by the Company's medical advisors if the Company ask for this, and as often as the Company consider this to be necessary at the Company's cost.

v. The Insured or someone claiming on his/ her behalf must promptly and in any event within 30 days of discharge from a Hospital give the Company documentation as listed out in greater detail below and other information the Company ask for to investigate the claim or the Company's obligation to make payment for it.

vi. In the event of the death of the Insured, someone claiming on his behalf must inform the Company in writing immediately and send the Company a copy of the post mortem report (if any) within 30 days*

*Note: In case the Insured is claiming for the same event under an indemnity based policy of another insurer and is required to submit the original documents related to his/ her treatment with that particular insurer, then the Insured may provide the Company with the attested Xerox copies of such documents along with a declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

**Note: Waiver of conditions (i) and (vi) may be considered in extreme cases of hardship where it is proved to the Company's satisfaction that under the circumstances in which the Insured was placed, it was not possible for the Insured or any other person to give notice or file claim within the prescribed time limit.

List of Claim documents

- Claim form with NEFT details & cancelled cheque duly signed by Insured
- Original/Attested copies of Discharge Summary / Discharge Certificate / Death Summary with Surgical & anesthetics notes
- Attested copies of Indoor case papers (Optional)
- Original copies Final Hospital Bill with break up of surgical charges, surgeon's fees, OT charges etc

- Original Paid Receipt against the final Hospital Bill.
- Original bills towards Investigations done / Laboratory Bills.
- Original copies of Investigation Reports against Investigations done.
- Original bills and receipts paid for the transportation from Registered Ambulance Service Provider. Treating Medical Practitioner certificate to transfer the Injured person to a higher medical centre for further treatment (if Applicable).
- Cashless settlement letter or other company settlement letter
- First consultation letter for the current ailment.
- In case of implant surgery, invoice & sticker.
- In cases where a fraud is suspected, we may call for any additional document(s) in addition to the documents listed above
- Aadhar card & PAN card Copies (Not mandatory if the same is linked with the policy while issuance or in previous claim)

  Please send the documents on below address
  Bajaj Allianz General Insurance Company
  2nd Floor, Bajaj Finserv Building,
  Behind Weikfield IT park,
  Off Nagar Road, Viman Nagar
  Pune 411014| Toll free: 1800-103-2529, 1800-22-5858

Paying a Claim

i. You agree that We need only make payment when You or someone claiming on Your behalf has provided Us with necessary documentation and information.

ii. We will make payment to You or Your Nominee. If there is no Nominee and You are incapacitated or deceased, We will pay Your heir, executor or validly appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.

iii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, We will settle the claim within thirty (30) days of the receipt of the last necessary document. 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.

iv. However, where the circumstances of a claim warrant an investigation, the Company will initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company will settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

v. If the insurer, for any reasons decides to reject the claim under the policy the reasons regarding the rejection shall be communicated to the insured in writing within 30 days of the receipt of documents. The insured may take recourse to the Grievance Redressal procedure stated under policy.

Process to buy this policy?

1. Discuss the policy benefits, coverage and premium details with your insurance advisor or visit our website (www.bajajallianz.com) for details
2. Actively seek information on the charges and exclusions under the policy
3. Fill the proposal form stating your personal details and health profile
4. Ensure that the information given in the form is complete and accurate
5. The Policy Schedule, Policy Wordings, Cashless Cards and Health Guide will be sent to your mailing address mentioned on the proposal form

Contact

Health Administration Team,
Bajaj Allianz General Insurance Co. Ltd.
2nd floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar-Pune - 411 014.
*Toll Free No. 1-800-225858 (for for BSNL/MTNL lines only) or 1-800-1025858 (for Bharti users - mobile / land-line) or 020-30305858

Cashless facility offered through network hospitals of Bajaj Allianz only.Cashless facility at 3300+ Network hospitals PAN India.

Please visit our website for list of network hospitals and network Diagnostic Centers , Website: www.bajajallianz.com or get in touch with 24*7 helpline number: 1800-103-2529 (toll free) / 020-30305858

Grievance Redressal Cell for Senior Citizens

Senior Citizen Cell for Insured Person who are Senior Citizens
'Good things come with time' and so for our customers who are above 60 years of age we have created special cell to address any health insurance related query. Our senior citizen customers can reach us through the below dedicated channels to enable us to service them promptly

Health toll free number: 1800-103-2529

Exclusive Email address: seniorcitizen@bajajallianz.co.in

Disclaimer: The above information is only indicative in nature and for more details on the coverage, terms and exclusions, please get in touch with nearest office of Bajaj Allianz General Insurance Co. Ltd

CIN: U66010PN2000PLC015329, UIN: BAJHLIP21005V022021

UNLIMITED SUM INSURED

HEALTH CHECK UP

WELLNESS DAY CARE

ROAD AMBULANCE

INCOME TAX BENEFIT

PRE & POST HOSPITALIZATION

UNLIMITED SUM INSURED

HEALTH CHECK UP

BAJAJ ALLIANZ GENERAL INSURANCE CO. LTD.
BAJAJ ALLIANZ HOUSE, AIRPORT ROAD, YERAWADA, PUNE - 411006.
IRDA REG NO.: 113.

FOR ANY QUERY (TOLL FREE)
1800-209-0144 /1800-209-5858

www.bajajallianz.com

bagichelp@bajajallianz.co.in

For more details on risk factors, Terms and Conditions, please read the sales brochure before concluding a sale.

Note: It is mandatory to keep updated your policy with your correct contact details and bank account details, to process any of your service requests faster and hassle-free. To update your contact details i.e., Mobile No., Email ID, PAN Card, and Bank Account details, please use chatbot, visit our website, contact your agent or nearest branch.

CIN: U66010PN2000PLC015329 | UIN: BAJHLIP21005V022021

BJAZ-B-0310/1-Oct-2020

Policy holders can download Insurance Wallet for one -touch access Available on: