United India Insurance Co.Ltd
Bancassurance Division,3-5-817,
7 th Floor, United India Towers
Basheerbagh, Hyderabad- 500 029

Andhra Bank
Head Office 5-9-11, Saifabad
Hyderabad - 500 004

AB AROGYADAAN & SUPER TOP UP GROUP MEDICLAIM INSURANCE PROPOSAL FORM FOR ANDHRA BANK ACCOUNT HOLDERS 2015-16

1) Name of the Branch & Zone, Branch Code No._____ _____

2)Account Number : _____ _____

3) Name of the Proposer (Main A/c holder only) :_____ _____

4) Postal Address:_____
_____

E.mail Id **Mobile Number 1.**

Mobile 2.

5) Period of Insurance : From _____ ____ TO_____ (Policy starts from the date of debit of premium till 08.06.2016).

6) Please tick the Sum Insured required

a) Arogyadaan Sum Insured per family Rs. 1,00,000 / 2,00,000 / 3,00,000 / 4,00,000 / 5,00,000.

b) Super Top Up Sum Insured per family Rs. 3,00,000 / 5,00,000 / 7,00,000 / 10,00,000 / 15,00,000.

b) Plan opted : Plan I / Plan II (Parents of the proposer are covered under Plan B only)

7)PremiumRs. _____ Debited from to A/c No._____ Date _____

8)Member Details:-

S. No.	Name of the Insured Person	Relation	Date of Birth	Sex	Existing Disease/ Illness/Injury	Treatment received for the past 3 years	Signature of the proposer/Member
1							
2							
3							
4							
5							
6							

9) Photographs of the Insured Persons (Photo to be pasted on Original only)

Account Holder	Spouse	Child 1	Child 2	Father	Mother
				Required to be affixed only if opted for Plan II	Required to be affixed only if opted for Plan II
NAME	NAME	NAME	NAME	NAME	NAME

I / We understand that AB Arogyadaan Policy and Super Top Up Policy are two separate policies issued by United India Insurance Co. Ltd. And hereby declare and warrant that the above statements are true and complete. I have read the salient features of the policy endorsed to the proposal form and accept the coverage subject to the terms, conditions and exclusions prescribed by the Insurance Company as per the Agreement between Andhra Bank and United India Insurance Company Limited. I / We understood that in case of any claim under the Policy Andhra Bank will not undertake any responsibility or will not accept any correspondence and the same have to be pursued with the Insurance Company / Specified TPA only.

I request you to renew the policy every year on due date duly debiting my account until further notice in writing to the contrary. I am aware that the Policy will be renewed basing on premium rates, terms & conditions prevailing at the time of renewal effective from the date of payment of premium.

Place:

Dated **Signature of Proposer**

FOR OFFICE USE ONLY

Premium remitted BA No……Dated …… for Rs. ……..

Date: _____

Signature of the Branch Manager

Original with Photos : United India Insurance Company Ltd.
2nd Copy : Andhra Bank, Branch, 3rd Copy : Customer

UNITED INDIA INSURANCE COMPANY LIMITED

Bancassurance Division, 7th Floor, United India Towers, Basheerbagh, Hyderabad - 500 029.

1. SCOPE:

The Policy Holder will be indemnified towards hospitalization expenses (as in patient only) incurred due to Illness/Accidental injury subject to the terms conditions and exclusions of the said policy

2. SUM INSURED:

The Sum Insured is a collective limit of compensation for the family members covered under the policy, i.e. Coverage is extended on a floater basis. The eligible members to be covered under this scheme are self, spouse and up to two dependent children under the Plan A, which can be extended to cover the parents also under Plan B. The entry level age of the family members can vary between three months to ***70*** years, whereas the entry level age for proposer can vary between 5 years and 70 years. If sum insured is enhanced during renewals, the enhanced sum insured will have fresh proposal status and claims will be dealt accordingly. The renewals are allowed lifelong for members already covered under the scheme provided the members are continuous. Dependent Children are –

- Male child who is employed without any source of income upto 26ys (completed) of age
- Female child who is unemployed & unmarried.

3. COVERAGES:

Expenses on Hospitalization for a minimum of 24 hours are admissible. However, this time limit is not applied to specific treatments, i.e., Dialysis, Chemotherapy, Radiotherapy, Eye Surgery, Lithotripsy (Kidney Stone Removal), D&C, Tonsillectomy taken in Hospital / Nursing Home and the Insured is discharged on the same day, the treatment will be considered to be taken under hospitalization Benefit…..For further details please refer to Claims Procedure.

4. CLAIMS PROCEDURE:

(a)CASHLESS FACILITY:

The insured person shall enjoy the cash less facility for taking treatment in the network hospitals listed in the TPAs Member Guide Book. For availing easy and expedite services step by step guidelines given in the Member Guide Book are to be carefully adhered to.

(b)TREATMENT AT NON-NETWORK HOSPITALS

Hospitalization Intimation to be given to either TPA or Insurance Company before or within 24 hours of admission. Expenses in Non NETWORK hospitals are reimbursed by TPAs up to the limit of sum insured. And all original documents should be submitted with in 30 days of discharge. Claim form is available at all branches of Andhra Bank/ In GHPL Web Site www.ghpltpa.com . For availing easy and expedite services step by step guidelines given in the Member Guide Book are to be carefully adhered to.

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

i. Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home not exceeding 1% of the sum insured per day or the actual amount whichever is less subject to maximum of Rs. 5000/-. This also includes nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

ii. Intensive Care Unit (ICU) expenses not exceeding 2% of the sum insured per day or actual

amount whichever is less subject to a maximum of Rs. 10,000/-.

iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.

iv. Anaesthetic, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, Orthopaedic implants, infra cardiac valve replacements, vascular stents, relevant laboratory/diagnostic tests, X-ray and such similar expenses that are medically necessary.

v. Hospitalization expenses (excluding cost of organ) incurred on donor in respect of organ

transplant to the insured. Note :

1. The amount payable under 4c (iii) & (iv) above shall be at the rate applicable to the entitled room category. In case the Insured person opts for a room with rent higher than the entitled category as in 4c (i) above, the charges payable under 4c (iii) & (iv) shall be limited to the charges applicable to the entitled category. This will not be applicable in respect of medicines & drugs and implants.

2. No payment shall be made under 4 c (iii) other than as part of the hospitalisation bill.

* Major surgeries include Cardiac surgeries, Brain Tumor surgeries, Pacemaker implantation for sick sinus syndrome, Cancer surgeries, Hip, Knee joint replacement surgery.

* The above limits specified are applicable per hospitalization/surgery.

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

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

Or any other surgeries/procedures agreed by the TPA/Company which require less than 24 hours hospitalization and for which prior approval from

TPA/Company is mandatory. This condition will also not apply in case of stay in hospital of less than 24 hours provided -

1 The treatment is such that it necessitates hospitalization and the procedure involves specialized infrastructural facilities available in hospitals.

2 Due to technological advances hospitalization is required for less than 24 hours only.

3 They are carried out in Day Care Centre networked by TPAs where requirement of minimum number of beds is overlooked but having (i) fully equipped

Operation Theatre, (ii) fully qualified Day Care Staff (c) fully qualified Surgeons/Post-Operative attending Doctors.

Note 1 : Procedures/treatments usually done in outpatient department are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in Day Care Centres.

Note 2: When treatment such as dialysis, Chemotherapy, Radiotherapy. Eye Surgery, Lithotripsy, O&C, Tonsillectomy, etc., is taken in the hospital / nursing home/Day-care Centre and the insured is discharged on the same day the treatment will be considered to be taken under hospitalization benefit section.

(d) For AYUSH Treatment, hospitalization expenses are admissible only when the treatment has been under gone in a Government Hospital or in any Institute recognized by the Government and/or accredited by Quality Council of India/National Accreditation Board on Health or any other suitable institutions.

(e) Company's Liability for all claims admitted in respect of any/all insured person/s during the period of insurance shall not exceed the Sum Insured stated in the schedule.

5 DEFINITIONS:

5.1. ACCIDENT:

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

5.2

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

B. "Chronic condition" A chronic condition is defined as a disease, illness, or injury that has one or more of

the following characteristics i. It needs ongoing or long-term monitoring through consultations,

examinations, check- ups and/or tests

ii. It needs ongoing or long-term control or relief of symptoms

iii. It requires your rehabilitation or for you to be specially

trained to cope with it iv. It continues indefinitely

v. It comes back or is likely to come back

5.3 ALTERNATIVE TREATMENTS:

Alternative Treatments are forms of treatment other than treatment "Allopathy" or "modern medicine and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian Context.

5.4 CASHLESS FACILITY:

Cashless facility "means a facility extended by the insurer to the insured where the payments, of the cost of treatment undergone by the insured in accordance with the policy terms and conditions, or directly made to the network provider by the insurer to the extent preauthorization approved.

5.5 CONGENITALANOMALY:

Congenital Anomaly refers to a condition(s) which is present since birth, and which is

abnormal with reference to form, structure or position. a. Internal Congenital Anomaly

which is not in the visible and accessible parts of the body.

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

5.6 CONDITION PRECEDENT:

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

5.7 CONTRIBUTION:

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

5.8 DAYCARE CENTRE:

A day care Centre means any institution established for day care treatment of illness and/ or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under;-- has qualified nursing staff under its employment- has all qualified medical practitioner(s) in charge- has a fully equipped operation theatre of its own where surgical procedures are carried out.- maintains daily records of patients and will make these accessible to the insurance companies authorized personnel.

5.9 DAY CARE TREATMENT:

Day care Treatment refers to medical treatment and or surgical procedure which is

i. undertaken under general or local anesthesia in a hospital/day care Centre in less than 24 hours because of technological advancement, and

ii. Which would have otherwise requires hospitalization of more than 24 hours.

Treatment normally taken on an outpatient basis is not included in the scope of this definition.

5.10 GRACE PERIOD:

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

5.11 HOSPITAL / NURSING HOME:

A Hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under the Clinical establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under

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

The term ' Hospital / Nursing Home ' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

5.12 HOSPITALIZATION:

Hospitalization means admission in a Hospital/Nursing Home for a minimum period of 24 consecutive hours of inpatient care except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours

5.13 ID CARD:

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

5.14 ILLNESS:

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.

Any one illness will be deemed to mean continuous period of illness and it includes relapse within 105 days from the date of discharge from hospital / Nursing Home where treatment has been taken. Occurrence of the same illness after a lapse of 105 days as stated above will be considered as fresh illness for the purpose of this policy.

5.15 INJURY:

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

5.16 IN PATIENT CARE:

In Patient Care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

5.17 INTENSIVE CARE UNIT:

Intensive Care Unit means an identifies section, ward or wing of a Hospital which is under the constant supervision of a dedicated medical practitioner(s) and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

5.18 MEDICALADVICE:

Any consultation or advice from a medical practitioner/doctor including the issue of any prescription or repeat prescription.

5.19 MEDICAL EXPENSES:

Medical Expenses means those expenses that an insured person has necessarily and actually incurred for medical treatment on account of illness or accident on the advice of a medical practitioner, as long as these are no more than would have been payable if the insured person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

5.20 MEDICALLY NECESSARY:

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

- is required for the medical management of the illness or injury suffered b y the insured;

- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;

- must have been prescribed by a medical practitioner;

- must confirm to the professional standards widely accepted in international medical practice or by the medical community in India.

5.21 NETWORK PROVIDER:

Network Provider means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

The list of network hospitals is maintained by and available with the TPA and the same is subject to amendment from time to time.

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

subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

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

5.22 NON NETWORK :

Any Hospital, Day care centre or any other provider is not a part of the network.

5.23 NOTIFICATION OF CLAIM

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

5.24 OPD TREATMENT:

OPD Treatment is one in which the insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of medical practitioner*.* The insured is not admitted as a day care or in-patient.

5.25 PRE-EXISTING DISEASE:

Pre Existing Disease is any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment, within 36 months prior to the first policy issued by the insurer.

5.26 PRE HOSPITALISATION MEDICAL EXPENSES:

Medical expenses incurred immediately 30 days before the insured person is hospitalized will be considered as part of a claim as mentioned under Item 1.2 above provided that;

i. Such medical expenses are incurred for the same condition for which the insured person's

hospitalization was required and ii. The inpatient hospitalization claim for such hospitalization is

admissible by the insurance company.

5.27 POST HOSPITALISATION MEDICAL EXPENSES:

Relevant medical expenses incurred immediately 60 days after the Insured person is discharged from the

hospital provided that ; a. Such Medical expenses are incurred for the same condition for which the Insured

Person's Hospitalization was required; and b. The In-patient Hospitalization claim for such Hospitalization

is admissible by the Insurance Company.

5.28 QUALIFIED NURSE:

Qualified Nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India and/or who is employed on recommendation of the attending medical practitioner.

5.29 REASONABLE AND CUSTOMARY CHARGES:

Reasonable Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.

5.30 RENEWAL:

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

5.31 ROOM RENT:

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

5.32 SUBROGATION:

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

5.33 UNPROVEN/EXPERIMENTAL TREATMENT:

Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is not based on established medical practice in India.

5.34 **MEDICAL PRACTITIONER:**

Medical Practitioner means a person who holds a degree / diploma of a recognized institution and is registered by Medical Council of respective State of India. The term Medical Practitioner would Physician, Specialist and Surgeon.

6. **EXCLUSIONS:**

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

6.1. Any Pre-existing condition(s) as defined in the policy, until 36 months of continuous coverage of such insured person have elapsed since inception of his/her first policy with the Company.

6.2. Any disease other than those stated in clause 6.3 below, contracted by the Insured person during the first 30 days from the commencement date of the policy. This exclusion shall not however, apply in case of the Insured person having been covered under an Insurance scheme with our Company for a continuous period of preceding 12 months without any break.

6.3 During the first year of the operation of the policy, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hyperthrophy, Hysterectomy for Menorrhagia / Myomectomy, or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout & Rheumatism, Calculus Diseases, Age related Osteoarthritis & Osteoporosis are not payable. Internal Congenital Disease means anomaly which is not visible and accessible parts of the body.

6.4 Total Knee Replacement will be covered in the policy after 36 months of continuous renewal without break applicable for fresh policies taken from 09.06.2013.

6.5 Injury / 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).

6.6 a. Circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident. b. Vaccination or inoculation.

c. Change of life or cosmetic or aesthetic treatment of any description such as correction of eye sight, etc., d. Plastic surgery other than as may be necessitated due to an accident or as part of any illness.

6.7 Cost of spectacles, contact lenses and hearing aids, including lasik operations.

6.8 Dental treatment or surgery of any kind including hospitalization.

6.9 Convalescence, general debility; run-down condition or rest cure, Obesity treatment and its complications including morbid obesity, Congenital external disease/defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, infertility, Sterility, Venereal disease, intentional self injury and use of intoxication drugs / alcohol.

6.10 All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB - III) or lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

6.11 Charges incurred at Hospital or Nursing Home primarily for diagnosis, x ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home.

6.12 Expenses on vitamins and tonics unless forming part of treatment for injury or diseases as certified by the attending physician.

6.13 Injury or Disease directly or indirectly caused by or contributed to by nuclear weapons/materials.

6.14 Treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these including caesarean section, except abdominal operation for extra uterine pregnancy (Ectopic pregnancy), which is proved by submission of Ultra Sonographic report and Certification by Gynaecologist that it is life threatening one if left untreated.

6.15 Naturopathy Treatment, acupressure, acupuncture, magnetic therapies, experimental and unproven treatments/ therapies. Treatment including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

6.16 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc.
Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings,

elastocrepe bandages, external orthopedic pads, sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer, alpha / water bed and similar related items etc., and also any medical equipment, which is subsequently used at home etc.

6.17 Change of treatment from one system of medicine to another unless recommended by the consultant/hospital under whom the treatment is taken.

6.18 All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, ayah, private nursing/barber or beauty services, died charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses.

6.19 Any kind of Service charges, Surcharges, Admission Fees/Registration Charges, Luxury Tax and similar charges levied by the hospital

6.20 All non-Medical expenses. The list of non-medical expenses is available in the company website www.uiic.co.in.

6.21 Domiciliary Hospitalization benefits are not covered under the policy.

6.22 Ailments pertaining to or arising out of Obesity and Psychiatric / Psychosomatic disorders are not covered under the policy.

CONDITIONS: The Proposal form, and the Policy issued shall constitute complete Contract of Insurance.

7.1 Every notice or communication regarding hospitalization or claim under this policy shall be delivered in writing at the address of the TPA office as shown in the Schedule. Other matters with regard to the policy may be communicated to the Policy Issuing Office and the TPA.

7.2 The premium payable under this Policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the company signed by a duly authorized official of the company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this Policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be a condition precedent to any liability of the Company to make any payment under this Policy.

7.3 Upon the happening of any event which may give rise to a claim under this Policy notice with full particulars shall be sent to TPA in the schedule immediately and in case of emergency hospitalization within 24 hours from the time of hospitalization.

All supporting documents relating to claim must be filed with TPA within 30 days from the date of discharge from the hospital. In case of Post Hospitalization treatment (60 days) all claim documents to be submitted within 15 days after completion of treatment.

7.4 The insured person shall obtain and furnish to the TPA with all original bills, receipts and other documents upon which a claim is based and shall also give the TPA /Company such additional information and assistance as the TPA / Company may require in dealing with the claim.

7.5 Any medical practitioner authorized by the TPA / Company shall be allowed to examine the Insured person in case of any alleged injury or disease requiring Hospitalization and so often as the same may reasonably be required on behalf of the TPA / Company.

7.6 If at the time when any claim arises under this Policy, there is in existence any other insurance (other than Cancer Insurance Policy in collaboration with Indian Cancer Society), whether it be effected by or on behalf of any Insured Person in respect of whom the claim may have arisen covering the same loss, liability, compensation, costs or expenses, the Company shall not be liable to pay or contribute more than its rateable proportion of any loss, liability, compensation costs or expenses. The benefits under this Policy shall be in excess of the benefits available under Cancer Insurance Policy.

7.7 COST OF HEALTH CHECK – UP:
The persons insured shall be entitled for Medical check up at the end of block of every three underwriting years provided there are no claims reported during the block. This may be availed by any insured person / s who have been continuously insured for three claim free years with the Company. Such expenses during the policy period will be reimbursed up to a maximum of 1% of the average Sum Insured of the preceding three years and will be

carried out by the Company authorised TPAs. This is applicable only for Arogyadaan policy and not for Super Top Up policy.

7.8 Super Top up Policy covers health risks of insured beyond a threshold limit of Rs. 5 Lac under AB Arogyadaan Policy.

7.**9 Renewal Clause:**

The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof and in any case not later than 30 days from the date of expiry of the current policy. The Company shall not be bound to give notice that such renewal premium is due, provided however that if the insured shall apply for renewal and remit the requisite premium before the expiry of this policy, renewal shall not normally be refused, unless the Company has reasonable justification to do so.

A policy that is sought to be renewed after the grace period of 30 days will be underwritten as a Fresh Policy only and the Policy conditions attributable to Fresh Policies would be applicable. 30 days grace period is to extend the renewal benefits of the policy as applicable only. Policy coverage will not be there during the lapsed period of the policy, hence claims arising during the lapsed period will not be considered.

7.10 Cancellation Clause:

The Company may at any time cancel the Policy on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the insured by sending seven days notice in writing by post to the insured at his last known address in which case the Company shall return to the insured a proportion of the last premium corresponding to the unexpired period of insurance if no claim has been paid under the policy. The insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate table given below provided no claim has occurred up to the date of cancellation:

PERIOD ON RISK	RATE OF PREMIUM TO BE CHARGED.
Up to one month	1/4th of the annual rate
Up to three months	1/2 of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate.

7.11 If any dispute or difference shall arise as to the quantum to be paid under the policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

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

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

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

7.14 DISCLOSURE TO INFORMATION NORM

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

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

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

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

7.15 Room rent & Nursing expenses:

1. Not exceeding 1 % of the Sum Insured or Max of Rs. 5000/- per day, whichever is less.
2. ICU Expenses: Not exceeding 2% of the Sum Insured or 10,000 per day or actual amount whichever is less
3. If the Insured Member is admitted in a Hospital room and opts for a room higher then his / her eligibility, as per terms and condition of policy, then the Insured member shall bear the ratable proportion of the expenses incurred for (a) Investigations and Diagnostic expenses, (b) Surgeon, Consultant and Anesthetist fees / expenses In the ratio to eligible room rent. divided by room rent actually incurred. The room rent actually incurred shall include Room rent, Nursing, duty doctor and Boarding expenses. The proportionate clause would be applicable only when other charges like Surgeon, Anesthetist, Medical Practitioner, Consultants, and Specialists Fees, Investigations & Diagnostic Expenses differ due to the insured opting for higher Room Category.

   Please refer the below example for better understanding

   EXAMPLE [1]

   If my Sum insured is Rs.1, 00,000/-, my room rent eligibility is Rs.1000/- per day (1% of Sum Insured) and I get admitted in Room of Rs.2000/- , (which is higher than my eligibility) , the proportionate deductions applicable to the claim amount would be - 1000/2000 X (all related expenses as mentioned above)

EXAMPLE [2]

In similar case, if my Sum Insured is Rs. 2, 00,000/-, that the eligibility would be "Rs. 2000/-" per day (1% of Sum Insured). In this case, there would be no proportionate deductions.

4. **Hospitalization expenses limited to:**

(a) Cataract : 10% of SI Subject to max of Rs.25, 000/-

(b) Hernia : 15% of SI subject to max of Rs.30, 000/-

(c) Hysteretomy/Myomectomy : 20% of SI subject to max of Rs.50,000/-

(d) For specified major surgeries : 80% of SI subject to maximum of Rs.4,00,000/ under Arogyadaan Policy and Rs. 12 Lac under Super Top Up Policy - Cardiac/Cancer/Brain Tumour/Pace Maker implantation/Hip replacement/Knee joint replacement/ Sick / Sinus syndrome.

(e) Pre and post Hospitalization Expenses: Actual subject to a maximum of 10%of the sum insured paid Policy Wise. 30 days in case of pre-Hospitalization and 60 days in case of Post Hospitalization.

7.16 ENHANCEMENT OF SUM INSURED

Sum Insured and Premium will vary at the option of each Account Holder. However, while renewing the policy , the Insured Account Holder can enhance Sum Insured.

The selected Sum Insured is final till the expiry of policy period. The Enhanced Sum Insured will not be applicable for Pre-existing conditions / disease i.e. in case the Insured has been hospitalized for any ailment during the expiring policy period, even if he/ she chooses to enhance the Sum Insured under the Policy at the time of renewal, the Sum Insured would be restricted to the Sum Insured under the expiring Policy for such Pre-existing condition / ailment.

The selected Sum Insured will float amongst all family members. Either one family member or all the family members put together can avail Sum Insured so selected and premium paid subject to policy terms and conditions.

7.17 All medical/surgical treatments under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency. Payment of claim shall be made through TPA to the Hospital/Nursing Home or the Insured Person as the case may be.

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It is hereby agreed and understood that, that this insurance being a Group Policy availed by the Insured covering Members, the benefit thereof would not be available to Members who cease to be part of the group for any reason whatsoever. Such members may obtain further individual insurance directly from the Company and any claims shall be governed by the terms thereof.

8. SUPER TOP UP POLICY CONDITIONS:

8.1. Super Top Up Policy is a Family Floater Insurance that covers health risks beyond a threshold limit of Rs. 5 Lac under Arogyadaan Policy.

8.2. Waiting period of 36 months is applicable for Pre-existing ailments.

8.3. This policy would be operational only after exhausting Sum Insured of Rs. 5 Lac under Arogyadaan Policy.

8.4. Pre and post hospitalization expenses are paid policy wise (Arogyadaan and Super Top Up Policy) up to a maximum of 10% of Sum Insured.

8.5. Room, Boarding and Nursing Expenses as provided by the Hospital / Nursing Home are payable upto 1% of Sum Insured per day maximum of Rs.5,000/-. This also includes Nursing Care, RMO charges, IV Fluids / Blood Transfusion / Injection administration charges and the like.

8.6 ICU Expenses not exceeding 2% of the sum insured to the maximum of Rs. 10,000 or actual amount whichever is less per day.

8.7. Limit for each Hospitalization for major surgeries is 80% of the Sum Insured up to a maximum of Rs. 12 Lac.

8.8. All other terms and conditions are as per AB Arogyadaan Policy.

IMPORTANT NOTICE

The Company may revise any of the terms, conditions and exceptions of this insurance including the premium payable on renewal in accordance with the guidelines/rules framed by the Insurance Regulatory and Development Authority (IRDA). We shall notify you of such changes at least three months be- fore the revision are to take effect.

The Company may also withdraw the insurance as offered hereunder after following the due process as laid down by the IRDA and we shall offer to cover you under such revised/new covers for which we shall have obtained from the Authority at such terms, conditions, exceptions and premium that the IRDA may have approved.

- **LIABILITY OF THE BANK**
  Bank is only acting as a facilitator in payment of Premium. The Proposal Form and the Policy issued shall constitute complete contract of Insurance between the Insured and the Insurer . Insurer shall be liable towards Medical Reimbursement of claim to the Insured.

In case you require any further information please feel free to contact your Bank or **United India Insurance Co.Ltd.,** on the phone numbers **040-23230537, 04023230527** or TPA M/s GOOD HEALTH PLAN LTD on Toll Free No. **1800 102 9919 / 1800 103 9919**