CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
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IRDA Regn. No.123; PAN AABCC6633K; CIN U66030TN2001PLC047977

CHOLA GROUP TOPUP PROTECT
CHOHLGP22160V012122
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Master policy will be issued in the name of Group Manager and individual certificate may be issued to the beneficiaries.

PERSONS WHO CAN BE INSURED

- This Insurance is available to persons (Self, Spouse & Parents) aged between 18 Years and 65 years (Completed age) at the commencement date of this policy.
- Children can be covered from the date of birth upto the age of 26 years (Completed age) at the commencement date of the policy, provided atleast one of the parents of the child is also covered under the policy
- The Primary Member availing the policy should be minimum 18 years on the Commencement date of the policy.
- Primary Member of the Group can avail the policy for his/her Spouse, Children upto two, dependent Parents on Individual Sum Insured Basis. On family floater basis policy can be availed for a maximum of 4 members covering Primary Insured, Spouse and upto 2 Children.
- Coverage of Primary Member is mandatory under the policy
- **Premium Payment options**: Premium under this policy shall be payable on Annual, Half-Yearly, Quarterly or Monthly basis. The Premium payment method opted by the Group Manager under the policy will be applicable to all the members covered under the policy. No option will be given to Individual beneficiary under the group to vary the Payment basis.

SCHEDULE OF BENEFITS

In the event of **Insured Person** suffering from an illness or Accident during the Policy Period that requires hospitalisation on an Inpatient basis or treatment defined as a **Day Care Procedure**, then this policy will pay for the Medical Expenses for the benefits mentioned below in excess of the **Deductible** stated in the **Policy Schedule/Certificate**.

The **deductible** will apply over aggregate of all admissible claims under the policy per annum.
In case of Individual Cover, the deductible will be applied over the aggregate of all the admissible claims made by the **Insured Person**.
In case of Family Floater Cover, the deductible will be applied over the aggregate of all the admissible claims made by all **Insured Persons** in the family.

COVERAGE	
In Patient Hospitalisation Expenses	Covered
Pre-Hospitalization Expenses	60 days
Post-Hospitalization Expenses	90 days
Emergency Ambulance Expenses	Covered
Day Care Procedures	Covered
Domiciliary Hospitalisation	Covered
AYUSH Coverage Expenses	Covered
Expenses considered for aggregate deductible	In Patient Hospitalisation Expenses
	Pre-Hospitalization Expenses
	Post-Hospitalization Expenses
	Emergency Ambulance Expenses
	Day Care Procedures
	Domiciliary Hospitalisation
	AYUSH Coverage Expenses
WAITING PERIOD	
Initial waiting period of 30 days	Applicable
Waiting period for listed illness	12 months
Waiting period for Pre existing Disease	36 months

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Note:

- In case of Individual cover, the benefits shown in the table above will represent our maximum liability for each **Insured Person** for any and all claims made during the **policy period**.
- In case of **Family floater** cover, the benefits shown in the table above will represent our maximum liability for any and all claims made by all Insured person(s) in the family during the **policy period**.
- The Sum Insured shall be greater or equal to the deductible amount.

COVERAGE

1 Inpatient Hospitalisation Expenses:
This Policy will indemnify for medically necessary inpatient treatment expenses, under different heads mentioned below, incurred during the policy period towards hospitalization for the disease, illness, medical condition or injury contracted or sustained by the insured person during the **Policy Period** as stated in the **Policy Schedule/Certificate** subject to **deductibles**, terms, conditions and exclusions mentioned in the Policy.

a. Room, Boarding charges as provided by the Hospital/Nursing Home in normal rooms or in ICU
b. Nursing Expenses incurred during In-Patient hospitalization
c. Surgeon, Anaesthetist, Medical Practitioner, Consultants & Specialist Fees
d. Hospital miscellaneous (medical costs) services (such as laboratory, x-ray, and diagnostic tests)
e. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, and Medicines & Drugs, Diagnostic Materials and Cost of Pacemaker, prosthetic and other devices implanted internally during a surgical procedure.
f. Hospitalisation expenses of the Organ donor during the stay as in-patient solely for the purpose of harvesting the organ, excluding pre and post hospitalisation expenses for such donor.

2. Pre Hospitalisation Expenses:
This Policy will pay for medical expenses incurred upto 60 days prior to the date of **Hospitalisation** subject to deductible provided that
a. The expenses were incurred after the first 30 day waiting period as mentioned in Exclusion no 5.1
b. Such Medical Expenses are incurred for the same condition for which the **Insured Person's Hospitalization** was required, and
c. The Inpatient **Hospitalization** claim for such Hospitalization is admissible by Us

Payment under this benefit will reduce the Sum Insured.

3. Post Hospitalisation Expenses:
This Policy will pay for medical expenses incurred upto 90 days from the date of discharge from the hospital subject to deductible provided that

a. Such Medical Expenses are incurred for the same condition for which the **Insured Person's Hospitalization** was required, and
b. The Inpatient **Hospitalization** claim for such Hospitalization is admissible by Us

Payment under this benefit will reduce the Sum Insured.

4. Emergency Ambulance Expenses:
This Policy will pay for Road Ambulance Expenses actually incurred to transfer the **Insured Person** following an emergency to the nearest **Hospital** with adequate facilities, provided that:

a) The ambulance service is offered by a healthcare or an ambulance service provider.
b) The Inpatient **Hospitalization** claim for such Hospitalization is admissible by **Us**

Ambulance Expenses will be reimbursed to the **Insured** on submission of original bills. Cashless facility will not be available for Ambulance Expenses/Services.

Payment under this benefit will reduce the Sum Insured.

5. Day Care Procedures:
This Policy will pay for Medical Expenses incurred as a Day Care Procedure/Treatment as per Annexure 2 that requires less than 24 hours of hospitalization, upto **Sum Insured** in excess of **deductible** mentioned in the **Policy Schedule/Certificate,** if it is performed in a network hospital. In case the procedure is performed in a non-network hospital, the same must be pre-authorized by us.

Pre-authorisation has to be obtained 72 hours prior to the date of admission in case of planned admission and within 24 hours in case of emergency admission.

Payment under this benefit will reduce the Sum Insured.

6. Domiciliary Hospitalisation:
This policy will reimburse the Medical Expenses incurred by an **Insured Person** for medical treatment taken at his/her home which would otherwise have required Hospitalisation provided:

a) on the advice of the attending Medical Practitioner, the **Insured Person** could not be transferred to a Hospital or
b) a Hospital bed was unavailable, and provided that:
   I. The condition for which the medical treatment is required continues for at least 3 days, in which case the Policy pays reasonable cost of necessary medical treatment for the entire period
   II. Pre-hospitalisation expenses and Post Hospitalisation expenses in accordance with Sections 3.2 and 3.3 will be covered under this benefit.

Cashless facility will not be available for such a claim. Payment under this benefit will reduce the Sum Insured.

7. AYUSH Coverage Expenses:
This **Policy** will pay for non-allopathic treatments that require more than 24 hrs of Hospitalization and Day care procedures for illness or accidental bodily injury sustained by the **Insured** upto **Sum Insured** in excess of deductible as mentioned in the **Policy Schedule/Certificate**. The treatment should have been undergone in AYUSH Hospital/AYUSH Day care centre as defined in the policy.

Payment under this benefit will reduce the Sum Insured

WAITING PERIODS

a. Waiting Periods:
i. Pre-Existing Diseases – Code – 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 policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the norms on portability stipulated by IRDAI, 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 Insurer.

ii. Specified disease/procedure waiting period – Code – Excl02:

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of first 12 months of continuous coverage after the date of inception of the first 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 Person 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) List of specific diseases/procedures are as below

1. **Congenital Internal Anomaly**,
2. Varicose veins and Varicose Ulcers
3. Rheumatism and arthritis of any kind
4. Treatment of diseases on ears/ tonsils /adenoids /paranasal sinuses / Deviated Nasal Septum
5. Stones in the Urinary and Biliary systems
6. Gastric or Duodenal Ulcer
7. Any type of benign Cyst/ Nodules/ Polyps/ Tumours/ Breast Lumps
8. Intervertebral Disc Prolapse, and Degenerative Disc / vertebral Disorders
9. Cataract
10. Benign Prostatic Hypertrophy
11. Myomectomy, Hysterectomy unless because of malignancy
12. Dilatation and curettage (D&C)
13. Anal Fistula, Fissure and Piles
14. All types of Hernia
15. Hydrocele
16. Chronic Renal Failure
17. Joint replacement Surgery unless because of accident

iii. 30-day waiting period – Code – 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 Person 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

GENERAL EXCLUSIONS

The policy does not cover any losses caused directly due to the following:

1. **Change-of-Gender treatments:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex. **Code – Excl07**
2. **Excluded Providers: Code-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 upto the stage of stabilization are payable but not the complete claim.
3. **Refractive Error:** Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres. **Code – Excl15**

4. **Unproven Treatments**: 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. **Code – Excl16**
5. **Sterility and Infertility: Code – Excl17**: Expenses related to 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
6. **Maternity: Code – Excl18:**
   i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;
   ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period
7. Injury / illness directly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike operations (whether war be declared or not), ionising radiation, contamination by Radioactive material, nuclear fuel or nuclear waste or from the combustion of nuclear fuel, civil war, revolution, insurrection, mutiny, martial law.
8. Expenses incurred for any dental treatment or surgery of a corrective, cosmetic or aesthetic nature unless it requires hospitalisation and is carried out under general anesthesia and is necessitated by Illness or Accidental Bodily Injury.
9. Any treatments or Investigation taken outside India
10. Treatment other than Allopathy and AYUSH

GENERAL CONDITIONS

1. Disclosure of Information:
The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policy holder/Insured.
(Explanation: 'Material facts' for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

2. Condition Precedent to Admission of Liability:
The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Claim Settlement (provision for Penal lnterest):
i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of last necessary document.
ii. ln the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
s (Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBl) at the beginning of the financial year in which claim has fallen due)

4. Complete Discharge:
Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5. Multiple policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be treated as the Primary Insurer and 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.
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy/policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
iii. If the amount to be claimed exceeds the sum insured under a single policy, the Primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions.
iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6. Fraud
lf any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. Cancellation of cover
i. The policyholder may cancel this policy at any time during the term, by giving 7 days written notice in writing and in such an event, the Company shall
a. refund proportionate premium for the unexpired policy period, if the term of policy upto one year and there is no claim(s) made during the policy period
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced
Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Migration
The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

9. Portability
The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date. If such person is presently covered and has been continuously covered without any lapses under any Health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

10. Renewal of Policy
The health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium clause of the policy.
i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
v. No loading shall apply on renewals based on individual claims experience

11. Withdrawal of Policy:
a. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the policy.
b. Insured person will have the option to migrate to similar health insurance product available with the company at the time of renewal with all the accrued continuity benefits to the extent of Sum Insured, cumulative bonus if any, Specific waiting periods, waiting period for pre-existing disease in the previous policy, moratorium period, provided the policy was renewed continuously without a break.

12. Moratorium Period:
After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits

13. Premium payment in Instalments:
If the insured person has opted for Payment of Premium on an instalment basis i.e. Annually, Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy).
i. Grace period of 15 days for Monthly and 30 days for Quarterly, Half-yearly and Annual mode would be given to pay the instalment premium due for the policy
ii. The policy will be in force during such grace period and any claim arising during the grace period will be payable subject to policy terms and conditions.

iii. 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
iv. No interest will be charged if the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

14. Possibility of Revision of Terms of the Policy including the Premium Rates:
The company may revise or modify the terms of the policy including the premium rates with prior approval of the Product Management Committee, of the Company. The insured person shall be notified three months before the changes are effected.

15. Nomination:
The policyholder is required at the inception of the policy and at the time of renewal to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. ln the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

16. Change of Address / Contact details
It is in the **Insured person's** interest to intimate us if there is any change in residential address and phone numbers.

17. Deductible
Deductible is a cost sharing requirement under this **Policy** that provides that the **Company** will not be liable for medical expenses upto a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the **Insurer**. A **deductible** does not reduce the **Sum Insured**. **Deductible** opted as per the **Policy Schedule/Certificate** will apply over aggregate of all admissible claims under the policy per annum by **Insured** (Individual cover) or insured family (in case of Family Floater cover).

18. Specific Exclusions (Applicable for other than Employer-Employee Groups):
a. A specific exclusion with waiting period may be applied on a medical condition/disease depending on the medical test done based on the Proposed Insured person's medical history and declarations as part of special conditions on the Policy with due consent from the policyholder.

19. Notification
a. Any and all notices and declarations for the attention of the Insurer shall be in writing and shall be delivered to the Insurer's address as specified in the Policy Schedule/Certificate.
b. Any and all notices and declarations for the attention of the Policy holder or any or all of the insured Persons shall be in writing and shall be sent to the Policy holder's/Primary Insured's address as specified in the Schedule/Certificate.

20. Transfer
Transferring of interest in this Policy to anyone else is not allowed

21. Governing Law
The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law. The section headings of this Policy are descriptive only and do not form part of this Policy for the purpose of its construction or interpretation.

22. Entire Contract

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The **Policy** constitutes the complete contract of insurance. Only the Insurer may alter the terms and conditions of this Policy. Any alteration that may be made by the **Insurer** shall be evidenced by a duly signed and sealed **endorsement** on the **Policy**.

23. Territorial Limits
The **Insurer's** liability to make any payment towards illness or accidental injury shall be to make payment within India and in Indian Rupees only for medical services or procedures rendered in or undertaken within India.

24. Assignment:
The policy can be assigned subject to applicable laws.

25. Claim Procedure
If the **Insured Person(s)** suffer from **Accidental** Bodily Injury or is diagnosed with an Illness which gives rise to or may give rise to a claim under this policy, then it is a condition precedent to our liability that the Insured shall immediately:
a. Give us notice of the claim at the earliest irrespective of notice provided to any other **insurer** for the same illness in case the Insured Person(s) hold multiple insurance policies
b. Expeditiously give or arrange for us to be provided with any and all information and documentation in respect of the claim and/or our liability for it that may be requested by us
c. If the Insured has any other insurance **policy** in addition to this Super Topup Insurance as on the date of claim which also covers any claim (in part or in whole) being made under this policy, then the Insured will have the right to require a settlement of his claim in terms of any of his policies. The insurer chosen by the Insured shall settle the claim, as long as the claim is within the limits of and according to terms of the chosen policy.
Provided further that, if the amount to be claimed under the policy chosen by the Insured, exceeds the sum insured under the policy after considering the deductibles or co-pay (if applicable), the insured shall have the right to choose the insurers from whom he/she wants to claim the balance amount. In such cases the respective insurers shall indemnify the hospitalisation costs in accordance with the terms and conditions of the chosen policy.
d. If the Insured make the first claim from the primary insurer and have not intimated Us immediately along with the other **Insurer** expecting that the total claim would not exceed the **sum insured** limit of such insurance, it would not amount to delayed intimation provided however that the **Insured** intimate Us immediately when the cost of treatment is likely to exceed the deductible amount under this policy or before the discharge, whichever is earlier

Type of hospitalization	Claim Intimation - Turn Around Time	
Cashless - Admission in Network Hospital	**Planned Hospitalization:** pre-authorization has to be obtained 72 hours prior to the date of planned admission	**Emergency Hospitalization**: within 48 hours of an emergency admission
Reimbursement - Admission in Non - Network Hospital (E mail: customercare@cholams.murugappa,com) or phone (@ Toll free no. 1800-208-9100)	**Planned Hospitalization** - Claim intimation has to be given to us on email or at the Toll free Number within 48 hours for planned hospitalization	**Emergency Hospitalization:** Claim intimation has to be given to us on email or at the Toll free Number within 24 hours of an emergency hospitalization

a. Cashless Claims
Obtain our pre-authorisation for any medical treatment in any of our network hospitals as well as identified list of hospitals by GIC for common empanelment through anywhere cashless facility. Insured can view or download the updated Hospital Network from the Company's website www.cholainsurance.com as well as Chola MS mobile application. Pre-authorisation shall, if we are satisfied as to the validity of the claim, specify:

1. the treatment authorised;
2. the place at which it has been authorised, and

3. Any other conditions applicable to either.

b. Reimbursement Claims

1. Upon Hospitalisation, the **Insured Person** or his/her dependents shall provide us with fully particularised details of the quantum of the claim to be reimbursed and all other information and documentation in respect of the claim and/ or our liability as listed below at the earliest possible opportunity not exceeding 30 days from date of discharge.
2. We shall be under no obligation to pay or arrange to make payment for any claim until and unless it is satisfied as to the validity and quantum of the claim.
3. The Insured shall obtain and furnish to the Company all copy of bills, receipts and any other documentation upon which a claim is based. `Except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed 'necessary'. The expenses towards doctors' fees for any additional medical examination required by us, at the time of claim shall be borne by us.
4. We shall only make payment (unless already paid direct to the service provider/ hospital) to the **Insured** or his/her Nominee.
5. **Insured** hereby acknowledge and agree that the payment of any claim by or on behalf of us shall not constitute on the part of us any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the Insured, it being agreed and recognised by the **Insured** that we are not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution (including a Network Hospital) whether pre-authorised or not.

6. Following documents are to be submitted for processing of the claim:

- Claim Form duly filled and signed by patient/ Insured.
- Original Discharge summary in the hospital letter head with the seal and sign of the doctor with complete details of diagnosis, treatment given, treatment advised etc
- Original Main bill from the hospital with cost wise break up.
- Original payment receipt (Receipt should have Serial No)
- Original investigation reports (such as X Ray, Lab Reports, Scan reports etc) – These are required for supporting the ailment, hence all reports taken prior / at the time or after the hospitalization are required.
- All pharmacy bills should be accompanied with relevant prescriptions. Bills should contain date and patient name. If pharmacy is charged in the Main Hospital bill, then proper itemized break up of those medicines should be obtained from the hospital.
- Implant stickers or invoice where ever applicable
- In case of Road traffic accident (RTA), copy of FIR and/or Medico legal Certificate (MLC) would be required.
- AML documents in case the claimed amount is above 1 lac
- Bank details along with the cancelled cheque for claim payment through NEFT

Note: When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted to us.

Our Customer Support and Claims Office contact details are as detailed below for the purpose of claim intimation, submission or for any queries / grievances:

Chola MS customer support operates 24/7 basis and the contact details are:

- Toll Free Phone No: 1800-208-9100
- E-Mail: customercare@cholams.murugappa.com

Address of Chola MS Health Claims Office:
Cholamandalam MS General Insurance Company Limited

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Chola MS HELP – Health Claims Department
New No.2, Old No. 234, Parry House,
3rd Floor, N. S. C. Bose Road
Chennai - 600001
Customer Care Toll Free No: 1800-208-9100
E-Mail: customercare@cholams.murugappa.com

d- TPA :
There is no TPA tie –up envisaged for this product. Any arrangement in future will be disclosed in the Policy to the Policy holders

26. Delay in intimation of claim
It is essential and imperative that any loss or claim under the **policy** has to be intimated to us strictly as per the policy conditions to enable us to appoint investigator wherever deemed necessary for loss assessment. This will enable us to render prompt service by way of quick and fair settlement of claim, which is our primary motto.
Any genuine delay, beyond the **Insured's** control will definitely not be a sole cause for rejection of the claim. However any undue delay which could have otherwise been avoided at Insured's end and especially if the delay has hindered conducting investigation on time to make proper assessment, to mitigate further loss, if any may not only delay the claim settlement but also may result in claim getting rejected on merits.

27. Authority to Obtain Records
The insured must procure and cooperate with us in procuring any medical records and information from the hospital relating to the treatment for which the claim has been lodged. If required, the **Insured Person** should give consent to us to obtain Medical records / opinion from the Hospital directly relating to the treatment for which claim has been made.
If required the Insured / Insured Person must agree to be examined by a Medical Practitioner of Company's choice at our expense

28. Any one illness / relapse period
If the hospitalisation is continuous and the illness relapses within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken will be treated as same illness.

29. Enhancement of Sum Insured or Deductible
Sum insured or **Deductible** can be enhanced only at the time of renewal subject to reported claim status and health condition of the **insured**. If the **Insured** decides to increase the **Sum Insured** or **Deductible** at the time of renewal, subject to our acceptance, then the coverage for the increased **Sum Insured** shall be as if a new policy is issued for the additional **Sum Insured**. The additional **Sum Insured** will be available subject to 30 days, 1 year and 3 year waiting periods as per section 5.1, 5.2 and 5.3 of the Policy Terms.
Sum Insured Enhancement will not be considered for Insured Persons over 65 years of age

30. Arbitration
The parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this policy.
Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

31. Automatic Termination
This **policy** shall terminate immediately on the earlier of the following events irrespective of the expiry date mentioned in the **Policy Schedule/Certificate**
• Upon the demise of the covered person, in which case the **Company** will refund premium calculated on pro-rata basis for the unexpired period subject there being no claim under the policy.
• Upon exhaustion of the Sum Insured. However this will not affect the renewal for the subsequent period.

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32. Disclaimer of claim
It is also hereby further expressly agreed and declared that if we shall disclaim liability to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a Court of law or pending reference before Ombudsman, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

SECTION 8. GRIEVANCE REDRESSAL MECHANISM

Mechanism for Grievance Redressal:-
In case of any grievance the insured person may contact the company through
Website : www.cholainsurance.com
Toll free : 1800 208 9100
E-Mail : customercare@cholams.murugappa.com
Courier : Manager , Customer Care,
Chola MS General Insurance Company Limited
Hari Nivas Towers First Floor
#163, Thambu Chetty Street,
Parry's Corner, Chennai -600001

Procedure of Grievance Redressal
- Please write to customercare@cholams.murugappa.com to register your complaint.
- In Case of Senior Citizen please write to seniorcitizensupport@cholams.murugappa.com or call our Toll free @ 1800 208 9100 (for Health products)
- On lodging the complaint, a complaint reference number will be provided. An acknowledgement will also be sent with the details of turn around time for resolution and complaint registration details.
- In case you are not happy with the resolution provided or delay of greater than 7 working days, you may follow the below escalation matrix.

Escalation Matrix
- In case you are dissatisfied with the response or have not received a response, you may escalate the same to our Nodal Officer – Nodalescalation@cholams.murugappa.com (Quoting the previous Service request number)
- In case you are still unhappy with the response or have not received a response within 7 working days, you may escalate the same to our Chief Grievance Officer - GRO@cholams.murugappa.com (Quoting the previous Service request number)

If after having followed the above steps and your issue still remain unresolved, you may approach the Insurance Ombudsman for Redressal. Login to https://www.cioins.co.in/Ombudsman to get details on Insurance Ombudsman Offices.

Office Details	**Jurisdiction of Office**
AHMEDABAD - Shri Kuldip Singh, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

BENGALURU – Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 I 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL- Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar - 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH - Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI - Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI -600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: ,bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

GUWAHATI- Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD- Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
JAIPUR - Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA- Shri P.K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R.Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur,

	Deoria, Mau, Ghazipur, Chandauli, BaIlia, Sidharathnagar.
MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 I 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, ShamIi, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA- Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune- 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.