Mosquito Disease Protection Policy – Group

Prospectus

Introduction:

Mosquito Disease Protection Policy – Group by HDFC ERGO is designed to offer coverage against Mosquito borne diseases like Dengue, Malaria, Chikungunya. The product has been designed to offer Indemnity as well as benefit cover for these ailments. An insured has an option to choose any one of these option and has wide range of Sum insured to opt for.

Section A – Coverage

1. Vector Borne Diseases – Indemnity

We will pay under below listed covers on Medically Necessary Hospitalization of the Insured Person due to

i) Dengue Fever
ii) Malaria
iii) Other Vector Borne Diseases:
    a. Chikungunya
    b. Japanese Encephalitis
    c. Kala-azar
    d. Lymphatic Filariasis
    e. Zika Virus

which is/are contracted during the Policy Period and as defined and opted under the Policy subject to waiting Period as specified on the Schedule of Coverage.

a) In-Patient Hospitalization Expenses

i. Room rent, boarding and Nursing charges restricted to Single AC Private Room
ii. Intensive Care Unit charges
iii. Consultation fees
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances
v. Medicines, drugs and consumables
vi. Diagnostic procedures

Note pertaining specifically to AYUSH Treatments only:
Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-Patient Hospitalization Expenses' cover if undertaken in an AYUSH Hospital. However, any medical expense other than In-patient care AYUSH treatment expenses are not covered under this Policy.

Proportionate Deduction

Room Rent & Proportionate deduction: Insured Person is eligible for **Room Rent** category of up to Single Standard AC Room. In case of admission to a room exceeding the aforesaid category, the reimbursement/payment of Room Rent charges including all **Associated Medical Expenses** incurred at Hospital shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of **Room Rent** charges. This condition is not applicable in respect of **Hospitals** where differential billing for **Associated Medical Expenses** is not followed based on Room category.

Insured Person shall bear specified percentage of admissible Claim amount under each and every admissible Claim if Co-payment under Section 1.1 c) is opted and specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

Health Care at Home

Insured Person has the option to avail Health Care at Home for Medically Necessary Treatment of Illnesses opted for and covered under Section 1, if prescribed by treating Medical Practitioner.

This Cover can be availed through Cashless Facility only as procedure under Claims Procedure - Section F.

Insured Person shall bear specified percentage of admissible Claim amount under each and every admissible Claim if Co-payment under Section 1.1 c) is opted and specified in the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

b) Reinstatement of Sum Insured

We will add to the Sum Insured under Section 1a), an amount equivalent to the admissible Claim amount under Section 1a) of the Policy subject to maximum of Basic Sum Insured subject to following conditions;

a. Sum Insured reinstated under this cover can be used only for subsequent Hospitalization of the Insured Person during Policy Year and is not applicable for hospitalization under Any One Illness

b. Any unutilized amount of Sum Insured reinstated cannot be carried over to next policy year

c) Pre and Post Hospitalization Cover

We will pay for Pre Hospitalization Medical Expenses and Post Hospitalization Medical Expenses up to number of days mentioned on Policy Schedule/Certificate of Insured, which are incurred on treatment of diseases for which Claim under Section 1a) is admissible under the Policy.

1.1) Optional Covers

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that, We will pay the expenses/Sum Insured under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance.

a) Outpatient Treatment Expenses

We will indemnify the Insured Person towards expenses incurred on;

i. Outpatient Consultation with Medical Practitioner
ii. Diagnostic Tests
iii. Pharmacy

for Medically Necessary Treatment of diseases as opted under Section 1a)

Special Conditions applicable to Outpatient Treatment Expenses

If the Claim is payable under this Section and if the Insured Person is subsequently hospitalized within 15 days for the Medically Necessary treatment of same illness, entire Claim shall be admissible under Section 1a) and 1d) only and payable up to the Sum Insured under Section 1a) and 1d).

b) Recovery Benefit

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule if period of Hospitalization for Claim admissible under Section 1, exceeds 10 continuous days.

This benefit is not applicable if Medical treatment is taken under Health Care at Home

c) Co-payment

On availing this option, Co-Payment as mentioned on the Schedule of Coverage in the Policy Schedule will be applied on each and every admissible claim under Section 1a).

d) Waiting Period Options

On availing this option, Waiting Period will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applicable for all the Claims under the Policy.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

2. Vector Borne Diseases – Benefit

a) In-patient Hospitalization Benefit

We will pay Sum Insured in the manner as specified in the Schedule of Coverage to an Insured Person due to Medically Necessary Hospitalization (including In-patient care AYUSH Treatment in an AYUSH Hospital) of an Insured Person due to;

i) Dengue Fever
ii) Malaria
iii) Other Vector Borne Diseases:
    a. Chikungunya
    b. Japanese Encephalitis
    c. Kala-azar
    d. Lymphatic Filariasis
    e. Zika Virus

which is/are contracted during the Policy Period and as defined and opted under the Policy subject to waiting Period as specified on the Schedule of Coverage

b) Reinstatement of Sum Insured

We will add to the Sum Insured under Section 2a), an amount equivalent to the admissible Claim amount under Section 2a) of the Policy subject to maximum of Basic Sum Insured subject to following conditions;

a. Sum Insured reinstated under this cover can be used only for subsequent Hospitalization of the Insured Person during Policy Year and is not applicable for Hospitalization under Any One Illness
b. Any unutilized amount of Sum Insured reinstated cannot be carried over to next policy year

2.2) Optional Covers

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that, We will pay the expenses/Sum Insured under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and up to the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

a) Outpatient Treatment Expenses

We will pay Sum Insured towards expenses incurred on;

i. Outpatient Consultation with Medical Practitioner
ii. Diagnostic Tests
iii. Pharmacy

For Medically Necessary Treatment of diseases as opted under Section 2a)

Special Conditions applicable to Outpatient Treatment Expenses

If the Claim is payable under this Section and if the Insured Person is subsequently hospitalized with in 15 days for the same illness, entire Claim shall be admissible under Section 2a) only and Sum Insured is payable under Section 2a) only.

b) Recovery Benefit

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance if period of Hospitalization for Claim admissible under Section 2 a), exceeds 10 continuous days.

c) Time Deductible

On availing this option, Time Deductible as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applied on each and every admissible Claim under the Policy.

d) Waiting Period Options

On availing this option, Waiting Period will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance will be applicable for all the Claims under the Policy.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

e) Annual Aggregate days limit

On availing this option, the no of annual aggregate days limit will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of Insurance

f) ICU multiplier

On availing this option the benefit will be modified as mentioned on the Schedule of Coverage in the Policy Schedule/Certificate of insurance, if the Insured Person is hospitalization in ICU.

Section B – my: Health Active

The services listed below are available to all Insured Person through Our Network Provider on Our **HDFC ERGO Mobile App** only.

i. **Health Coach:**

An Insured Person will have access to Health Coaching services in areas as given below:

- Disease management
- Activity and fitness
- Nutrition
- Weight management.

These services will be available through **Our HDFC ERGO Mobile App** as a chat service or as a call back facility.

ii. **Wellness services**

- **Discounts:** on OPD, Pharmaceuticals, pharmacy, diagnostic centers.
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs:** stress management, Pregnancy Care, Work life balance management.

Disclaimer applicable to HDFC ERGO Mobile App and associated services

It is agreed and understood that Our **HDFC ERGO Mobile App** and Wellness services are not providing and shall not be deemed to be providing any Medical Advice, they shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this benefit.

Section C – Waiting Periods and Exclusions applicable to Section 1 & 2

We will not make any payment for any claim in respect of the Insured Person, caused by, arising from or attributable to any of the following unless expressly stated to the contrary in this Policy;

i) **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.

ii) **Investigation & Evaluation: Code – Excl04**
a) Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

iii) **Rest Cure, rehabilitation and respite care–Code – Excl05:** 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 physical, social, emotional and spiritual needs.

iv) **Unproven Treatments: Code – Excl16 –** Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

v) Any treatment taken on Outpatient

vi) Hospitalization for treatment under any system other than allopathy.

vii) Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

Following additional exclusions shall apply under Section 1

i) Charges related to a Hospital stay not expressly mentioned as being covered.
ii) **Non-Medical expenses** such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges etc. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.
iii) 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. **Code – Excl14**

Conditions

1. Entry Age:

Proposer	Dependent
Minimum Entry Age – 18 Years	Minimum Entry Age – 91 day
Maximum Entry Age – 65 yrs	Maximum Entry Age - 65 yrs

2. Type of Policy:

- Benefit basis (lump sum or per day)
- Indemnity basis

3. Sum Insured Type

- For Indemnity: Individual/ Floater
- For Benefit (lump sum): Individual
- For Benefit (per day): Individual/ Floater

4. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the **Insured Person** or by his agent or the hospital/doctor/any other party acting on behalf of the **Insured Person**, with intent to deceive the Insurer or to induce the Insurer to issue an insurance Policy:

a) the suggestion, as a fact of that which is not true and which the **Insured Person** does not believe to be true;
b) the active concealment of a fact by the **Insured Person** having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

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

5. Non-Disclosure or Misrepresentation

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

a) cancelled ab initio from the inception date or the **Renewal** date (as the case may be), or the Policy may be modified by Us at **Our** sole discretion, upon 15-day notice by sending an endorsement to **Your** address shown in the Schedule and
b) the claim under such Policy if any, shall be prejudiced.

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

a) Permanently exclude the disease/condition and continue with the Policy
b) Incorporate additional waiting period of not exceeding 3 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.
c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

The above options will not prejudice the rights of the Company to invoke cancellation under clause 5 i above.

6. Disclosure of Information

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any **Material Fact** by the Policyholder.

7. 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.

8. 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.

9. Multiple Policies (Applicable to Section 1)

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 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 **Insured Person** shall have the right to choose insurer from whom he/she wants to claim the balance amount.
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 be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

10. 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.

11. 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 at least 30 days before the policy **Renewal** date as per IRDAI guidelines on **Migration**. 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 in waiting periods as per IRDAI guidelines on **Migration**.

12. 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 30 days before, but not earlier than 60 days from the **Policy** renewal date as per IRDAI guidelines related to **Portability**. 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 in waiting periods as per IRDAI guidelines on **Portability**.

13. Coverage for Dependents

- **Individual Sum Insured Option:** Self, Spouse, Dependent Children, Dependant Parents/in laws ,Grand Mother Grand Father ,Grand Son ,Grand Daughter ,Daughter in Law, Son in law, Sister, Brother ,Sister in law ,Brother in law, Nephew ,Niece
- **Floater Sum insured option: Self, Spouse, Dependent Children, Dependent Parents/in laws**

14. Sum Insured Options

1. For Indemnity
    - 30,000
    - 50,000
    - 75,000
    - 100,000
    - 200,000
    - 250,000
    - 300,000
    - 400,000
    - 500,000
2. For Benefit (lump sum) – Rs 1000 to Rs 100,000
3. For Benefit (per day) – Rs. 1000 per day to Rs 10,000 Per day

15. Pre Policy Check ups

Pre policy checkup is not required.

16. Grace Period

i) A Grace Period of 30 days for Renewals is permissible and the Policy will be considered as continuous for the purpose of all waiting periods. However, we shall not be liable for any treatment availed for an Illness or Accident during the Grace Period

ii) For Renewals received after completion of 30 days Grace Period, the policy would be considered as a fresh policy and all Waiting Periods including those mentioned under Section E will start afresh. All the Renewal benefits earned on the previous Policy will lapse.

Section. 2 If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

i)

ii) All eligible claims reported in the installment grace period would be payable if otherwise admissible as per terms and conditions of the policy

iii) For Policies on instalment basis, Grace Period is available as given below.

Installment Premium Option	Grace Period applicable
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

17. Sum Insured Enhancement:

The Insured Person member can apply for enhancement of Sum Insured at the time of renewal. The acceptance of enhancement of Sum Insured would be based on the health condition of the Insured Persons& claim history of the policy.

18. Renewal

A 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 conditions stated under Moratorium clause.

i. Renewal of a health insurance policy shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policies.

ii. The company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

iii. No loading shall apply on renewals based on individual claims experience

iv. The Company shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the Policyholder, the Insurer may underwrite only to the extent of increased sum insured.
v. Renewal premium due can be paid prior to the due date as per norms set out by the Company.

1.1. Free look Period

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

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

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to:
a. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
b. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

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

19. Cancellation

a. The Policyholder may cancel this Policy by giving 7 days' written notice and in such an event, the Company shall refund to the Insured a pro-rata premium for the unexpired Policy Period.

Note : For Policies where premium is paid by instalment : In case of admissible claim under the Policy, future instalment for the current Policy Year will be adjusted in the claim amount and no refund of any premium will be applicable during the Policy Year

b. The Company may cancel the Policy at any time on grounds of established fraud or non-disclosure or misrepresentation by the Insured Person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of established fraud or non-disclosure or misrepresentation.

c. Refund of Policy premium in case of death of Insured Person/s: Policy premium shall be refunded proportionately for the deceased Insured Person, for the unexpired Policy Period in case of death of any Insured Person/s.

d. Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or any benefit has been availed by the Insured Person under the Policy.

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20. Premium Payment in Installments

If the **Insured Person** has opted for Payment of Premium on an installment basis i.e. 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)

i. **Grace Period** as mentioned in the table below would be given to pay the installment premium due for the **Policy**.

Options	Installment Premium Option	Grace Period
Option 1	Half Yearly	30 days
Option 2	Quarterly	30 days
Option 3	Monthly	15 days

ii. If premium is paid in instalments then coverage will be available during the grace period also. (Note: In case of non-instalment premium payment, coverage shall not be available for the period for which no premium is received).

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 installment premium is not paid on due date.

v. In case of installment premium due not received within the **Grace Period**, the **Policy** will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The **Company** has the right to recover and deduct all the pending installments from the claim amount due under the **Policy**.

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

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The **Insured Person** shall be notified three months before the changes are effected.

22. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the **Company** will intimate the **Insured Person** about the same 90 days prior to expiry of the Policy.

ii. **Insured Person** will have the option to migrate to similar health insurance product available with the Company at the time of **Renewal** with all the accrued continuity benefits such as waiver of Waiting Period as per IRDAI guidelines, provided the policy has been maintained without a break.

23. Nomination

The **Policyholder** is required at the inception of the **Policy** to make a nomination for the purpose of payment of claims under the policy in the event of death of the **Policyholder**. Any change of nomination shall be communicated to the **Company** in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the **Policyholder**, the Company will pay the nominee {as named in the **Policy Schedule**/Certificate of Insurance/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.

24. Claim Settlement (Provision for Penal Interest)

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ii. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of intimation.
iii. In 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 intimation to the date of payment of claim at a rate 2% above the bank rate..
iv. If requested by **Us** and at **Our** cost, the **Insured Person** must submit to medical examination by **Our Medical Practitioner** as often as **We** consider reasonable and necessary and **We/Our** representatives must be permitted to inspect the medical and Hospitalization records pertaining to the treatment of **Insured Person** and to investigate the circumstances pertaining to the claim.
v. **We** and **Our** representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim

25. Additional Benefits

Income Tax Benefit as per Sec 80 D of the IT Act on the premiums paid for this policy,

Section F – Claims Procedure

On the occurrence of any Vetor Borne Diseases that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.

Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website
Claim Intimation Timelines	Within 14 days of the diagnosis of Vector Borne Diseases
Particulars to be provided to Us for Claim notification	1. Policy Number, 2. Name of the Insured Person(s) named in the Policy schedule/Certificate of Insurance availing treatment, 3. Nature of disease/illness/injury, 4. Name and address of the attending Medical Practitioner/Hospital 5. Date and time of event if applicable 6. Date of admission
Claims documents for Vector Borne Diseases	1. Claim Form duly signed by the Insured Person; 2. Copy of Discharge Summary / Discharge Certificate; 3. First consultation letter from treating Medical Practitioner 4. Medical certificate confirming diagnosis, and the treatment of Vector Borne Diseases from Medical Practitioner 5. Certificate from treating Medical Practitioner, specifying the duration and etiology 6. All pathological Investigation Report. We may require the Insured Person to undergo medical examination by Medical Practitioner authorized by Us to obtain an independent medical opinion for the processing of the claim. Any cost towards such a medical examination will be borne by Us. 7. NEFT details & cancelled cheque 8. All original medicine / pharmacy bills along with prescription by Medical Practitioner
Claims documents for Outpatient Treatment due to Vector Borne Diseases	1. All original consultation/diagnostic/pharmacy bills along with prescription by Medical Practitioner
Conditions for obtaining Cashless facility for Vector Borne Diseases	1. Cashless facility can be availed only at Our Network Provider. The complete list of Network Providers and Empaneled Service Providers is available on Our website and can be obtained by contacting Us. 2. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of Network Providers before applying for Cashless Claim. 3. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital

	and locations match with the details as per Cashless authorized. 4. We will make payment for the Cashless authorized amount directly to the Network Provider 5. Applicable for Section 2 – In case the hospital bill amount is lower than the payable benefit, We will directly pay You the difference between the benefit payable and the hospital bill amount. However, if the hospital bill amount is higher than the payable benefit, You will be require to settle the balance hospital bill on Your own. Conditions for Health Care at Home On receipt of duly filled pre authorization form with other sufficient details to assess the request, We will inform our Home Healthcare service provider who will follow the following process: i. Meet the treating medical practitioner and verify the requirement along with the prescription/discharge summary (if applicable) and the condition of the patient ii. Verify the past medical history of the patient iii. Complete physical examination of the patient iv. Check if the patient requires any equipment, devices etc v. Share the care plan and treatment cost estimation with Us. On receipt of the complete documents We may; i. issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable OR ii. reject the request for pre-authorization specifying reasons for the rejection. On rejection of Pre-Authorization under Home Healthcare, Claim procedure under Cashless treatment or Reimbursement may be followed.
Claims documents submission	In case of any Claim for the Insured Events, the list of documents as mentioned above shall be provided by the Policy Holder/ Insured Person, immediately but not later than 30 days of date of occurrence of an Insured Event, at own expense to avail the Claim
Condonation of delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

26. Section 41 of Insurance Act 1938 (Prohibition of Rebates):

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or
renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of premium shown on the policy, nor

shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the prospectus or tables of the insurers.

2. Any person making default in complying with the provision of this section shall be punishable with fine which may extend to Ten Lakh Rupees.

IRDAI Regulation no 5- This policy is subject to regulation 5 of IRDAI (Protection of Policyholder's Interests) Regulation

1.2. Redressal of Grievance

In case of any grievance the insured person may contact the Company through:

- Website: www.hdfcergo.com
- Contact us: 022 6234 6234 / 0120 6234 6234
- E-mail: grievance@hdfcergo.com
- Contact Details for Senior Citizen: 022 – 6242 – 6226
- E-mail specific for Senior citizens : seniorcitizen@hdfcergo.com

Insured Person may also approach the grievance cell at any of the Company's branches with the details of grievance.
If Insured Person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at cgo@hdfcergo.com

For updated details of grievance officer, kindly refer the link: https://www.hdfcergo.com/customer-voice/grievances

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contact us at	https://www.hdfcergo.com/customer-care/grievances Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - : 022 6234 6234 / 0120 6234 6234
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call - : 022 6242 6226 Email id: seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - : 022 6242 6226 Email id: seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - : 022 6242 6226 Email id: seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
Visit us	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd., D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West) Mumbai-400078	The Chief Grievance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

If Insured Person is not satisfied with the redressal of grievance through above methods**,** the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://bimabharosa.irdai.gov.in/

DISCLAIMER: THE ABOVE IS DESCRIPTIVE ONLY. THE ACTUAL TERMS AND CONDITIONS CAN BE FOUND IN THE POLICY DOCUMENT. INSURED'S ARE ADVISED TO READ THE POLICY DOCUMENT COMPLETELY FOR A FULL DESCRIPTION OF THE TERMS AND CONDITIONS OF COVERAGE AND THE EXCLUSIONS RELATING THERETO.

Insurance is the subject matter of solicitation

Plans:

Vector Borne Diseases Covered	Comprehensive Plan - Indemnity	Comprehensive Plan - Benefit - Lump Sum Insured	Comprehensive Plan - Benefit Per day Sum Insured
Dengue	Y	Y	Y
Malaria	Y	Y	Y
Chikungunya	Y	Y	Y
Japanese Encephalitis	Y	Y	Y
Kala Azar	Y	Y	Y
Lymphatic Filariasis	Y	Y	Y
Zika	Y	Y	Y
Inbuilt Covers			
In Patient Hospitalization Expenses	Y	Y	Y
Health Care at Home	Y	-	-
Reinstatement of Sum Insured	Y	Y	Y
Pre and Post Hospitalization Cover	Y	-	-
Other Options and Covers			
Outpatient Treatment	Y	Y	Y
Recovery Benefit	Y	Y	Y
Waiting Period Options	Y	Y	Y
Co-payment	Y	-	-
Time Deductible	-	Y	Y
ICU Multiplier	-	-	Y
My : Health Active	Y	Y	Y

Vector Borne Diseases Covered	Dengue Plan - Indemnity	Dengue Plan - Benefit	Dengue Plan - Benefit

		Lump Sum Insured	Per day Sum Insured
Dengue	Y	Y	Y
Inbuilt Covers			
In Patient Hospitalization Expenses	Y	Y	Y
Health Care at Home	Y	-	-
Reinstatement of Sum Insured	Y	Y	Y
Pre and Post Hospitalization Cover	Y	-	-
Optional Covers			
Outpatient Treatment	Y	Y	Y
Recovery Benefit	Y	Y	Y
Waiting Period Options	Y	Y	Y
Co-payment	Y	-	-
Time Deductible	-	-	Y
ICU Multiplier	-	-	Y
My : Health Active	Y	Y	Y

Vector Borne Diseases Covered	**Malaria Plan - Indemnity**	**Malaria Plan- Benefit Lump Sum Insured**	**Malaria Plan - Benefit - Per day Sum Insured**
Malaria	Y	Y	Y
Inbuilt Covers			
In Patient Hospitalization Expenses	Y	Y	Y
Health Care at Home	Y	-	-
Reinstatement of Sum Insured	Y	Y	Y
Pre and Post Hospitalization Cover	Y	-	-

Optional Covers			
Outpatient Treatment	Y	Y	Y
Recovery Benefit	Y	Y	Y
Waiting Period Options	Y	Y	Y
Copayment	Y	-	-
Time Deductible	-	Y	Y
ICU Multiplier	-	-	Y
My : Health Active	Y	Y	Y

Optional Covers

Optional Covers For Sum Insured On Indemnity Basis	
Outpatient Treatment	50% of the Sum Insured, subject to maximum of Rs. 5,000
Recovery Benefit	Rs. 20,000
Co- payment Options	5%, 10%,15%, 20%,25%
Waiting Period Options	7 days ,15 days

Optional Covers For Sum Insured On Benefit Basis – Lump sum Payout	
Outpatient Treatment	50% of the Sum Insured, subject to maximum of Rs. 5,000
Recovery Benefit	Rs. 20,000
Waiting Period Options	7 days ,15 days
Time Deductible Options	1 day, 2 days

Optional Covers For Sum Insured On Benefit Basis – Per day Payout	
Recovery Benefit	Rs. 20,000
Waiting Period	7 days ,15 days

Time Deductible Options	1 day, 2 days
Annual Aggregate Days limits options	10,15,25,30 days
ICU Multiplier	1x, 2x, 3x, 4x, 5x

Annexure I - List of Non-Medical Expenses

S. No.	Item	S. No.	Item
1	BABY FOOD	35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
2	BABY UTILITIES CHARGES	36	SPACER
3	BEAUTY SERVICES	37	SPIROMETRE
4	BELTS/ BRACES	38	NEBULIZER KIT
5	BUDS	39	STEAM INHALER
6	COLD PACK/HOT PACK	40	ARMSLING
7	CARRY BAGS	41	THERMOMETER
8	EMAIL / INTERNET CHARGES	42	CERVICAL COLLAR
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)	43	SPLINT
10	LEGGINGS	44	DIABETIC FOOT WEAR
11	LAUNDRY CHARGES	45	KNEE BRACES (LONG/ SHORT/ HINGED)
12	MINERAL WATER	46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
13	SANITARY PAD	47	LUMBO SACRAL BELT
14	TELEPHONE CHARGES	48	NIMBUS BED OR WATER OR AIR BED CHARGES
15	GUEST SERVICES	49	AMBULANCE COLLAR
16	CREPE BANDAGE	50	AMBULANCE EQUIPMENT
17	DIAPER OF ANY TYPE	51	ABDOMINAL BINDER
18	EYELET COLLAR	52	PRIVATE NURSES CHARGES-SPECIAL NURSING CHARGES
19	SLINGS	53	SUGAR FREE TABLETS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)

21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	55	ECG ELECTRODES
22	TELEVISION CHARGES	56	GLOVES
23	SURCHARGES	57	NEBULISATION KIT
24	ATTENDANT CHARGES	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	59	KIDNEY TRAY
26	BIRTH CERTIFICATE	60	MASK
27	CERTIFICATE CHARGES	61	OUNCE GLASS
28	COURIER CHARGES	62	OXYGEN MASK
29	CONVEYANCE CHARGES	63	PELVIC TRACTION BELT
30	MEDICAL CERTIFICATE	64	PAN CAN
31	MEDICAL RECORDS	65	TROLLY COVER
32	PHOTOCOPIES CHARGES	66	UROMETER, URINE JUG
33	MORTUARY CHARGES	67	AMBULANCE
34	WALKING AIDS CHARGES	68	VASOFIX SAFETY